Tools to assist in the implementation of Extended Scope Practice Allied Health Roles Starter Pack
FOREWORD

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Since 2005 the ACT Health Directorate has had a keen interested in extended scope practice for Allied Health to explore new and novel models of care. This work has been undertaken in collaboration with the International Centre for Allied Health Evidence at the University of South Australia. This partnership has ensured that this work has academic rigour, whilst at all times focussing on health care delivery and patient-centred care.

This tool pack includes documents to assist other healthcare providers/institutions introduce extended scope practice roles, highlighting the requirements as well as the potential pitfalls. The aim of this pack is to ensure that efficient workforce redesign principles are employed at other sites and that these principles are underpinned in evidence-based practice and research.

The work included in this pack has been developed under the guidance of a committed and hardworking team whose ethos is innovative and patient-focused care. The team includes Doctors, Allied Health, Educators, Academics, Nurses, Managers and Executives, this work would not have been possible without them.

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DRAFT EVALUATION FOR EXTENDED SCOPE OF PHYSIOTHERAPY ROLES  

EXTENDED SCOPE PHYSIOTHERAPY PRESENTATION  

RISK MANAGEMENT STRATEGIES  

CONCEPT EVALUATION REPORT  

DEFINITIONS OF CLINICAL LEADERSHIP IN ALLIED HEALTH  

DUTY STATEMENT AND SELECTION CRITERIA LITERATURE REVIEW AND DEVELOPMENT
SECTION 1: EVALUATING AN ALLIED HEALTH PROJECT

Evaluating an allied health project

A step-by-step guide to a Best Practice evaluation

Content of guide

1. Introduction to allied health projects
2. The role of evaluation
3. Planning the evaluation
4. Designing the evaluation
5. Implementing the evaluation
6. Reporting evaluation findings
Section 1: Evaluating an Allied Health Project

Users of the guide

- Designed for allied health personnel
  - Clinicians
  - Project managers
  - Clinical managers
  - Policy makers
  - Students
  - Academics

Project Evaluation

The Project

- Title
- Aims
- Participants
- Methods
- Desired outcomes
  etc
The PDSA cycle

Plan
• Objectives and aims of the project
• Operationalise the project (who, what, where and when)

Do
• Operationalise the plan
• Document processes and outcomes
• Data collection

Study
• Study the results
• Compare data to predictions and expectations
• Summarise what was learned

Act
• Reflect on current learnings
• What changes are to be made based on current learnings
• Prepare for the next cycle with any changes

Choosing evaluation measures

• Deciding on what measures are most useful is one of the most critical aspects of setting up an evaluation
• To demonstrate change, you need a baseline (comparison) measure and at least one subsequent measure (to look at the difference between them)
• You also need to recognise that other measures might emerge through your evaluation (the PDSA cycle at work)
• You may want to think in terms of Key Performance Indicators (KPIs) which reflect key measurable outcomes (More about this in later modules)
Module 1

Introduction to Allied Health projects

Step 1 in the guide to a Best Practice evaluation

Aims of Module 1

• This module encourages evaluators to
  – Consider allied health, its diversity and varied roles and responsibilities
  – Identify stakeholders whose views need to considered
  – Reflect on what is actually being undertaken in the project, and how this could be measured
  – Reflect on the best utilisation of available networks
Navigation panel Module 1

1. The Intricacies of Allied Health
2. Project aims
3. Interventions (what does the project actually do)?
4. Stakeholders and Networks
5. The project and its design
6. Project measures
7. Checklist for Module 1

The intricacies of Allied Health
What is allied health?

- **Allied health** is an ‘umbrella’ term which encompasses a range of health disciplines
  - Historically they are loosely connected disciplines which are
    - Not medicine or nursing, and are often
    - Environment- or organisation-specific
- **Allied health disciplines** undertake a range of tasks
  - Risk screening
  - Assessment
  - Diagnosis
  - Education
  - Counseling
  - Organisation
  - Treatment planning and delivery
  - Prescription and manufacture
Allied health

• Allied, Scientific and Complementary Health (Turnbull et al 2009)
• Defining the role of the allied health providers in your project is one of the early steps in setting up an evaluation

Consider these issues

1. Which allied health disciplines are directly involved in **rolling out the project** for which you are designing the evaluation?

2. Which allied health disciplines are **indirectly involved in the project?** (how?)

3. Are there any other allied health networks, and other health disciplines which are important to the roll-out of the project, and its evaluation?
Project Aims

What is the project intended to do?

- A project should always have clearly spelt-out intentions that are widely understood
- Different words can be used to describe project intentions (aims, objectives, goals, purpose etc)

- What is the project intending to do?
- How is it going to do this?
Interventions

- In allied health, the intent of a project is often to test the effectiveness (or impact) of an intervention

  *Intervention* is a loose term. It could be a new treatment, or a new way of organising or conducting parts of a service, or it could be a marketing drive for new patients

- Any *intervention* usually involves the integration of different allied health tasks which need to be defined and actioned
  - This brings issues of reliability and standardisation

Interventions

- Before a project is implemented, the intervention needs to be carefully considered, described and debated

- There will be different elements to any intervention, for instance
  - Who will deliver it?
  - How will it be delivered?
  - What resources are required for its delivery?
  - How long will it be delivered?
Consider these issues

1. What allied health tasks are involved in the *intervention* being tested in the project?
2. Is there a common understanding of the *intervention* and the tasks entailed in it?
3. Is there a common understanding of why this *intervention* is being tested (and not some other approach)?

Consider these issues

**Standardisation & generalisability**

4. Is there a required level of skill in conducting the *intervention*? If one person is providing the *intervention*, the question is
   – Would others do it the same way?
5. If two or more people are providing the *intervention*, the question could be
   – Are they doing it the same way?
Stakeholders and Networks

Stakeholders

• Which groups are involved in, or likely to be influenced by, the project?
• Stakeholders usually involve
  – Consumers (patients, their families)
  – Funders (patients if they are paying directly, insurance companies, hospitals, Government)
  – Allied health disciplines/ providers
  – Medical & nursing personnel involved in referral, or multidisciplinary team management
  – Health sectors (hospital, community services etc)
Networks

• Successful projects (and their evaluations) require active and supportive networks
• Define the networks that the project (and your evaluation) will require as early as possible
  Develop the network early
  Nurture your network throughout the evaluation
  Often it is the network that underpins successful project completion & supports a comprehensive evaluation

Networks

• Engage representatives of the network and the stakeholders in a Project Reference Group to steer the evaluation
  — Ensure that you recruit an experienced independent chairperson to steer the discussions
• Establish simple Terms of Reference
• Provide regular feedback to this group and ask members for help and advice whenever required
  Don’t ‘go it alone’
Consider these issues

1. Identify all possible stakeholders in the project, and how they might be involved
2. Consider what they might need to know about the project
3. Think about how (and when) these things could be measured in the evaluation
4. Consider who should be on your Project Reference Group and why?
5. Consider the your terms of reference that can assist this committee to be most help to you

The project and its design
Key considerations in any project

- What is the new concept (intervention) being tested?
- Are you clear on
  - Who did what previously?
  - What were the past practices?
  - What data is available on past practices?
  - Whether there is a need for the new concept?
  - What is the desired outcome of the new concept?
  - Is it likely to be sustainable?
- Is believable historical service use data available?
  - Are previous incidents or complaints well documented?
  - How was service use measured?
  - Is relevant cost data available?
- Is believable patient health outcome data available?
  - What was measured?
  - In what form was it measured?

The Project

- Establish a clear need for this project
  - Read the background literature
- Establish clear aims of the project
  - What does it actually intend to achieve?
- Identify who is going to be involved in the project?
  - Stakeholders, subjects/patients, allied health personnel etc
  - Map personnel and responsibilities
- Is there a budget?
  - Who is responsible for tracking the budget and being accountable for expenditure?
The Project

- Are there plans to continue the project idea after the project budget is exhausted?
  - How could the project be sustainable?
  - By what steps will the project be implemented?
  - What project measures will be taken, and at what stages throughout the project?
  - How will the measures be taken?
    - Retrieved from other data sources post hoc, taken objectively by project staff throughout the project etc.
  - In what form will the measurements be provided?
    - Hard copy, electronic etc.

Consider these issues

1. Consider available ‘historical’ data in the light of how it will be used in the project
   a. Where will you get the data from?
   b. Who will supply it to you and in what form?
   c. Is it robust / believable?
   d. Can you access it readily or do you need assistance to do so?
   e. Do you understand it?
   f. Do you have to collect more data before the project can viably start?
Project measures

What do you already know about the history of local data collection? What do you know about the current situation?

Structural project measures

Structures
- Membership of the team, relationships between team members, roles of team members & how the team complement compares with literature findings
- Requirements for team training
- Communication mechanisms within the team
- Referral mechanisms to the team
- Information dissemination about the team
**Process project measures**

**Processes**
- Team members’ perspectives on team functionality and operations (*compared with previously*)
- Equity of patient access to the team
- Duplication of services within the team
- Gaps in service delivery within the team
- Record keeping reflecting team input and decision-making
- Patients’ perspectives on the team approach (*perhaps also compared with whatever happened previously*)?

**Outcome project measures**

**Outcomes**
- Measures of health change compared with baseline
- Measures of cost of service delivery compared with baseline
- Timeliness of referral (efficiencies)
- Change in waiting times (efficiencies)
- Actual budget expenditure vs estimated
Consider these issues

1. What measures could you use to demonstrate whether the project has achieved what it intended?
2. What measures are currently available for use as comparators?
3. What measures do you need to collect for the evaluation?
4. What is the best way of collecting them?

ACT Evaluators’ reference material

- ACT Scope Document template (link) may be useful for Checklist Questions 1, 2 and 8 (next slide)
- The ACT Stakeholder Register Template link (presented earlier) may be useful for Checklist Question 5 (next slide)
Section 1: Evaluating an Allied Health project

Checklist

1. Has the project been completely defined in terms of intent and timeframe? *i.e. does everyone involved with it understand what will happen?*
2. Have the project aims been completely clarified? *i.e. does everyone involved with it understand what will be achieved?*
3. Have all possible project measures been considered, related to project aims?
4. Has the project ‘intervention’ been clearly outlined in terms of allied health tasks and personnel?
5. Have project stakeholders and networks been
   – defined
   – engaged?
6. Is a supportive Project Reference Group in place?
7. Are the project and evaluation resources clear and committed?
8. Is the evaluation budget
   – defined
   – managed independently from the project?
9. What historical project measures are available? Are they believable?
10. What new project measures are feasible to collect?

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SECTION 2: THE ROLE OF EVALUATION

Module 2

The role of evaluation

Step 2 in a step-by-step guide to a
Best Practice evaluation

The role of evaluation

• Aims of this module are
  – Provide an overview of key elements of an evaluation
  – Highlight different theoretical perspectives which may underpin an evaluation
  – Outline potential threats to successful evaluation (risks, budget)
Navigation Panel

- Designing a good evaluation
- Theoretical models within which to consider the evaluation
- Individualising the evaluation theory
- Project and evaluation risks
- Checklist for Module 2
Designing a good evaluation

Elements of the evaluation

- Evaluations should be project-specific
- Being a project evaluator means:
  - Being independent of the project
  - Obtaining appropriate ethics approvals
  - Being able to unpick all relevant aspects of the project roll-out
  - Being open to collecting a range of information using a range of approaches
  - Defining & measuring key project elements
  - Providing interim reports
Elements of the evaluation

• Evaluation elements unpick project aims
  – There is no right or wrong approach to defining evaluation elements
  – The elements need to:
    • Directly relate to project aims
    • Be measurable
    • Be simple and useful to more than one stakeholder
    • Provide a complete picture of the project, via the evaluation

Consider these issues

1. If you are unsure, it might be appropriate at this point to revisit the project aims and the list of project measures that you identified during Module 1
   a. Is your evaluation approach still going to achieve its purpose?
   b. Do you have the right personnel engaged in the project, the evaluation and the Project Reference Group?
   c. Do you need to extend your networks?
Theoretical models within which to consider the evaluation

Unpicking the project aims

• Quality improvement models assist in
  – Unpicking project aims
  – Identifying relevant evaluation measures
  – Identifying what makes a successful project
A. Structure, Process, Outcome Model

Avis Donabedian (1980)

Section 2: Planning the evaluation

**B. Ishikawa (Fishbone) Charts**

Kaoru Ishikawa (1968)


Section 2: Planning the Evaluation

Cause and Effect Diagram

people  materials  measurements  Desired Outcome
machines  methods  environment

C. The Institute of Medicine Model

IOM (2000)

Kohn LT, Corrigan JM, Donaldson MS (2000): To Err is Human: Building a Safer Health System. Institute of Medicine (IOM)
tt://books.nap.edu/openbook.php?isbn=0309068371

Module 2: Slide 13

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Section 2: Planning the evaluation

Module 2: Slide 17

Identify and reduce unsafe practices
- Reduce risky environments
- Provide less harmful care

Improve efficiency in service delivery
- Reduces wastage
- Cost efficiency
- Accountability

Improve timeliness of health services
- Reduce waiting times
- Ensure timely management
- Aims of optimal outcomes

Change ineffective practices
- Use more effective treatments
- Screen patients more sensitively
- Improve outcomes in health care

Patient centred practices
- Recognises patients as active participants in health care
- Ensures partnership approach
- Optimal collaborative decision making
- Ownership of health care

Ensure equity of service
- Improves consistency of service
- Reduces variability
- Reduces bias in health care services

Quality health care

Individualising the evaluation theory

Consider each quality element

- Relevant to the project aims &
- Relevant to the evaluation
  - Not every element may be relevant to every evaluation
- **People**  **Equity**
- **Machines**  **Timeliness**
- **Methods**  **Effectiveness**
- **Measurements**  **Efficiency**
- **Materials**  **Safety**
- **Environment**  **Patient centeredness**
PDSA cycle

Plan
- Objectives and aims of the project
- Operationalise the project (who, what, where and when)

Do
- Operationalise the plan
- Document processes and outcomes
- Data collection

Study
- Study the results
- Compare data to predictions and expectations
- Summarise what was learned

Act
- Reflect on current learnings
- What changes are to be made based on current learnings
- Prepare for the next cycle with any changes

Consider these issues

1. Revisit the proposed evaluation measures ('outcomes') [ACT Health Scope Document Template link]
   a. Are your proposed measures still linked to the project aims?
      • If not, modify them NB It is OK to do this several times before you get it right!!! [ACT Health Scope Change Document Template link]
   b. Now, think about how each outcome could be measured using the simplest and most error-free approach
Section 2: Planning the evaluation

**Evaluation map**

**Project Evaluation**

- What?
- Why?
- How?
- Where?
- When?

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**The Project**

- Title
- Aims
- Participants
- Methods
- Outcomes
- Etc

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**Example of a evaluation data collection map**

- Collected within 6 weeks of enrolling the client
- Collected within 6 months of enrolling the client

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Consider these issues

1. What approaches will you use to evaluate whether the project met its aims?
2. Can you marry these with your proposed outcomes?
3. How will you collect data relative to these aims and outcomes?
4. Can you draft your evaluation map?
5. What will you do to minimise measurement error and slippage in data collection?
6. What resources do you require to measure the evaluation outcomes?

7. Do you have a data analysis plan?
   a. Consider the ways you might analyse your proposed data
   b. Do you need training to do this?
8. Do you know how you will report the findings?
9. How does your data analysis plan link up with the evaluation plan?
10. How does your data analysis plan address the project aims?
Project and Evaluation Risks

Risks

• In every project, and every evaluation, there are risks that things won’t go to plan
• Identifying potential risks early is essential to avoiding or at least managing them
• Many new projects are met unenthusiastically in the workplace
  – This can be an early risk to project failure unless you use this to your advantage
Budget

• Every project should have a carefully worked out budget, and the costs of evaluation should be built into it
  – The evaluation should take approx 10% of the project budget
• The entire budget, and the end-of-project reconciliation should be available to the evaluator
• Work out what is possible within the evaluation budget & stick to it

Budget

• Be careful when calculating your evaluation budget
• Staff costs should be calculated as gross wage (including oncosts and any loadings)
  – Talk to the accountant or pay roll personnel
• Build in proper costs for transcribing interviews/ focus groups, printing, mailing, data entry
• Double the estimated time for analysis and report writing
Consider these issues

1. What risks are there to your project being completed on time and as required?
2. What risks are there to the evaluation being conducted appropriately and congruently with the project?
3. What is the budget for the project?
   1. Is it sufficient for the project?
4. Is there the potential to sustain the project after the budget is exhausted?
5. Is the evaluation budget appropriate?
6. Are the required resources in place?

Checklist

1. Have you defined the important elements that underpin a successful evaluation of the project?
   - Think laterally across the three quality care models
   - List the elements relevant to your evaluation
2. Can each of these elements be measured?
3. How will you measure them?
   - There may be different ways in which they could be measured, think laterally
4. Do you know how you will analyse the data?
Planning the evaluation

Step 3 in a step-by-step guide to a Best Practice evaluation

• Aims of this module are
  – Outline processes and strategies to be put in place during planning an evaluation
  – Provide an overview of different types of research designs that may be suitable for evaluation
  – Highlight a range of evaluation measures that could be considered
  – An overview of timelines and reporting framework
Navigation panel Module 3

- Getting started
- Starting from a position of power
- Evaluation is research
- Choosing the evaluation design
- Single case N=1 studies
- Controlling for bias
- Upskilling
- Day-to-day planning
- Checklist for Module 3
Getting Started

How best should I go about the evaluation?

Current position
- The project plan is drafted
- The resources required to run the project are identified & in place
- The project tasks are clear
- The project aims relate to the evaluation outcomes
- A comprehensive Project Reference Group is established & reflects stakeholder and network representatives

Title
- Project aims
- Project participants
- Project methods
- Project outcome
Starting from a position of power

Have others done something similar?

- Review the literature
  - Peer reviewed literature
  - Government reports & other grey literature
  - Conference proceedings
- Talk to your network, and others in your organisation
- Can you use a background literature review and/or local stakeholder interviews to frame the evaluation?
Consider these issues

1. Has someone else reported something similar to your evaluation in the literature?
2. What skills do you need?
3. Are there particular issues in the evaluation that might incur ethics concerns?
4. How will you recruit your required number of subjects in the most robust manner?

Consider these issues

5. Can you construct your evaluation framework early, by listening to people talk about the project, and identifying the range of stakeholder perspectives about the project and its likely impact? **NB Early ‘gut feelings’ are important when it comes to available data, and the fit of project to environment**
Section 3: Planning the evaluation

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Evaluation is research

Module 3: Slide 12

Evaluation ‘Research’

- Evaluation is research
- Research etiquette is required no matter how small the evaluation
  - Evaluation design
  - Ethical considerations
    - Independent and separate from the project ethics approval
  - Subject recruitment
  - Subject numbers
Choosing the evaluation design *(understanding the underlying research approach)*

Evaluation is a form of research

- An evaluation is research
- Make sure you understand the research approach that you are going to take
- Descriptive research entails
  - Comprehensive measurement set to fully describe people, services, workloads
  - Description of differences between groups
- An experiment entails
  - Comparison between groups
  - Comparisons between before and after measures
**Descriptive research**

- **People**
  - Demographics
  - Perspectives
  - Experiences
  - Service use
  - Group effects for important subgroups
    - Do older people behave differently from younger people?
    - Do untrained assistants have more adverse event reports compared to trained assistants?

Every measure, and all uses of it, MUST link to the project aims.

- **Services**
  - Type
  - Efficiency
  - Effectiveness
  - Timeliness
  - User preferences (differences for important subgroups)
  - Costs
  - Opportunities for savings
  - Barriers / enablers to uptake

Every measure, and all uses of it MUST link to the project aims.
**Descriptive research**

- **Workload**
  - Tasks
  - Efficiency
  - Effectiveness
  - Training
  - Timeliness
  - Referral processes
  - Communication processes
  - Worker preferences
  - Costs
  - Opportunities for change
  - Barriers / enablers to change

Every measure, and all uses of it MUST link to the project aims.

**Experimental research**

- This research approach tests whether the project has changed any of the project measures
  - Pre – post measures for one group
  - Comparison of groups (historical processes vs new processes)

- Important to reflect on opportunities to maximise quality of study design
  - Subject selection
  - Allocation of intervention
  - Control of bias
Types of experimental evaluation approaches

- Specific application of an intervention
  - pre-post
  - straightforward comparative administration
  - cross-over designs
- Strategies to control bias
  - blinded / non-blinded
  - randomised / non-randomised
  - controlled / non-controlled

Intervention allocation

- Straightforward design
  - For only one group, the group receives intervention A only
    • a comparison between pre & post measures
  - For two groups, Group 1 receives intervention A only, Group 2 receives intervention B only
    • a comparison between responses to A or B
**Intervention allocation**

- Cross-over design
  - Group 1 receives intervention A followed by intervention B, Group 2 receives intervention B followed by intervention A
  - a comparison between responses to A and B

**Single case (N=1) studies**
Considering N=1 data

- Specific application of experimental theory to *one person (one site etc)*
  - Uses repeated baseline measures to establish variability
  - Allows for repeated post-intervention measures to establish variability
  - Provides an understanding of time effect
  - Allows investigation of repeated introduction & removal of interventions

Considering N=1 data

- Issues for N=1 data
  - Looking for relative mean effects compared with baseline
  - Looking for ‘drop-off’ effects or sustainability of effect
  - Looking for variability of effect
  - Looking at other issues:
    - Cost of intervention
    - Response of subject to intervention (did they like one better than another etc)
Section 3: Planning the evaluation

**Analysis for N=1 study**

Evaluation measures: Baseline 1, Intervention, Baseline 2

- Outcome measure
- Intervention
- Post intervention measures
- Baseline 1 measures
- Baseline 2 measures

Time period

Module 3: Slide 23

**Mixed methods**

Module 3: Slide 25
**Evaluation measures**

- Anticipate a complex story to explain the full ramifications of the evaluation
- Collect as much different data as possible to address project aims
- Embrace ‘mixed methods’ for data collection eg
  - Objective health data (eg BMI)
  - Objective service use data (occasions of service)
  - Subjective health data (pain, satisfaction)
  - Qualitative data (individual perspectives, enablers, barriers, patient-centeredness)
  - Costing data ($)

**Consider these issues**

1. What evaluation design(s) will you use?
2. What can you do to maximise study quality?
3. Will you use a ‘mixed methods’ approach for collecting evaluation data?
4. What data will you collect?
5. How does each data source address the project aims?
6. Has an evaluation plan and timeframe been determined?
Controlling for bias

- **Blinding (subject, therapist, measurer)** reduces measurement / expectation bias
  - Measurer blinding should be possible in an evaluation
- **Random selection of subjects** from the subjects receiving the intervention produces a representative sample
- **Consecutive sampling** over different time periods can also produce a representative sample
  - Either should be possible in an evaluation
- **Controlling** provides an uncontaminated baseline of natural effect (to compare with treatment effect)
  - This could be possible in an evaluation
Consort diagram

Assessed for eligibility (patients approached) (n=664)
(Patients approached during control phase (n=308), patients approached during intervention phase (n=356))

Excluded (n=147)
- Not meeting inclusion criteria (n=107)
- Refused to participate (n=20)
- Other reasons (n=18)

Included in study (n=517)

No Checklist (n=210)
- Removed allocation (n=209)

Lost to follow-up (n=122)
- Died (n=2)
- D/C Nursing home (n=18)
- D/C another hospital (n=8)
- Readmitted (n=18)
- Unable to contact by phone (n=22)
- Did not return questionnaire (n=22)
- Declined (n=19)

Data available for analysis (n=383)

Checklist (n=107)
- Removed allocation (n=68)

Lost to follow-up (n=42)
- Died (n=2)
- D/C Nursing home (n=5)
- D/C another hospital (n=4)
- Readmitted (n=13)
- Phone disconnected (n=1)
- Unable to contact by phone (n=4)
- Did not return questionnaire (n=12)
- Declined (n=1)

Data available for analysis (n=55)

Upskilling

- Make enough time to train yourself first
  - How many hours per week can you commit to the evaluation?
    - Do you have other calls on your time?
    - Can you get help?
    - Make Plans A, B and C
  - What skills do you need to complete the evaluation?
    - Library searching skills
    - Computer programs
    - Statistical analysis
    - Interviewing skills
    - Qualitative analysis
    - Writing up skills
  - Is there the opportunity for a trial run?
Consider these issues

1. By now you should have identified areas in which you, or your staff, might need some training to assist you to complete the evaluation without stress.
2. You should list the required training areas, and identify people/organisations/opportunities to obtain training.

Turning negatives into positives

- Many new projects are met unenthusiastically in the workplace.
- Good evaluators seek to identify why this happens:
  - Barriers to project roll out
  - Enablers/incentives to project roll out
- Turn negatives into positives:
  - Why are things happening this way?
  - What is required to influence change?
  - What can be learnt?
Section 3: Planning the evaluation

Day-to-day planning

Timelines & Evaluation Plan
Establish a reporting framework to deal with all data

• Develop a reporting format
• Obtain feedback from the Project Reference Group on it, and modify it early
• Undertake trial-run analysis on all types of data
• Identify time periods for interim reporting during project roll-out

Consider these issues

1. Design your evaluation report
   a) Think about how you will report on:
      – how you measured each aspect of your evaluation
      – How you analysed the data
      – your findings
   b) Will you need to write differently (provide different information) for different types of readers of your report (stakeholder perspectives)?
### Checklist

1. Has a comprehensive literature review been undertaken to identify what others have done in the past?
2. Has the planning had sufficient time?
3. Has the evaluation research approach been determined?
4. Will ethics approval be sought?
   - If No, why not?
   - If yes, from where will ethics approval be obtained?
5. Do you understand the historical and current local issues which might impact on the data that is available for the evaluation?
6. Do you understand the constraints on the available data?

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### Checklist

7. Have all potential data sources been identified?
8. Are appropriate supports / training / resources in place to collect data from all these sources?
9. Can data be collected throughout the evaluation period?
   - If not, what plans are in place for intermittent data collection?
10. Is there an agreed evaluation timeline?
11. Have risks to evaluation integrity been identified?
Module 4

Designing the evaluation

Step 4 in a step-by-step guide to a Best Practice evaluation

Designing the evaluation

- Aims of this module are
  - Provide an overview of evaluation measures
  - Recognise potential barriers to evaluation and strategies to overcome these barriers
  - Highlight processes to consider when operationalising an evaluation (such as rigour, timelines, communication, reporting)
Navigation panel Module 4

- Mapping the evaluation against the project
- How many subjects is enough?
- Timing the evaluation
- Addressing the barriers
- Learning on the job
- Getting value from the Project Reference Group
- Checklist for Module 4
Section 4: Designing the evaluation

Mapping the evaluation against the project

- Title
- Project aims
- Project participants
- Project methods
- Project outcome

Reconsider the evaluation methods and measures

- Are your chosen measures relevant to the project aims & relevant to the evaluation
- Do they measure important aspects of:
  - People
  - Machines
  - Methods
  - Measurements
  - Materials
  - Environment
  - Equity
  - Timeliness
  - Effectiveness
  - Efficiency
  - Safety
  - Patient centeredness
How many subjects is enough?

- This is the age-old question to which there is no simple answer in evaluation research.
- The answer to this question balances a statistically robust sample size calculation with:
  - Capacity to recruit subjects in the project time frame.
  - Historical subject numbers.
  - Likelihood that subjects will consent.
  - Variability between subjects in their response to the intervention.

Timing the evaluation

- Set up your evaluation timeline.
- Allow twice as much time as you think you need for analysis and reporting.
- Map out every evaluation measure and when you will take it, against the timeline.
- Map out the methods of data capture:
  - Record audit, objective measurement, interview/focus groups, survey, extraction of automatically captured data etc.
Learning on the job

- The more information you can capture before the project is implemented, the better your evaluation will be.
- Often it is impossible to know how important a data source will be until you collect it.
  - Data sources may not be as valuable as you thought, either!!
- Don’t skimp on learning as much as you can, using any data collection method available.

Timelines & Evaluation Plan

Example Gantt Chart showing key dependencies in a recruitment process.
Research etiquette

• Revisit your evaluation design and make sure that you have covered all research etiquette bases
  • Explain the research design(s) you are using in the evaluation
  • Ethics requirements
  • Subject recruitment and your consort diagram
• Make sure you have a reporting framework in place (revisit Module 3 for information on this)

Consider these issues

1. Against your timeline, list
   a. Every evaluation measure you will take
   b. The sources of data for these measures
   c. When you will take each measure *(most will be taken more than once during the evaluation)*
   d. What data collection methods you will use
   e. How long it will take you to collect each measure
   f. How you will analyse each measure
Consider these issues

2. Make sure your reporting framework allows you to:
   a. Address the project aims and evaluation questions
   b. Take account of all your data
   c. Link data to the evaluation questions, which should in turn address the project aims

Getting value from the Project Reference Group

- Meet with the Project Reference Group as early as possible (preferably before the project rolls out)
- Obtain feedback from the Project Reference Group on the final evaluation approach
- Engage its help to undertake a trial-run data collection (even a virtual one)
- Make early contact with all stakeholder groups to ensure their participation in the evaluation
  - The Project Reference Group can help with this
ACT Evaluators’ reference material

- ACT Health Progress Report Template link might be useful to assist when constructing interim reports on evaluation progress (addressing all questions in the Checklist)
- ACT Health Risk Report Template link (might be useful for Checklist Questions 9 and 10)

Checklist

1. Do you have a working trialled evaluation design?
2. Have you engaged all stakeholder groups?
3. Have you received permission from all stakeholders to participate in the evaluation?
4. Do you have ethics approvals in place?
5. Do you have a trialled data collection approach in place?
6. Do you have a draft analysis and reporting framework?
7. Is your Project Reference Group in place?
8. Is it supportive of the evaluation plan?
9. Have you identified barriers to the project and addressed them in the evaluation?
Checklist

10. Have you identified risks to the evaluation and addressed them?
11. Do you have details of the project budget?
12. Do you have access to the project budget reconciliation?
13. Do you have an evaluation budget in place?
14. Does the budget match the evaluation requirements?
   • If not, make last minute modifications
15. Do you have an evaluation timeline in place, listing data collection, analysis and reporting phases?
Module 5

Implementing the evaluation

Step 5 in a step-by-step guide to a Best Practice evaluation

Implementing the evaluation

- Aims of this module are
  - Provide an overview of key issues during operationalising the evaluation
  - Outline examples of baseline evaluation measures
  - Highlight data organisation strategies and checklist
  - Managing your evaluation to meet time and reporting requirements
  - Highlight opportunities for ongoing learning and refinement
Navigation Panel Module 5

- Implementing the evaluation
- Baseline evaluation measures
- Data organisation
- Timelines & Evaluation Plan
- Making the PDSA cycle work for you
- Interim meetings with the Project Reference Group
- Checklist for Module 5
Implementing the evaluation

Baseline evaluation measures

- People
- Machines
- Methods
- Measurements
- Materials
- Environment

Equity
Timeliness
Effectiveness
Efficiency
Safety
Patient centeredness
Data organisation

- The key to a low stress evaluation program is good preliminary planning and organisation
- Set up data collection processes ahead of time
  - Make appointments to speak to people
  - Get to know the people who will be extracting routine health service delivery data
- Use labour saving devices
  - Digital data recorders, video cameras
  - Electronic data downloads

Data organisation

- Organise your files using a simple system
- Multiple pieces of data can be confusing
  - Use a data map
  - Save & date data electronically (if possible) using separate folders
  - Check off evaluation data against the timeline
- Save hard data in clearly marked folders
  - Consent forms
  - Survey responses
Data checklist

Keep an accurate & dated record of what data you collect at each time period. Make sure you check the integrity of all the data you receive as soon as possible.

If there are any errors, or missing data, you can address them at the time. It is much harder to address errors or missing data later. This also may indicate problems with data collection processes which should be addressed now.
**Timelines & Evaluation Plan**

<table>
<thead>
<tr>
<th>ID</th>
<th>Task Name</th>
<th>Duration</th>
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<th>Finish</th>
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<td>8</td>
<td>Peer review</td>
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**Making the PDSA cycle work for you**

**Plan**
- Objectives and aims of the project
- Operationalise the project (who, what, where and when)

**Do**
- Operationalise the plan
- Document processes and outcomes
- Data collection

**Study**
- Study the results
- Compare data to predictions and expectations
- Summarise what was learned

**Act**
- Reflect on current learnings
- What changes are to be made based on current learnings
- Prepare for the next cycle with any changes
Interim meetings with the Project Reference Group

- At each interim meeting with the Project Reference Group, provide a 1 page report
  - An update on data collection (use your data checklist) linked to project aims
  - Identify problems that need to be dealt with
    - Ask for Project Reference Group assistance if required
  - Outline modifications to data collection
  - Describe interim findings / trends etc

ACT Evaluators’ reference material

- ACT Health Progress Report Template link might be useful to assist when constructing interim reports on evaluation progress (addressing Checklist Question 1)
- ACT Health Risk Report Template link (might be useful for Checklist Question 4)
- ACT Health Issues Register Template link (might be useful for Checklist Question 5)
Checklist

1. Is the evaluation running to plan?
2. Is the evaluation achieving what it intended?
3. Does the evaluation data address the project aims?
4. Are untoward events occurring?
5. Can they be explained?
6. Are project staff and the project reference group being informed of interim evaluation findings, as appropriate?
Reporting on the evaluation

Aims of this module are to

- Highlight key strategies in final reporting of an evaluation
- Outline the pragmatics of final reporting (such as purpose, style, format)
- Provide communication and dissemination strategies to key stakeholders
Navigation Panel Module 6

- The evaluation report
- Reporting the findings
- Checklist for reporting on project structures
- Checklist for reporting on project processes
- Checklist for reporting on project ‘outcomes’
- Modifying the report
- Disseminating the findings
- Checklist for Module 6
The evaluation report

Project evaluation

Did the project achieve what it set out to do?

Project purpose
Project aims
Project participants
Project methods
Project outcome

Using evaluation measures

- People
- Machines
- Methods
- Measurements
- Materials
- Environment

Equity
Timeliness
Effectiveness
Efficiency
Safety
Patient centeredness
The Evaluation Report

- No ‘one size fits all’ reporting style
  - Each evaluation is different
- The report should be shaped around the project aims and how best to answer them
- Who will be reading the written report?
  - Make sure that it is written for its readers
  - You may need to provide different versions of the same information for different readers
    - 1 / 3 / 25 approach?

Purpose of the evaluation report

- To report on the project aims using the chosen evaluation measures
  - To consider whether the project aims were met by the project roll-out
- To correlate the project measures to tell a story about the project impact and roll-out
- To provide recommendations for future similar projects
- To provide core learnings & insights for others
Tell a story around the project aims

- A good evaluation report should tell you whether the project achieved what it set out to achieve, and how this was measured
- You may be reporting on multiple data sources relative to project aims
  - Report on each data source separately to start with, relative to the project aims
  - You might combine data later to correlate information and weave a story

Reporting the findings

- Start with a simple answer to the project aims
  - This project does not offer anything new in terms of cost effectiveness, timeliness of referral or patient satisfaction
  - Provide a summary of the methods, outlining the key approaches
  - Use graphs, tables, matrices to provide the data that backs this statement up
  - Report the detail of the evaluation methods in an Appendix for reference
Section 6: Reporting on the evaluation

Reporting the findings

- Evaluation methods are often not an integral element of the evaluation report
- This is not a ‘research’ report, even though the evaluation is based on research etiquette
  - The methods need to be available for interested readers

ACT Evaluators’ reference material

- ACT Health Scope Document Template (link) may be useful. This document discusses objectives, initial product end description, business benefits expected and deliverables which we have loosely described as in this guide as ‘outcomes’
- The ACT Health Finalisation Report Template link may be useful to report the project findings
**Checklist for reporting on project structures**

1. Consider each structural issue and how it changed over the course of the evaluation

2. How did project structures influence project roll-out and impact
   - Project governance
   - Project staffing/other project resources
   - The environment
   - Recruiting participants
   - IT systems, data sources & linkages
   - Record keeping

**Checklist for Reporting Processes**

1. Consider each process issue and how it changed over the course of the evaluation

2. How did project processes influence project roll-out and impact
   - How well were project tasks undertaken?
   - Was there consistency in the way things were done?
   - Was staff training sufficient?
   - Was the environment appropriately primed for the project?
   - Did behaviours change over time? If so, how?
   - Was the budget sufficient??
Checklist for Reporting ‘Outcomes’

1. Consider each evaluation ‘outcome’ and how it related to the project aims
   • Each project aim should be addressed by a measure of ‘outcome’
     – Evaluation outcomes can be any changes to structure, process, costs, governance, health measures, behaviours etc
2. Outcomes may also include project expenditure

Overall Checklist

1. Have you provided a succinct statement of whether the project met its aims?
2. Could your evaluation approach have been better?
3. Did you use the most appropriate data sources for the project evaluation?
   – If not, how could this have been done better next time?
4. Have you worded your recommendations regarding project sustainability, modifications to the project, and future evaluations?
5. Have you drafted your report to the Project Reference Group?
6. Have you completed a finalisation report? (See ACT Health Finalisation Template link)
Final meeting with Project Reference Group

- Schedule the meeting prior to the evaluation due date
- Provide a draft final report for discussion regarding
  - Layout
  - Analysis
  - Findings
  - Interpretation of findings
  - Recommendations

Modifying the report

- The Project Reference Group may suggest alternative data interpretations and recommendations
  - The Project Reference Group reflects key stakeholders & interests of your networks
  - Respect these views
  - Data analysis relevant to project aims can usually have more than one side
  - The evaluation report should reflect this
Disseminating the findings

• Report to **project participants** using as many opportunities as possible
  – Lunchtime staff meetings
  – Grand rounds
  – Local and state conferences
  – Newsletters
  – Websites
  – Media releases

Disseminating the findings

• Report to **project funders** using
  – Succinct reporting styles
  – Provision of information on costs: benefits (value for money)
    • Report costs saved by the project
  – Face-to-face meetings with key stakeholders to present and defend the findings
  – Newsletters or specific evaluation handouts
Disseminating the findings

- Report to other researchers and evaluators using
  - Peer-reviewed publications
    - Choose appropriate health evaluation journals
  - National and international conference presentations
  - Evaluation report on an appropriate website

Congratulations

- You have nearly made it to the end!
- We hope that learning about how to plan for, implement and report on your evaluation was fun, and has provided you with the impetus to get out there now, and do it for yourself!
- Allied health projects need to be conceptualised and evaluated properly to capitalise on the many good ideas that people have!
Learnings

• Whilst you are opening the champagne:
  – Reflect on what lessons you learnt from undertaking this evaluation
  – How will you report these lessons so that others can learn from them
DRAFT EVALUATION FOR EXTENDED SCOPE OF PHYSIOTHERAPY ROLES
1. Evaluation for the Pilot Extended Scope Physiotherapy Roles

Prepared by Karen Grimmer and Steve Milanese
International Centre for Allied Health Evidence
University of South Australia
How best to measure the success of the ACT Health ESP Initiative?

A new initiative is usually implemented to fill an identified gap, or to improve practices that are recognized as being less than optimal. Success of such new initiatives can, therefore, be measured in many ways. Success can be measured simply by whether the gap was filled, or the suboptimal practices were improved. Terms such as Key Performance Indicator, Critical Success Factor or benchmark are often used as outcomes to measure the success of new initiatives.

When measuring anything related to the impact of a new initiative, it is important to keep in mind that things that are measured get done more often than things that are not measured. The decision for ACT Health regarding the most appropriate and achievable measures of success for the ESP initiative relate to:

1) What ACT Health believes is important to measure (as an organisation).
2) What key stakeholders believe is important to measure (for instance other health workers, funders, patients, registration bodies, the community)
3) What ACT Health can measure accurately and repeatedly which will best address the impact of the new initiative.

Considering KPIs: The term KPI is poorly defined in the literature. In theory it provides a series of measures against which internal managers can judge a business and how it is performing. A KPI cannot be established without a clear understanding of what is possible. Thus it is wise to set upper and lower limits for KPIs in terms of historical practice, and what peers are doing. This means that an understanding of benchmarks is essential to make KPI’s useful (and specific to the organisation), as they put the level of current performance in context. Benchmarks also help in checking what other successful organisations see as crucial in building and maintaining competitive advantage. KPIs should provide all staff with clear goals and objectives, coupled with an understanding of how they relate to the overall success of the organisation. Published internally and continually referred to, they strengthen shared values and assist in working towards common goals.

Considering CSFs: Another term commonly used when estimating the success of a new initiative is critical success factors. These refer to a small number of areas in which satisfactory results will ensure successful competitive performance for the individual, department, or organization. CSFs are reported where there is an entirely new business, which cannot be built on earlier testing, or measured against others’ performance. Four types of CSFs have been reported in the business literature which may be relevant to the ESP initiative:

1. Industry CSFs resulting from specific industry characteristics;
2. Strategy CSFs resulting from the chosen competitive strategy of the business;
3. Environmental CSFs resulting from economic or technological changes; and
4. Temporal CSFs resulting from internal organizational needs and changes.
1. Organisational, Clinical and Stakeholder KPIs for the Pilot Roles
ACT Health Advanced and Extended Scope Physiotherapy Practice

Each CSF should be measurable and associated with a target goal. Whilst it might be possible to quantify a CSF (the number of patients seen per month), a CSF can also be relative (for instance improved acceptance of ESP in the workplace).

Goals of the new ACT Health initiative
Advanced / extended scope physiotherapy practitioners working in Orthopaedic outpatient clinic and ED will

- Make significant improvements to routinely collected service delivery data**
- Introduce new ways of treating patients in ED and Orthopaedic Outpatient clinic that have similar or better outcomes than currently, quicker response times and lower costs
- Significantly improve patient journeys
- Are well accepted by patients (satisfaction), and
- Are valued and well integrated into those healthcare teams working in orthopaedic outpatient clinic and ED

**Improvements in orthopaedic outpatient clinic routinely collected data include:

- Reduced mean wait-time for outpatient appointment
- Reduced numbers added to the surgical wait-list
- Reduced waiting times for elective surgery

**Improvements in ED routinely collected data include:

- Reduced time waiting to be seen
- Reduced length of stay in ED
- Relieve Medical staff for more complex cases (to be negotiated)

ACT Health available data routinely collected
Orthopaedics

- wait-time for outpatient appointments (from referral point to appointment) (median, measures of variability)
- numbers of clients added to the surgical wait-list (additions)
- numbers of clients referred for an Outpatient Orthopaedic appointment each year
- waiting times for elective surgery

Emergency Department

- Time waiting to be seen, Length of stay, Discharge destination (all stratified by diagnosis code, triage category, consulting health provider)

Additional data in both sites could include a) the use of alternative pathways of care (imaging, prescribing; b) referral to other health practitioners (or other services); c) stakeholder satisfaction (quantitatively and qualitatively) and d) interesting cases.

In Outpatients data could also include health outcomes from patients (if data could be collected at least twice).

In ED outcome data could be captured if patients were telephoned after discharge to obtain follow-up information on the outcome instrument.
Suggested nomenclature

For the ACT new initiative of introducing ESP into Outpatients and ED, we recommend that the success of the initiative is measured using Critical Success Factors. This is because the ESP initiative in Australia is occurring in previously unchartered waters, and we have found no well-founded benchmarks of performance for ESP relevant to Australia, or ACT Health requirements, which could underpin measurable KPIs. Once the pilot program has been completed in ACT, metrics derived from the CSFs could be reinterpreted in terms of KPIs and benchmarks for future use.

Suggested Critical Success Factors

| Industry | • Provide more opportunities for patients to consult an appropriate health provider in ED or Orthopaedic Outpatient clinics  
|          | • Significantly reduce waiting time for consultations  
|          | • Ensure no increase in adverse events  
|          | • Create exemplar multidisciplinary teams with recognized skills and shared responsibilities |
| Strategy | • Create professionally-acceptable ESP positions in ED and Orthopedic Outpatients clinics in terms of evidence-based new practices for ESP Physiotherapists, which are underpinned by legislation, national registration, credentialing, professional training, policy, continuing education, career advancement and remuneration  
|          | • Provide exemplars for other advanced/ extended scope practice roles in ACT Health and elsewhere (the right individuals in the positions, appropriate and achievable role descriptions, appropriate professional, clinical and academic supports in place, acceptable career advancement and professional recognition)  
|          | • Establish appropriate, professionally acceptable and evidence-based frameworks and processes for training and credentialing of ESP  
|          | • Demonstrate value for money |
| Environmental | • Reduce waiting time for consultations  
|             | • Reduce waiting lists  
|             | • Reduce numbers of patients progressing to more expensive and avoidable health care options  
|             | • Demonstrate continuing stakeholder satisfaction with ESP (other health providers, funders, managers, patients, ESPs)  
|             | • Appropriately address issues which decrease stakeholder satisfaction  
|             | • Demonstrate cost benefits and savings (considering costs, cost savings, health outcomes, satisfaction, opportunity costs) |
| Temporal | • Improve quality of care currently provided  
|          | • Measure and enhance patient health outcomes  
|          | • Significantly reduce unnecessary costs  
|          | • Produce a more streamlined process of triage, assessment and management in ED and Orthopaedic Outpatients |
Opportunities for data collection & research in ESP Orthopaedic Clinic

**Historical Practices Audit**
- Notes of the cohort of patients for commencement ESP review
  - Waiting time
  - OP service history
  - Diagnosis
  - Chronicity
  - ESP assessment of alternative treatment options

**Setting the scene**
- Interview ED Staff regarding ‘usual’ decision-making algorithms for diagnostic groups (ankles, backs etc) & their perspectives on ESP role

**Collect ongoing**
- Usual data (Diagnosis, Waiting times, imaging)
- Prescribing patterns
- Prospective qualitative descriptions of journeys of exemplar patients
- Outcome measures at two contacts (Appendix 1)
  - Generic Patient-Specific Scale
  - Resumption of Daily Activities of Living Scale (modified)
  - Pain Self-efficacy Questionnaire
- Patient satisfaction with ESP (random selection, Patient Satisfaction Subscales&/or by interview [one contact only])
- OP staff satisfaction every month for 6 months (by interview)
- ESP Satisfaction every month for 6 months (by self-report diary and interview)
- Adverse events

**Reflective Research opportunities**
- Pre-ESP descriptive data
  - Review of historical data on
    - Waiting time to subsequent appointments
    - % flow on to surgery
    - Wait time for surgery (emergency & elective)
    - Typical patient journey

**Research opportunities after patient has been first assessed by ESP**
- **With audit data**
  - ESP validation of diagnosis
  - Validation of ESP assessment of alternative treatment options

**Research opportunities over time**
- Change in general satisfaction
  - Patients
  - OP staff
  - ESP
- Adverse events
- Change in patient outcome measures stratified into end-point clusters (progress to surgery, progress to other treatments etc)

---

1. Organisational, Clinical and Stakeholder KPIs for the Pilot Roles
ACT Health Advanced and Extended Scope Physiotherapy Practice

Opportunities for data collection & research in ESP ED

Historical Practices Audit
Notes of the cohort of recent typical patients who could have been seen by ESP
- ED presentation history
- Diagnosis
- Imaging ordered
- Medications ordered
- Ongoing Referrals (where, to whom?)

Setting the scene
- Interview ED Staff regarding ‘usual’ decision-making algorithms for diagnostic groups (ankles, backs etc)
- Perspectives on ESP role

Collect ongoing
Usual data (Diagnosis, Waiting times, imaging)
Prescribing patterns
Prospective qualitative descriptions of journeys of exemplar patients
Outcome measures (Use telephone follow-up for second measure)
Patient satisfaction with ESP (Patient Satisfaction Subscales delivered at point-of-contact or by follow-up telephone interview with randomly selected patients)
ED staff satisfaction every month for 6 months (by interview)
ESP Satisfaction every month for 6 months (by self-report diary and interview)
Adverse events

Validation
Co-assessment by ESP and ED specialists of randomly selected patients for diagnosis & treatment plans

Reflective Research Opportunities
- Pre-ESP description of audit data
- Review of historical routinely collected data on
  - Waiting time in ED
  - Referral to OP clinics
  - Waiting time to OP appointments
- Typical patient journey

Immediate research opportunities
With audit data
- ESP estimation of possible alternative treatment options
With wait list data
- Change in waiting time
- % Progression to OP clinics and which ones
- % progression to other forms of treatment
- Waiting times for subsequent treatment

Research opportunities over time
- Validation of ESP diagnosis and treatment plans
- Change in imaging, prescribing, referral patterns
- Change in general satisfaction
  - Patients
  - OP staff
  - ESP
- Adverse events

The International Centre for Allied Health Evidence (iCAHE)
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University of South Australia  GPO Box 2471  Adelaide SA 5001 Australia
To receive iCAHE updates register online at www.unisa.edu.au/cahe

## Research possibilities

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<th>Qualitative research</th>
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<td>Interesting cases</td>
<td>Progression to surgery and why</td>
<td>Compliance with guidelines-based care for common conditions</td>
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<td>Progression to other forms of treatment (what are they, the success of this, patient perspectives)</td>
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<td>Historical treatment approaches for patients similar to the ones to be seen by ESP</td>
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<td>Compliance with guidelines-based care for common conditions</td>
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**Appendix 1**

Generic patient-specific scale

**INITIAL ASSESSMENT**

Please identify up to 5 important activities related to your usual duties at work or at home that you are unable to do, or have difficulty with, as a result of your health problem. Write them in the box below.

Today, how difficult do you find each of these activities? *(Put a number in the box against today’s date indicating your level of difficulty. Use the scale below for each activity)*

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For recording other difficulties which the patient may identify at later dates

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On previous visits, you had difficulty with the activities on the above list. Today, how much difficulty do you have with these activities? *(Please rate your level of difficulty in the appropriate box using the scale above)*

**References**

## Resumption of Activities of Daily Living Scale

Since your injury, to what extent have you resumed your usual activities in each of the following areas? If you do not do an activity, put N/A (non-applicable) beside the scale. As you rate each activity, think of how you are today. Circle the number on the scale for each question.

1. **Sleeping patterns**

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2. **Sexual activity**

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3. **Self-care (e.g. washing, dressing)**

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4. **Light household chores (e.g. doing dishes, making beds, preparing meals)**

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5. **Heavy household chores (e.g. yardwork, cleaning windows, doing laundry)**

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6. **Shopping**

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7. **Socialising with friends and family inside your home**

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8. **Socialising with friends and family outside your home**

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9. **Travelling (in cars, buses, etc) for less than 30 minutes**

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10. **Travelling (in cars, buses, etc) for longer than 1 hour**

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11. **Engaging in your usual recreational activities**

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12. **Engaging in your usual paid employment**

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The Resumption of Activities of Daily Living (RADL) Scale assesses the extent of recovery from the time of injury to the initiation of treatment, and concurrent with the course of treatment, using the individual’s customary level of functioning as benchmark (Williams, 1998).

The scale consists of 12 items, with scores ranging from 0-100 (0%=not at all, 100%=complete resumption. The total RADL score can be calculated by summing the responses and dividing by the number of items answered. At least 9 out of the 12 items should be answered in order to calculate a total score.

References
# Pain Self-Efficacy Questionnaire

Please rate how confident you are that you can do the following things at present, despite the pain. To indicate your answer circle one of the numbers on the scale under each item, where 0 = not at all confident and 6 = completely confident.

Remember, this questionnaire is not asking whether or not you have been doing these things, but rather how confident are you that you can do them at present, despite the pain.

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<tr>
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<th>Completely confident</th>
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<td>1. I can enjoy things, despite the pain.</td>
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<tr>
<td>2. I can do most of the household chores (e.g. tidying-up, washing dishes) despite the pain.</td>
<td>0 1 2 3 4 5 6</td>
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<td>3. I can socialise with my friends or family members as often as I used to do, despite the pain.</td>
<td>0 1 2 3 4 5 6</td>
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<td>4. I can cope with my pain in most situations.</td>
<td>0 1 2 3 4 5 6</td>
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<td>5. I can do some form of work, despite the pain. (&quot;Work&quot; includes housework, paid and unpaid work.)</td>
<td>0 1 2 3 4 5 6</td>
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<td>6. I can still do many of the things I enjoy doing, such as hobbies or leisure activities, despite the pain.</td>
<td>0 1 2 3 4 5 6</td>
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<td>7. I can cope with my pain without medication.</td>
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<td>8. I can still accomplish most of my goals in life, despite the pain.</td>
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<td>9. I can live a normal lifestyle, despite the pain.</td>
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<td>10. I can gradually become more active, despite the pain.</td>
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### References


Patient Satisfaction Subscales

There are five category responses for each question (1= strongly agree- 5= strongly disagree). While this version of the instrument originally focused on 'back pain' it can be applied to any condition about which a patient consults a therapist. Therapists wishing to use the scale for other conditions should substitute the appropriate wording instead of (problem).

Information

- The therapist gave me enough information about the cause of my problem
- The therapist did not give me a clear explanation of the cause of my pain
  - The therapist gave me a clear explanation of the cause of my pain (A+)
- The therapist told me what to do to prevent further problems

Caring

- The therapist seemed to believe that my pain was real
- The therapist did not understand the concerns I had about my problem
  - The therapist understood the concerns I had about my problem (A+)
- The therapist did not seem comfortable dealing with my problem
  - The therapist seemed comfortable dealing with my problem
- The therapist was not concerned about what happened with my pain after I left the office
  - The therapist was concerned about what happened with my pain after I left the office

Effectiveness

- The treatment the therapist prescribed for my problem was effective
- The therapist seemed confident that the treatment he/she recommended would work
- The therapist gave me a clear idea of how long it might take for my problem to get better

General Questions

- After seeing the therapist I did not know what I needed to do for my problem
  - After seeing the therapist I knew what I needed to do for my problem
- The therapist did not listen carefully to my description of my problem
  - The therapist listened carefully to my description of my back problem
- The therapist made me feel less worried about my problem
- The therapist performed a thorough examination of me
- The therapist did not understand what was wrong with me
  - The therapist understood what was wrong with my back
- The therapist should have ordered more tests
  - The therapist ordered as many tests as necessary
- The therapist should have referred me to a specialist
  - The therapist referred me to a specialist
### Identifying positive and negative questions in the published version of the questionnaire

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<td>The therapist gave me enough information about the cause of my problem</td>
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<td>The therapist did not give me a clear explanation of the cause of my pain</td>
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<td>The therapist told me what to do to prevent further problems</td>
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<td>The therapist seemed to believe that my pain was real</td>
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<td>The therapist did not understand the concerns I had about my problem</td>
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<td>The therapist was not concerned about what happened with my pain after I left the office</td>
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<td>The therapist seemed confident that the treatment he/she recommended would work</td>
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<td>After seeing the therapist I did not know what I needed to do for my problem</td>
<td>-</td>
</tr>
<tr>
<td>The therapist did not listen carefully to my description of my problem</td>
<td>+</td>
</tr>
<tr>
<td>The therapist made me feel less worried about my problem</td>
<td>-</td>
</tr>
<tr>
<td>The therapist performed a thorough examination of me</td>
<td>-</td>
</tr>
<tr>
<td>The therapist did not understand what was wrong with me</td>
<td>-</td>
</tr>
<tr>
<td>The therapist should have ordered more tests</td>
<td>-</td>
</tr>
<tr>
<td>The therapist should have referred me to a specialist</td>
<td>-</td>
</tr>
</tbody>
</table>

### References

Extended scope physiotherapy

Quality

Aims

• To identify quality elements of the ESP health professional
• To identify measures by which the quality of service can be assessed
• To discuss ways in which the new service can be evaluated
  — Including baseline data
Quality of person

Leadership

• It is an essential element in the job description
  – Clinical
  – Quality improvement
  – Mentoring
  – Change champion
Clinical leadership

- Clinical expert
  - Has significant input into training programs
  - Assists in complex case review
  - Involved in maintaining and enhancing the clinical competencies of others
- Leads by clinical example
- Provides continuing professional development to more junior staff
  - Within and between disciplines
- Promotes the profession to other health disciplines
- Promotes health outcomes which can be achieved from the new program

Evidence based practice
Evidence based practice

• Plays a significant role in translating research evidence into clinical practice by;
  – Bridging the gap between current best evidence and clinical reasoning by individual therapists for individual patients
  – Considering patient preferences within the context of clinician competence and local environment
  – Facilitates this in the wider inter-professional team, within and outside of the institution
• Promotes clinical research within and outside of the institution

Mentoring

• Within and between professions
  – Complex case review
  – Career pathways
  – Problem solving
Research

- Establishes viable relationships with researchers
- Assists in turning clinical questions into answerable research questions
- Builds networks to support clinical research
- Has an understanding of research principles
- Has an appreciation of the value of research
- Builds a culture of research translation into practice

Quality of service
Baseline data

- No new service can be evaluated properly without a comparison with what has gone before
  - Issues to consider
    - Comparable data items between existing and proposed initiative
    - Timeframe over which the data is collected
      - Seasonal variation
      - Service delivery changes
      - Changes to patient profiles
    - Access to the data
    - Integrity of the data
    - Clear research questions
    - Dedicated time to analyse and report

Measures of impact

Relevant outcome measures?

<table>
<thead>
<tr>
<th>Process</th>
<th>Cost</th>
<th>Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Waiting times</td>
<td>- Direct</td>
<td>- Effectiveness of treatment</td>
</tr>
<tr>
<td>- Referral rates</td>
<td>- Salary costs (usual care vs</td>
<td>- Diagnostic accuracy</td>
</tr>
<tr>
<td>- Suitability of referrals</td>
<td>ESP care)</td>
<td></td>
</tr>
<tr>
<td>- Role substitution</td>
<td>- Administrative and training</td>
<td></td>
</tr>
<tr>
<td>- Access to treatment</td>
<td>costs</td>
<td></td>
</tr>
<tr>
<td>- Percentage of patients</td>
<td>- Indirect</td>
<td></td>
</tr>
<tr>
<td>managed entirely by the ESP</td>
<td>- Cost of waiting</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- medical management</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- Quality of life</td>
<td></td>
</tr>
</tbody>
</table>
Research questions

• All evaluations require a clear research question, underpinned by robust data items
• Does the new service improve processes?
  – Patient journey
  – Referral patterns
  – Release other health professionals to do more complex tasks
  – Streamline service provision
  – Streamline and support training

Research questions

• Does the new service improve outcomes?
  – Patient satisfaction
  – Staff satisfaction
  – Quality of care
  – Safety of care
  – Consistency of care decisions
  – Patient throughput (length of stay, length of admission, length of wait)
  – Costs of service delivery
  – Health outcomes (short and long term)
RISK MANAGEMENT STRATEGIES

- Adverse Medicines Events line: 1300 134 237
- Webpage http://ame.mater.org.au/
- Processes, evaluation, planning.....
- Ethics (including patient interviews)
- Evidence-based practice (training, qualifications, research, evidence-based models of care)
- Right person in right position at the right time (all the recruitment and HR issues previously discussed)
- Executive sponsor
- Medical sponsor
ACT Health Jan 2011

Using the Institute of Medicine Model to consider the quality of the pilot Extended Scope Physiotherapy Practice Program, ACT Health:

Safety: There is no evidence of adverse health events for patients who consulted a physiotherapist, however there is some evidence that some patients were not happy with the process. This appears to reflect more their lack of understanding of the system, and knowledge about physiotherapists rather than poor treatment or poor health outcomes. There is no evidence that the physiotherapist provided less safe treatment than would usually have been provided by medical personnel.

Effectiveness: There is evidence from the triaging exercise and the patient management exercise that the physiotherapy care was effective in terms of improving patients’ pathway through the system and improving their health outcomes. There needs to be a greater capacity to follow patients up over time to take repeated measures of health outcomes to confirm this. There is no evidence that the physiotherapist produced any poorer outcomes than would usually have been provided by medical personnel.

Equity: All patients were given the opportunity to consult the physiotherapist, and to have a quicker path through the ‘system’.

Patient-centredness: There is the capacity for the physiotherapist-led approach to be more patient centred than the usual medical approach, particularly reflected by the triaging phonecalls. Physiotherapists have a strong commitment to, and understanding of, quality of life and they have the capacity to ask the ‘right questions’ at the ‘right time’.
Timeliness: The physiotherapist-led service appeared to provide more timely care for patients, in that their waiting time was significantly reduced. Whether this is sustainable over time is yet to be tested.

Efficiency: The physiotherapist-led service was efficient, particularly in easing the pathway through the ‘system’ for patients who had been waiting for treatment for some time. It is possible that the MDT OP clinic is more efficient by its very nature, with the medical personnel being given a different perspective on care, and the impetus to provide a different type of service to ‘usual’.

SWOT Analysis

Strengths: Provision of advanced and extension of scope of physiotherapy practice has strong precedents in the UK and in other Australian states, and evidence of success in terms of good patient outcomes and reduced waiting times. Physiotherapists by nature of their training have the ‘right’ approach to triaging and patient evaluation which will assist in both ED and OP initiatives, and can be rolled out more widely in future. This is because the physiotherapy philosophy is to assess the whole person and consider presenting problems in terms of function, activities of daily living, symptoms related to these measures, and quality of life. This adds a different dimension to the type of assessment and care usually provided by medical and nursing personnel.

Weaknesses: There are many.

There is limited understanding by other health and support personnel of the roles that could be played by physiotherapists, and possibly limited recognition by these individuals of what could be achieved with advanced and extended scope training of physiotherapists.

The lack of a formal training program is a major barrier to progression of this initiative, as the success/failure of the program rests on individuals, not on a new ‘system’. This should be addressed with some urgency, even if it holds up the roll out of the program.

Lack of awareness by other health professionals and support staff of the capacity of the advanced/extended scope physiotherapy program to improve processes and outcomes has the potential to sink this initiative, particularly if the success of the program is based on individuals, rather than a ‘systems’ approach. Similarly, lack of patient education about physiotherapists and their new role has the capacity to limit the roll out of the program.

Opportunities: There are many. A formal training program will enhance the physiotherapy profession’s skill base across the board, and will produce a recognised group of practitioners with excellent clinical, diagnostic and management skills that will promote the profession.

On the basis of a formal training program and evidence from the pilot study, other health care providers should be able to better understand how extended/out of scope roles of physiotherapists can assist in changing and improving systems, unload currently overstretched professional groups and improve patient flow.

Threats: There are many. The lack of a current formalised training program limits the success of this initiative to the impact of individuals. If the ‘wrong’ individual is appointed to an extended
scope position, who does not have the required clinical or person skills, this will do a lot more damage to the program than waiting for a formal training program to be implemented.

The physiotherapy profession itself needs to be educated about the benefits of this approach to practice. There could be internal resistance from sectors of the profession and training institutions, or there could be fragmented training programs implemented which could dilute training quality and do not support a cohort of advanced and extended scope practitioners.

Other health professionals need to be educated about the program, and their support established. This will require change champions to be identified in medical and nursing staff, and support staff in each hospital which adopts this initiative, to assist the physiotherapists in the role to navigate professional and systems boundaries.

Reference

DEFINITIONS OF CLINICAL LEADERSHIP IN ALLIED HEALTH
Definitions of Clinical Leadership in Allied Health

Prepared for Jo Morris
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ABN: 82 049 056 234

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CRICOS Provider Number 001218

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Definitions of clinical leadership in allied health

Methods
We scanned commonly-used library allied health databases (Cinahl, Ovid, Pubmed, Proquest) over the past five years for articles reporting on clinical leadership, and we similarly searched grey literature sources using Google Scholar. We found 10 references relevant to this enquiry, mostly from the grey literature (Government and organizational reports) and conference proceedings.

We report the summaries of clinical leadership attributes directly from the evidence sources, with the relevant references.

Findings
There was considerable disparity in the definitions and how they were operationalised. There was no single definition that encapsulated everything required by ACT Health. Thus there is an opportunity for ACT to produce a composite definition of clinical leadership tailored to the ESP Physiotherapy program.

The SARRAH definition seems to be most applicable in the first instance (3). There are elements of the other definitions which could be incorporated into an ACT-specific definition.

- The Strategies and Attributes section in Reference 1
- The Section on Various levels of activity/ leadership in Reference 2
- The diagram and section on Benefits of clinical leadership in Reference 4
- The leadership qualities section in Reference 5
- The section on ‘Conditions/qualities for resilient leadership’ in Reference 7.
1. **Clinical Leadership Program**

Clinical Excellence Commission, NSW


*Definition:* “Clinical Leadership’ occurs at all levels of patient care and refers to:

- the process of leading a set of activities that improve the delivery of safe clinical care, and
- the set of attributes required to lead a team, unit, stream or cluster.

*Strategies and attributes*

- strategies for sustainable patient safety and system improvement
- knowledge of self, team dynamics and process improvement
- leading sustainable system improvement and patient safety initiatives
- work affectively with clinical information
- developing a culture of patient centered care within an environment that supports workplace learning
- knowledge of contemporary approaches to patient safety and clinical quality systems
- skills in communication, conflict resolution and team leadership
- ability to influence direction of health policy
- personal and professional clinical leadership skills
2. **The Challenge of Allied Health Management and Clinical Leadership**
Meredith Swaby
Western Health, Melbourne, March, 2003

**Definition:** Clinical leadership utilises the influence of clinical expertise to enhance the clinical knowledge and skills of other, thus enabling performance of assigned tasks. There is an expectation that those in a clinical leadership role demonstrate a high level of clinical expertise that is shared with others in the team. Clinical leadership is achieved through a hierarchy of leadership, meaning that there are clinical experts (senior clinicians) within each of the clinical services streams. For example identified experts might be individuals in pediatric, acute and sub-acute services that hold their position because of clinical expertise/maturity. Their specialist knowledge will provide support, supervision and education to staff operating within a particular service stream.

**Clinical leadership aims to improve...**
- Strategic planning, giving clear direction for the attainment of organisational goals
- Flexibility & adaptability in the face of changing market demands
- Defined mechanisms of accountability and continuous quality improvement
- Ongoing sensitivity to cost through enhancing productivity & resource utilisation

**Various levels of activity/leadership**

<table>
<thead>
<tr>
<th>Clinical</th>
<th>Internal processes</th>
<th>Strategic</th>
</tr>
</thead>
<tbody>
<tr>
<td>budget/ funding</td>
<td>communication</td>
<td>values/ vision/ mission</td>
</tr>
<tr>
<td>secure resources</td>
<td>accountability</td>
<td>goal clarity</td>
</tr>
<tr>
<td>service delivery</td>
<td>information management</td>
<td>business plan</td>
</tr>
<tr>
<td>productivity &amp;</td>
<td>policies and protocols</td>
<td>innovation and</td>
</tr>
<tr>
<td>efficiency</td>
<td></td>
<td>creativity</td>
</tr>
<tr>
<td>quality</td>
<td></td>
<td>decision making</td>
</tr>
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<td>best practice</td>
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</table>

<table>
<thead>
<tr>
<th>Staff</th>
<th>External</th>
</tr>
</thead>
<tbody>
<tr>
<td>performance appraisal</td>
<td>external influences</td>
</tr>
<tr>
<td>supervision</td>
<td>networking</td>
</tr>
<tr>
<td>teamwork &amp; cohesion</td>
<td>relationship building</td>
</tr>
<tr>
<td>motivation &amp;</td>
<td>collaboration</td>
</tr>
<tr>
<td>facilitation</td>
<td>consultation</td>
</tr>
<tr>
<td>delegation</td>
<td></td>
</tr>
<tr>
<td>conflict management</td>
<td></td>
</tr>
<tr>
<td>recruitment</td>
<td></td>
</tr>
</tbody>
</table>
Definition: Clinical leadership refers to both a set of tasks to lead improvements in the safety and quality of health care, and the attributes required to successfully carry them out (Victorian Quality Council 2005). Leadership can be both formal and informal, and operationalised as part of the clinician’s organizational position or through their relationships with colleagues.

Clinical leadership behaviour

- **Developing Personal Qualities**: Qualities such as self-awareness, self-reflection, self-management, professionalism, and self-development.
- **Working with Others**: Developing networks, building and maintaining relationships, team building, developing others, engaging with clients and consumers, and collaborating with other service providers.
- **Improving Services**: Ensuring patient safety, critically evaluating, encouraging innovation, evaluating services, improving health care processes, developing new services and roles.
- **Managing Services**: Planning, managing resources, managing people, and managing performance.
- **Setting Direction**: Identifying opportunities for change, applying knowledge and evidence, making decisions, evaluating impact and outcomes.
4. **Clinical Leadership in Community Health**

Project Report, Victorian Healthcare Association

March 2009


Definitions from other sources

- The Victorian Quality Council’s definition of clinical leadership: *both a set of tasks to lead improvements in the safety and quality of healthcare, and the attributes required to successfully carry them out*

- Australian Council on Healthcare Standards (ACHS) describes the attribute of leadership as *the ability to provide direction and cope with change. It involves establishing a vision, developing strategies for producing the changes needed to implement the vision, aligning people and motivating and inspiring people to overcome obstacles.*

- Kouzes and Posner (2007) define these practices as the leader’s ability to *model the way, inspire a shared vision, challenge the process, enable others to act and encourage the heart*

Proposed definition

- There is a strong relationship between effective clinical supervision and clinical leadership to support processes and improve quality and safety of services delivered to the community.

- A proposed definition of clinical leadership for the community health sector *“Clinical leadership in Community Health is the process of developing a culture and leading a set of tasks to continually improve the quality and safety of service delivery to consumers. Effective clinical leadership involves individuals with the appropriate skills and attributes, at all levels of an organisation, focusing on multidisciplinary interdisciplinary service delivery.”*

<table>
<thead>
<tr>
<th>Governance Level</th>
<th>Service Program Level</th>
<th>Clinician Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Board CEO</td>
<td>Clinical Leaders</td>
<td>Consumer/Client Interaction</td>
</tr>
<tr>
<td>Executive Team</td>
<td>Program Managers Team Leaders</td>
<td>Clinical intervention</td>
</tr>
</tbody>
</table>

Figure pp7. Representation of Clinical Leadership across an organisation

Roles of clinical leaders

- Ensuring a focus at the service and program level to improve quality and safety
- Current knowledge and understanding of health service policy, evidence based practice, relevant research;
- An ability to apply research and evidence based practice within the organisation for improvements in service delivery, program development and design
- Active involvement in the formal quality and safety structures and initiatives within the organization
- Ensuring clinicians possess the qualifications, skills and experience for effective and safe service delivery
- Promoting professional and skill development across the organization
- Providing clinical supervision as appropriate
- Working effectively with consumers and community to inform program design and clinical treatment practice
- Contributing to effective information management
- Utilising data for service planning, evaluation, clinical risk management and improvements in clinical service delivery
- Workforce redesign
- Developing innovative models of care.

Benefits of clinical leadership

- Improved communication across the organisation. This was particularly evident in multidisciplinary teams and therefore influenced clinical practice
- Greater understanding of practitioners role in service delivery and the emerging interface issues across the care continuum;
- Provision of staff support to undertake their role and feeling valued as part of the service delivery team and assistance in addressing administrative and line management issues
- Promoting innovation and driving “bottom up” practice change.

References

Victorian Quality Council (2005): Better Quality, Better Health Care: 10
Kouzes JM, Posner BZ (2007): The leadership challenge. Wiley and Sons, NY
5. **Clinical leadership and clinical governance: a review of developments in New Zealand and internationally**

Report commissioned by the Clinical Leaders Association of New Zealand for the Ministry of Health
Lyn Wright, Pauline Barnett, Chris Hendry
August 2001
http://www.moh.govt.nz/moh.nsf/0/38dd32b7a22ca197cc256bb20081a301/$FILE/CLANZlitreviwefinal.pdf

**Definition:** *clinical leadership is defined as leadership by clinicians of clinicians*
- Clinical leaders are those who still retain a clinical role but, at the same time, may participate in management, including resource management.
- ‘Clinician’: *all health professionals including doctors, nurses, midwives, therapists and allied health professionals involved in direct patient care.*
- Clinical leadership has been a key factor in promoting better quality and ensuring that the best possible quality outcomes from limited resources.
- Clinicians can play a key role in identifying poor quality care, including where such care is leading to waste of resources. Furthermore, they have a key role in influencing the behaviour of their colleagues.
- If clinical leadership is to be effective then it must be true leadership in which clinicians, whatever their views on clinical autonomy and financial management, are both behind and supported by their clinical leaders.

**Leadership qualities**
- have a vision of the ultimate goal
- excel in communicating this vision and values to others
- inspire trust and confidence
- help others to feel capable and to realise their own potential
- have enormous energy and drive, and are action-oriented.
6. **The renaissance of clinical leadership (in nursing)**

M. J. Cook, Associate Dean, Faculty of Health, St. Martin’s College, Lancaster, UK

http://www3.interscience.wiley.com/cgi-bin/fulltext/120706364/PDFSTART

Definition: The definition of a clinical nurse leader contains the precept that clinical nursing leadership is focused on ‘continuous improvement through influencing others’. To achieve continuous improvement requires nurses to understand the leadership of effective change.

- Factors which influence leadership styles: external environment, internal environment, experience and understanding.
- Four leadership styles are outlined: transactional, transformational, connective and renaissance.
- Actual and potential leaders of nursing need to be conversant in health and social policy and the art and science of management and research, whilst sustaining their knowledge of the

![Diagram](image)

Fig. 1 The leadership model. Reprinted by permission of the publisher, Churchill Livingstone, from Cook M. J. (1999) Improving care requires leadership in nursing, *Nurse Education Today*, 19, 310.
7. **Clinical leadership: Developing the role of complementary therapy coordinators**

Complementary Therapies in Clinical Practice (2006) 12, 80–82

http://www.sciencedirect.com/science?_ob=MImg&_imagekey=B7MFN-4JRVCS5-1-1&_cdi=23263&_user=170565&_pii=S1744388106000107&_origin=search&_coverDate=05%2F31%2FF2006&_sk=999879997&view=c&wchp=dGLzVzb-zSkWA&md5=14358abd426e522670d2df42a7b3aca3&ie=/sdarticle.pdf

**Notes on clinical leadership skills/ training**

- Coaching, mentoring and supervision can also provide coordinators with the support locally to develop their clinical and team leadership skills.
- The nurturing of leadership skills is vital for practitioners to improve clinical practice, deliver integrated health care and establish role models for future clinical leaders in integrated medicine.
- To be thrust into a ‘leadership’ role based upon the length of time in an organisation or amount of clinical experience rather than recognition of inherent leadership skills or training can be challenging.
- Leadership skills need to be recognised, honed and trained and not everyone is suited to or wishes to undertake such a role.
- Leadership involves many facets including role modeling, supervision and therapist training and liaising with members of a multidisciplinary team.
- Clinical leadership programmes better equip practitioners to support, manage and develop their teams. These schemes improve patient-centered care linked to practitioner development and mentorship.

**Conditions/qualities for resilient leadership**

- Remaining curious about the work and its boundaries by evaluating and researching your practice
- Having the ability to present and disseminate best practice
- Using a facilitative style that recognises and supports others to lead
- Accessing, mentoring and supervision
- Maintaining ongoing clinical practice to maintain and develop expertise
- Seeking out and value champions and supporters
- Being comfortable with promoting you and your team’s work and skills
- Embracing change and transformation
- Identifying sources of financial support to develop you and your team (e.g. travel and academic scholarships)
- Networking and collaboration
- Recognising and working with conflict and resistance to change
8. **Clinical leadership and involvement strategy**  
East Riding of Yorkshire NHS, Primary Care Trust  
March 2008  

*Strategic direction for improving clinical leadership*
- Strengthened partnership working between commissioners, local providers of clinical services, partners, patients and the public.
- Speed up the pace of development and implementation of clinical pathways and service redesign, informing the commissioning process and contractual agreements.
- Increase the number of clinicians who are directly contributing to local plans to improve clinical services and the patient experience.
- Deliver greater effectiveness of the Clinical Executive Team enabling it to carry out the remit to its full potential.
- Increase the opportunities for practicing clinicians to develop

9. **RCN Clinical Leadership NEWS Programme Newsletter**  
Royal College of Nursing  
SPRING 2004  
(magazine on clinical leadership aims/ goals/ workshops)

- By developing the skills of clinical leaders, patient care can be influenced for the better.
- *The programme has had a profound impact, not only on the participants but also the teams they work within. The opportunity to reflect on the impact of leadership on delivering quality care cannot be underestimated.*
- Clinical leaders have been becoming proactive and not reactive, a well-recognised attribute of leadership.
- Programme helps participants increase their awareness of local and national contexts of health care delivery and provides an opportunity for them to become more influential.
- Effective leadership is a key ingredient in modernising today’s health service. Better clinical leadership means better patient care and improved working practices for NHS staff.

10. **Allied health professionals and clinical leadership**  
Roland Petchey, September, 2008  
http://www.hsj.co.uk/allied-health-professionals-and-clinical-leadership/1875191.article

- Allied health professionals are being required to work more flexibly, promote change and develop extended roles that cross professional and organisational boundaries.
- Improvements in patient care can only be achieved if clinical leadership encompasses the entire clinical workforce at both operational and strategic levels.
- Allied health professionals’ clinical work requires an analytical, holistic and collaborative approach, as well as qualities including emotional intelligence and strong communication, negotiation and motivational skills, which are vital for effective leadership.
DUTY STATEMENT AND SELECTION CRITERIA
2. Duty Statement and Selection Criteria

Prepared by
Karen Grimmer-Somers and Steve Milanese

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CRICOS Provider Number 001218
Job Description for Advanced/ Extended Scope Practice Positions in ED and Orthopaedics for ACT Health

Methods
We took two approaches to developing this job description for ACT Health.

1. We reviewed the key attributes of an advanced scope/ extended scope practitioner identified in the literature review undertaken by iCAHE for Phase 1 of this project from ACT Health, and used these scope the position attributes
2. We synthesized job descriptions and person specifications from a range of position papers produced by NHS hospitals and Trusts (UK) for Advanced and Extended Scope positions. These were provided by Steve Milanese, who is a member of the Chartered Physiotherapy Society (CSP). These descriptions are not available to non-members of CSP.

Based on these findings we developed a matrix of key criteria, and populated this with person specifications extracted from the NHS documentation.

Results
1. There are two key sections from our Phase 1 Literature Review report that inform a draft ASP/ ESP job description.

a) Barriers and Enablers (cited from Phase 1 report summary)
   • Elements that are vital to the success of ESP physiotherapy posts include medical support, clear role definition, and strategies to ensure rigorous establishment and evaluation of clinical competencies as part of a wider risk management plan.
   • Elements that may facilitate the continuation of a successful ESP physiotherapy post include maintaining professional inclusion, satisfying ongoing training needs and trans-disciplinary models of working
   • Further factors that may prove to be barriers, if not accounted for in the service development plan, are practical administrative requirements, career implications, collateral impact and the influence of patients’ rights and expectations.

b) Professional requirements (cited from Phase 1 report)
   • There is uncertainty in the literature regarding the professional requirements necessary for ESP physiotherapists.
   • A combination of formal and informal training methods is described; however it is generally accepted that clinicians should possess a suitable level of experience. A minimum of 5 years post-entry level qualification has been described.
   • Appropriate training methods can be planned following consideration of the precise nature of any proposed ESP role. Consultation with all stakeholders to determine whether formal or informal methods, or a combination of the two, are appropriate is considered paramount.
Relevant to person specifications: The Australian Physiotherapy Association (APA 2004) recommended that an extended scope practitioner has the following minimum experience:
- At least five years clinical experience post entry-level physiotherapy qualification
- At least three years experience in the relevant specialist area; and/or
- Completion of APA specialisation training to ‘titled’ member level in the relevant specialist area; and/or
- Completion of a recognised postgraduate qualification and/or advanced training in the relevant specialist area

2. Position descriptions from NHS include a variety of attributes and competencies (there are some overlaps, however there is little consistency). Our synthesis of the criteria identified that consistently reported key criteria are organizational skills, knowledge and aptitude, qualifications, and clinical leadership.

Job Specifications
We mapped the person specifications extracted from NHS documents against the NHS key criteria, and against the criteria from the Phase 1 literature review (See Table 1).

We have not at this stage determined the essential or desirable nature of these criteria at this point (except for the essential qualifications) as we believe that it would be better to first consider the ways in which these criteria could be demonstrated before putting a definitive job description together. It may well be that no one applicant will meet all criteria, and therefore it might be appropriate to simply ‘check off’ applicants against the criteria in the first selection round.

What is now required is consideration of how each of these specifications could be demonstrated in an interview, and what the minimum criteria are that ACT Health will consider for a successful applicant (i.e. when not to appoint).

1 NB The ACT Criteria for ESP is five years experience in a relevant specialist area
### Table 1. Matrix of criteria and specifications

<table>
<thead>
<tr>
<th>Organisation</th>
<th>Qualifications</th>
<th>Clinical leadership</th>
</tr>
</thead>
</table>
| Role definition | Understanding of the broad notion of ASP/ESP roles with:  
• ACT Health  
• the hospital  
• the department/team | Understanding of the scope and requirements of being a clinical leader (specialist, mentor, clinical supervisor, quality improvement leader) |
| Risk management | Understanding of appropriate  
• organizational regulations and standards (e.g., OHS, HR)  
• department-specific regulations, standards, and processes (as above)  
Capacity to identify and take steps to ameliorate risks at organizational, department, and individual (clinician, patient) levels | Evidence of a leadership role related to risk identification and management within a department |
| Competency and training | Experience of being a leader within an organization i.e., mentor, clinical supervision etc  
Demonstrated capacity to clinically reason and problem-solve a complex clinical caseload | All Essential Registration to practice physiotherapy in ACT  
Post-graduate qualification in the relevant area of ASP/ESP  
A CPD portfolio providing evidence of ongoing CPD at post-graduate level relevant to role (i.e., ASP: An understanding of requirements for training to extend the scope of the role; ESP: Evidence of completion of training relevant to the role)  
At least five years recent experience working clinically in the acute management area [NB experience needs to be immediately applicable to the area of practice required i.e., orthopaedics, |
| | | Experience and/or training in clinical leadership  
Outcomes of being a clinical leader |
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<th>Organisation</th>
<th>Qualifications</th>
<th>Clinical leadership</th>
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| Support                                          | Understanding and working knowledge of the relevant governance issues and the reform agenda underpinning roll-out of the ASP/ESP role  
Understanding the ACT Health system                                                                                             | Evidence of the applicant’s own mentoring in place from within and/or outside discipline |
| Communication Skills                             | Highly effective written and oral communication skills                                                                                         | Proven ability to establish and maintain relationships with key internal and external stakeholders |
| Evaluation, research and service development     | Experience and demonstrated ability to effectively develop, co-ordinate and evaluate services to meet organisational requirements                  |                                                                                                                                              |
| Quality Improvement                              | Proven ability in managing systems for clinical governance.                                                                                     | Development of clinical practice and quality improvement activities, staff education and performance evaluation and research |
| Practical organisational issues                  | Understanding the requirements of the role in terms of time-management, space, record keeping, communication with others in the team, line management etc | Capacity to communicate and problem solve                                                                                                 |
| Collateral impact                                | Understanding of how the role may impact on others in the organisation in the short and long term, and plans to recognise and address this       | Understanding of the continuum of ‘usual’ clinical practice (for grades/ levels of physiotherapists), advanced scope and extended scope practice |
| Career related Issues                            | Capacity and willingness to assist in charting a career path for ASP/ ESP within ACT Health  
Promote professional research and contribute to advances of the profession                                                                                                                                                                                                                     | Capacity to evaluate health service quality and to contribute to role evaluation |
| Patient related issues                           | Understanding of appropriate organisational outcome/ output measures  
Understanding of appropriate health and process outcome measures                                                                                                                            | Capacity to critically review individual patient records, to collect and interrogate measures of outcome, and establish ongoing audit procedures |
ORTHOPAEDICS

Duty Statement

The Orthopedic Department ESP is expected to:

1. Provide high level and up to date evidence-based Orthopaedic specific physiotherapy services.
2. Communicate effectively with patients and carers, other staff and doctors, maintaining confidentiality at all times.
3. Generate, analyse and interpret data; and advise ACT Health as required.
4. Develop, co-ordinate and evaluate services to meet organisational requirements.
5. Undertake responsibility for appropriate professional education and evaluation and participate in continuous quality improvement of physiotherapy services.
6. Lead in the quality review and management activities.
7. Participate in multidisciplinary and physiotherapy teams.
8. Provide professional supervision and clinical leadership to staff within the professional field

Selection Criteria: (answerable as part of the application)

1. Extensive experience of at least five years in providing expert musculoskeletal assessment, diagnosis and appropriate onward management for patients presenting with chronic and/or acute pain to an Outpatient clinic.
2. Proven ability to promote and demonstrate best practice, facilitating the integration of the evidence base into practice through an advanced level of clinical reasoning and decision making.
3. Highly effective interpersonal and written and oral communication skills, including the demonstrated ability to establish and maintain relationships with internal and external service providers and stakeholders.
4. Demonstrated ability to supervise/mentor professional staff and students as a clinical leader
5. Proven ability in managing systems for clinical governance through the development of clinical practice and quality improvement activities, staff education and performance evaluation and research.
6. Experience and demonstrated ability to effectively develop, co-ordinate and evaluate services to meet organisational requirements, including organisational outcome/ output measures.
7. Demonstrated ability to consistently display commitment to, compliance with and leadership in high quality Customer service, Workplace Diversity, Occupational Health and Safety and Industrial Democracy principles, and practices relevant to legislation relating to these areas and an understanding of and commitment to the organisation’s values.
EMERGENCY DEPARTMENT

Duty Statement

The ED ESP is expected to:

1. Provide high level and up to date evidence-based emergency department specific physiotherapy services
2. Communicate effectively with patients and carers, other staff and doctors, maintaining confidentiality at all times.
3. Generate, analyse and interpret data; and advise ACT Health as required.
4. Develop, co-ordinate and evaluate services to meet organisational requirements.
5. Undertake responsibility for appropriate professional education and evaluation and participate in continuous quality improvement of physiotherapy services.
6. Lead in the quality review and management activities.
7. Participate in multidisciplinary and physiotherapy teams.
8. Provide professional supervision and leadership to staff within the professional field

Selection Criteria

1. Extensive experience of at least five years in providing expert musculoskeletal assessment, diagnosis and appropriate onward management for patients presenting with a musculoskeletal complaint to the Emergency Department or a similar musculoskeletal primary contact role.
2. Proven ability to promote and demonstrate best practice, facilitating the integration of the evidence base into practice through an advanced level of clinical reasoning and decision making.
3. Highly effective interpersonal and written and oral communication skills, including the demonstrated ability to establish and maintain relationships with internal and external service providers and stakeholders.
4. Demonstrated ability to supervise/mentor professional staff and students as a clinical leader
5. Proven ability in managing systems for clinical governance through the development of clinical practice and quality improvement activities, staff education and performance evaluation and research.
6. Experience and demonstrated ability to effectively develop, co-ordinate and evaluate services to meet organisational requirements, including organisational outcome/ output measures.
7. Demonstrated ability to consistently display commitment to, compliance with and leadership in high quality Customer service, Workplace Diversity, Occupational Health and Safety and Industrial Democracy principles, and practices relevant to legislation relating to these areas and an understanding of and commitment to the organisation’s values.
References


