Progress Report Four

REPORT DUE: Thursday 6th November, 2014

Date: 29th October, 2014
Hub Name: NE Hub
Sites: Austin Health, Nillumbik Health & Darebin Community Health
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Progress with aims and project plan:

Elements completed since Progress report 2. (as per GANTT chart):

- 2.4 Focus Groups (1 x remaining)
- 3.3 Create discipline / team specific task lists
- 3.4 Review lists with managers
- 3.5 Conduct Quantification Surveys

Elements in progress (as per GANTT chart):

- 1.2 Liaise with managers
- 1.4 Ongoing consultation
- 2.6 Update of internet site
- 3.6 Enter project quantification data into Access
- 4.2 Analyse data from data collection
- 4.7 Use data analysis to commence strategic and goal development planning

Progress is on-schedule.

Task List Ratification

The project team and working group decided to generate generic clinician specific task lists and generic case management task lists for the Quantification survey.

Clinician specific – Austin – HIP (excluding CLink), Nillumbik Health, Darebin Community Health
Case management – Austin – Aged Care Community Packages, NE Area Mental Health & CLink.

Commencement with Strategic planning

Discussions have commenced with Working group members and program managers about important strategic directions that programs have/are considering.

Key themes and opportunities:

Education about AHA Supervision and Delegation Framework

As mentioned in other progress reports, the seemingly missed opportunity of staff education. Teams with existing AHAs have tended to delegate tasks within the capabilities of the individual AHA. This does not always reflect the grading of the AHA.

Limited attendance (by staff in the NE Hub) at the Department of Health Supervision and Delegation Framework workshops seems like a missed opportunity to bring an added depth of knowledge to the project and the clinical teams.

Enquiries have been made to Fiona Maher at Wodonga Tafe. A quote has been submitted for conducting 2 x 3 hour workshops in Melbourne. This has been viewed favourably by PCP Executive Officer (project sponsor), and will be discussed at the next Working group meeting.

Community Service & Health Industry Skills – Scoping report of training gaps

The Community Service & Health Industry Skills Council released a report (New roles in Community Services & Health Scoping project) in June 2014. This outlines the scope of the current training in AHA Certificate courses. It also used information from Focus groups with relevant professional stakeholders to identify gaps in current training. This has been a useful document to use in discussions with program/ team managers, particularly in regards to the current training of AHA's and future direction of AHA continuing professional development and competencies.

AHA Core competencies document (Austin OT)

As a result of Stage 2 (AHA Implementation program), Austin Health Occupational Therapy department have recently co-ordinated a student project focusing to develop a competency document for the acute and acute neurosciences AHA roles. These documents have been generously provided to demonstrate the potential and breadth of a competency document.

During discussions with program/ team managers and within Focus Groups, a recurring theme was the challenges of clinician's perspective of level of competence of AHA's. Whilst only some aspects of these documents would be generalisable, the background, format, layout and design provide a substantial example and framework for hub organisations to consider.

"Generic" task lists have potential to be used at other sites/teams/programs not involved in this hub, ie. Banyule CH.

Thematic analysis of the tasks relevant for a team (multi-disciplinary) based AHA, has identified the generalisability of scope of tasks. A number of other organisations (ie. Banyule Health) were interested in Stage 3 of the AHA Implementation Program, however had workforce pressures that limited participation. There is potential in the future for the Quantification survey to be used (with possible small amendments) at Banyule Community Health, with significantly less staffing resources to lead the project.

Communication and Stakeholder engagement:

Working Group

The Working Group has had one meeting since the last training day. The frequency of the Working Group meetings has changed to bi-monthly. Plans for Quantification Survey format were discussed and agreed.

The role of Working Group members, with regards to liaising with the team was reinforced.

Nillumbik Health has agreed to participate in the Quantification survey in the pilot phase, with knowledge that survey may be required to be repeated if significant issues arise.

Meetings with managers/working groups/ staff

The project team have had face-to-face meetings with all program/team managers to discuss and ratify the Quantification list. Timing of the Quantification survey has been confirmed with each team, as well as contact staff members and process for delivery/ collection.

General electronic correspondence to all staff

Emails have been sent to all program/ team managers with requests to forward on to team members. The email is specific for each team, and outlines the timing of the Quantification survey, what it involves and survey collection process.

Internet site

The NEPCP website has been updated with links to the Clinician and Case management Quantification surveys.

Risks and Issues:

Quantification Survey format potentially requires subjective judgement.

Headings and general description

The format of the Quantification Survey was discussed at the Working Group, with suggestions for headings with general definitions. This was discussed further the Alfred/Monash program team and discouraged.

Complex cases requiring subjective judgement

The inclusion of the “Complex cases” heading and subsequent multiple interpretations of the definition, was causing concern that might potentially affect the final results. It was felt that complex cases referred to a judgement call about the client, and that some tasks may be appropriate for basic and complex clients. The heading was removed from both clinician and case management quantification surveys.

In order to ensure that valuable data about actual tasks performed was not lost. Clinicians have been encouraged to use tick boxes to indicate the tasks completed.

Adding tasks not on task list

Clinicians have been encouraged to consider the full scope of practice for an AHA. As a result, concerns have been raised that these may have not have been identified during the Focus groups. To mitigate, the option for “other” has been added. Clinicians have been requested to specify tasks, so project team can ratify with managers.

Quantification data return rate has potential to be sub-optimal

Quantification survey return rate has the potential to be sub-optimal, thereby affecting the overall outcome. Strategies utilised to increase return rate have been based on evaluation/ feedback from other stages and the community program pilot.

Strategies include:

- Pilot with Nillumbik Health with adequate time for adjustments.
- Structuring the process of Quantification survey handout/ collection including; hardcopies of survey on coloured paper to standout, names list on front of envelope to check off returned survey, (chocolate) incentives for survey returns and customised emails for managers to forward on to staff.

Using these strategies, the return rate at Nillumbik Health during the pilot was 100% (1 role not surveyed due to staff leave).

Lessons learnt:

Pilot Quantification process with Nillumbik

The pilot at Nillumbik was useful to identify the strategies that would assist maximising the return rate, and prepare for potential questions. Staff had no, or minor questions about the survey. This has been consistent throughout the Quantification of other programs.

Additionally, the process of simplifying (from the team perspective) the survey collection process, has meant a greater return rate. In order to maximise this return rate, it has also required a significant amount of follow up from the project team.

Simplify process for survey returns

The process of simplifying the survey returns/ collection has been of been of benefit to both the program/team champions, as well as the project staff. Thorough detailing of the individuals in scope, and the number sequencing attributed to each program, has meant that we can follow up the number of surveys that are outstanding.

Encourage program champions to check all details included on the survey

Due to the double sided layout of the Quantification survey, a high number of surveys have been returned without the specific team/hours worked/grading/discipline details. The number sequencing has allowed us to establish the appropriate team or staff member, and complete relevant details.

Lists for each team /work area were very similar, allowing "generic" forms to be developed.

The process of forums and focus groups have had beneficial effects, including early engagement with clinicians, opportunities to discuss the benefits of the AHA role and potential direction that would improve existing roles.

However, the task lists generated by the teams during the focus groups were very similar, and saturation level was achieved prior to completion of all groups. As a result of the similarities, a generic form was able to be created.

In future, there is potential for this form to be "re-used" without the preceding focus groups. Though early, open conversation is essential for engagement.

Allied Health Assistant Implementation Program
Stage Three – Metropolitan Community & Ambulatory Services

Key Performance Indicators	Measure	Progress
Attendance at Training days (n=6)	**100%**	4/6 (100%)
Project plan (incl risk and communication strategy)	**100%**	Completed
Steering committee: meeting schedule, TOR	**100%**	Completed
Consult with staff and managers	**100%**	Ongoing
Schedule for staff engagement forums	**Dates**	Completed
Schedule small focus groups	**Dates**	Completed
Workforce survey (survey monkey) participation rate	**Response rate ≥ 80%**	83.9%
Progress reports (total number = 5) completed and submitted	**100%**	4 completed
Staff engagement forums	**Total No. of forums incl. senior managers conducted (dates)**	10
	No. staff attended (AHA and AHP) each session	Not recorded
Focus groups	**No. of focus groups conducted**	13
	No. staff attended (AHA and AHP) each small focus groups	97 (91 AHP/CC, 8 AHA)/ 171
TOTAL: Forums and Focus groups	**% staff attended forums or meetings**	Not recorded
	% staff attended focus groups	57%
Completed baseline data collection	**100%**	Completed
Baseline data finalised and entered into Access database	**Yes**	Completed
Data collection forms completed	**Yes**	Completed
Project quantification survey completed	**Response rate ≥ 80%**	In progress
Quantification data entered into Access data base	**Yes**	In progress
FINAL Completed Access data base submitted to program team	**Yes**	Not commenced
Strategic goal setting completed	**Yes**	Ongoing
Strategic plan for integrating the AHA workforce completed	**Yes**	Not commenced
Steering committee endorsement of strategic plan	**Yes**	Not commenced
Steering committee report completed	**Y or N**	Not commenced
Steering committee presentation completed	**Y or N**	Not commenced
Hub Final report completed and submitted	**Yes**	Not commenced