Queensland Health

Allied Health Service-critical Workforce Framework

June 2024

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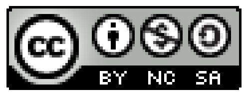

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Further information on this project:

The suite of Service-critical Workforce resources include this framework, a project report, toolkit and resources folder. Documents are available on QHEPS (intranet) for Queensland Health employees at https://qheps.health.qld.gov.au/alliedhealth/html/rural-remote, or to external agencies by contacting the Office of the Chief Allied Health Officer by email.

The Office of the Chief Allied Health Officer, Department of Health, Queensland Health, PO Box 2368, Fortitude Valley BC QLD 4006, email allied_health_advisory@health.qld.gov.au, phone (07) 3328 9298.

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Document authorship and history:

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PART 1. Overview: Service-critical Workforce Framework

1.1 Background

Queensland Health employs more than 10,000 allied health professionals and allied health assistants. Allied health teams play a valuable role in delivering effective, patient centred health care across the system including acute, sub-acute, ambulatory, community and preventative services.

The *Optimising the allied health workforce for best care and best value: A 10-year Strategy 2019-2026* ("the 10-year Strategy") (Queensland Heath, 2019) provides direction for the allied health workforce to improve services for the people of Queensland. The 10-year Strategy's goals are to optimise the allied health workforce to provide best care and best value; provide healthcare that is integrated and delivered in partnership as close to home as possible for clients; and develop and implement sustainable models of care that meet health care needs into the future.

The Service-critical Workforce Framework ("the Framework") has been developed by the Office of the Chief Allied Health Officer (OCAHO) in collaboration with hospital and health services (HHSs) and Kristine Battye Consulting (KBC) Australia. The Framework supports the goals of the 10-year Strategy and will inform local and system-level actions that optimise access, capabilities and sustainability of the allied health workforce and services.

1.2 Purpose

The purpose of The Framework is to support allied health teams to identify and examine workforce-related risks to service continuity and sustainability, and to develop strategies to manage these risks through workforce or service redesign or improvement initiatives. The Framework has a dual focus on planning for:

- the management of short term/ emergent risks e.g., unplanned vacancies or leave impacting services, and
- medium to longer term capacity building to reduce the likelihood and consequence of workforce turnover and staffing instability.

1.3 Aim

The aim of the Framework is to better equip allied health teams with strategies to maintain service access, quality, and continuity and to sustain critical service capabilities by reducing the impact of workforce instability including vacancies and short-term staffing cycles.

Enabling the effective transfer of these strategies across organisations, sectors and disciplines is a key aim of this framework.

1.4 Scope

The Framework has been developed for allied health services in public healthcare settings. The Framework focusses on rural and remote allied health services. The impact of a position vacancy or workforce turnover in these small, multi-professional teams can include significant service disruption including a partial or full suspension of services for the relevant profession or clinical area. The Framework is also likely to be relevant to teams in urban locations that have small establishments, or that have skill sets that are difficult to attract, or that take an extended period to 'grow' internally i.e., specialised services.

The Framework has a focus on critical clinical functions; however, the processes outlined can be applied to other key functions in a service such as management, clinical leadership, education or research.

1.5 Principles

Principles for the implementation of the Framework in allied health teams are:

1. Patient-focused services that include shared decision-making, informed self-management and patient choice are integrated across the health sector and supported by continuity of care.
2. Cultural capability and safety underpin all aspects of service and workforce planning.
3. Strong allied health leadership is a critical foundation and driver of service and workforce planning.
4. Outcomes will enable high-quality, sustainable clinical practice and models of innovative service delivery staffed by a flexible and skilled workforce.
5. Service and workforce planning are a fundamental platform for service sustainability and performance.
6. Service and workforce plans are rigorously monitored and routinely reviewed to ensure that they remain fit for purpose and deliver desired outcomes for the team and community.

1.6 Context

Allied health workforce establishments in rural and remote areas are generally characterised by limited staffing, commonly with multi-disciplinary teams comprised of one or few members of each relevant profession. Workforce maldistribution affecting allied health recruitment in rural and remote areas is an entrenched issue in the Australian healthcare system, requiring health services to respond with multi-level strategies for managing periods of workforce shortage and turnover. Nationally, the allied health workforce in rural and remote areas is often less experienced and characterised by high turnover rates (Cosgrave et al., 2018; Miles et al., 2006). In addition, COVID-19 responses limited international and Australian health care worker movement, particularly in the period 2020-22, impacting workforce flexibility and recruitment outcomes for many rural and remote services.

1.7 Assumptions

Assumptions that underpin the implementation of the Service-critical Workforce Framework in rural and remote allied health services are:

- All members of the healthcare team provide important and valuable contributions to patient care, clinical outcomes and service performance.
- Local allied health teams understand the needs of their community, their service requirements and workforce challenges and so are well placed, with support, to analyse and pro-actively manage risks associated with workforce instability.
- Allied health organisational / operational and professional leaders will strongly and actively support allied health teams to examine and develop strategies to address known and predicted workforce-related service risks.
- Some factors impacting allied health recruitment and retention are amenable to organisation and local team intervention including professional support and development, team culture, workload management and supervisor capacity building (Cosgrave et al., 2018; Russell et al., 2021; Shoo et al., 2005) and should be addressed with short and medium term strategies to reduce the frequency and impact of workforce turnover and skills loss.
- There are a range of external and system-level factors that influence allied health workforce stability including the national training pipeline, domestic and international workforce markets and visa/migration policy, workforce demographics and employment trends. Local teams have limited capacity to directly influence broad systems, but these factors should be reflected in the assessment of workforce sustainability risks and the planning and investment in strategies to maintain a local workforce.
- Turnover and periods of vacancy in rural and remote allied health teams are inevitable, and so strategies to mitigate the impact on patient care, clinical outcomes, service and business continuity should be planned and documented to enable the team to respond appropriately.
- Although the suspension or rationing of services (e.g., triage and clinical prioritisation) is a potentially valid short-term approach to managing unplanned leave or vacancy, it is not an appropriate strategy for predictable, repeated or longer-term management of workforce instability. Limiting consumers' access to services is the least desirable strategy for managing staffing challenges.

1.8 Outcomes and outputs

The Framework guides an allied health team to:

- Identify, assess and understand the service impact of workforce instability including unplanned leave, vacancies and turnover in allied health positions.
- Pro-actively plan and document strategies that reduce the likelihood and consequence of vacancies and turnover on critical service functions of the team.
- Action and evaluate / monitor strategies implemented to manage service disruptions associated with workforce instability.

The main output for the team is a **Service-critical Workforce (SCW) Action Plan** that will:

- Concisely present the risk assessment
- Describe appropriate risk management strategies including actions, responsibilities and timeframes.

Strategies that are implemented to manage workforce-related service risks may require changes to the service, workforce, or business model for the team. The Framework provides some guidance for planning these changes but implementation sits outside the scope of the Framework and should be managed using relevant change management / redesign methods.

PART 2. Key concepts

"The ability of a country to meet its health goals depends largely on the knowledge, skills, motivation and deployment of the people responsible for organizing and delivering health services" (World Health Organization, 2010).

The concept of service-critical workforce reflects that healthcare is an industry that is highly reliant on the availability of an appropriately skilled workforce. Many skills sets that are integral to the delivery of healthcare are complex, and have long training pathways or restrictive entry requirements (e.g., qualification-based regulation or credentialing). This can provide important surety for safety and quality, but also makes small teams vulnerable to significant disruption when the capabilities or capacity required to deliver critical service functions are lost due to leave, turnover and vacancy. This is also a risk for teams with limited diversification or horizontal distribution of skills across the available workforce i.e., highly specialised / siloed teams.

2.1 Understanding workforce and functions

The term **service-critical workforce** reflects the interaction between the ***functions*** that are required to deliver safe, effective and efficient care for consumers, and the ***workforce*** that can provide those functions. It is related to the familiar concept of "right worker, at the right time, in the right place, with the right skills".

Although all healthcare teams and all team members are integral to service delivery, each position needs to be understood in the context of the functions it delivers to support the service. The loss of some functions due to position vacancy and turnover leads to serious service disruption including service closure or suspension, rationing of access or the need for patients to travel to attend other services. For other functions there can be adequate breadth and depth of capabilities across the team and an adequate workforce size and capacity to accommodate the loss of functions previously provided by a vacant role, at least in the short to medium-term. Planning, particularly in teams with small establishments, should focus on strategies to reduce the risk of losing critical functions that produce serious service impacts and restrict consumers' access to care.

To examine the concept of "service-critical workforce", two elements of the team's service functions need to be considered:

1. How *critical* is each function to patient care and service outcomes / performance?
   The functions required to meet service outcomes and performance requirements need to be understood and **critical service functions**, that will lead to serious service disruption if not delivered, should be identified.
2. How *accessible* is each function within the team?
   This relates to the **capacity and capability** of the workforce. The team should understand which positions can provide each critical service function, and the extent to which the knowledge, skills and experience (capabilities) to deliver these functions can be easily and quickly replaced if required.

Element 1: Critical service functions

All positions in an allied health team deliver a range of functions that support the team's outcomes and performance. These may include:

- clinical / client care functions – assessment, intervention, diagnosis, care planning and coordination, client education and advocacy, clinical documentation etc.
- business functions – finance and human resources management
- quality and safety functions – clinical governance, evaluation and monitoring, quality improvement
- administrative and operational functions - equipment management, stock control, consumables ordering, appointment scheduling
- education and workforce development functions – coordinating or providing staff training or supervision, student education
- research functions – undertaking or supporting research activities
- leadership functions – strategic and operational planning and reporting, representing the team in HHS and external meetings, fostering team support and cooperation, workflow coordination / work allocation.

How critical is a function? This is determined by the consequence if that function is not adequately performed, or not performed within a required timeframe. Functions may have different levels of criticality over time. The loss of some functions from the team leads to immediate service disruption. Many clinical functions and some fundamental HR (e.g., approving leave and rostering) and finance functions (e.g., approving invoice payment) are in this category. Other functions become critical if not delivered within the team over the medium to long-term, such as the impact on graduate recruitment and workforce sustainability if clinical education and graduate support are suspended for many months.

Box 1. Why examine what positions do (i.e., their functions) in addition to whether the positions are filled (i.e., recruitment and retention)?

Traditional workforce planning focuses primarily on numbers - total staffing establishment, vacancies, turnover. Consequent workforce strategies focus on maintaining a full establishment, primarily through 'like-for-like' replacement of workers when positions become vacant i.e., locums or permanent recruitment. In a workforce market with many highly skilled and mobile potential recruits, this approach is usually adequate and service disruptions associated with normal turnover cycles are limited. In this environment, workforce planning can focus on episodic recruitment and onboarding of recruits from the strong pool of available workers.

However, in situations of high demand for healthcare workers and strong competition for workforce within and across sectors, a sole focus on recruitment to maintain service continuity will be inadequate. Turnover is inevitable, even within teams with good retention. People retire, get promoted or change organisation. Can a healthcare team assume that its vacant positions will be consistently and rapidly filled by workers with the required experience and skills? If the answer is no, the risks posed to service continuity need to be assessed and managed alongside traditional workforce planning measures.

Box 1. (continued)

Risk assessment requires an understanding of the functions delivered by each position and person in the team, and which functions will lead to serious service disruption if they are lost in the short, medium or longer terms. Strategies to retain or obtain access to these functions include traditional attraction and recruitment approaches. However, additional strategies are required to temporarily address the gap in critical service functions and maintain consumers' access to care while a position is vacant and following recruitment e.g., intensive training of new recruits or temporarily sourcing the function from outside the team. The team also needs strategies to reduce the risk of frequent turnover that results in recurrent loss of critical service functions e.g., diversification of skills across the team, addressing retention risks, building the pool of potential recruits or partnerships with other services to fill gaps when required.

Workforce planning in small multi-disciplinary teams generally needs a dual focus on maintaining a fully staffed and highly capable team, and pro-actively managing the risks to service continuity posed by the reality of turnover in a challenging workforce market.

Element 2: Workforce capability and capacity

Within the allied health team, each role and team member:

- contributes to the **capacity** of the team to deliver the required service outcomes i.e., each is a 'set of hands' that assist the team to 'get the job done', and
- contributes to the **capability** of the team through delivering a range of functions that requires specific skills, knowledge and experience that the employee possesses.

A vacancy impacts on the capacity of the team as there are fewer people to do the required work. It can also reduce the team's capabilities through the loss of skills sets while the position is vacant and for the induction / training period of a new team member. Both a loss of capacity and capability will impact the team's ability to meet the performance requirements of the organisation and expectations of their community.

Box 2. Why differentiate capacity and capability?

For service-critical workforce planning it is important to differentiate between capacity and capability as the problems each pose and strategies to address each challenge can differ.

Capacity is a 'people power' issue. Even an experienced team with a well-distributed skills mix will experience service risks if only half the positions are filled. Capacity can also be compromised if positions or team members are located in the wrong place or available at the wrong time to deliver care. Risk assessment in relation to capacity will focus on vacancy and turnover trends, alignment of service demand (location / facility, frequency and timing of services) and consumer or service demands. Strategies for capacity issues may relate to the restoration of workforce establishment (i.e., filling vacancies, reducing turnover); workload allocation in the team; service scheduling and rostering; surge workforce measures (e.g., locum appointment or temporary increase in allied health assistant hours); sourcing capacity from elsewhere (e.g., secondment), or forming service partnerships with another HHSs or agency that can be 'flexed up' if required to meet short-term service demands.

Box 2. (continued).

Capability can be more difficult to assess and address, particularly in small and geographically isolated teams. Capability relates to the skills, knowledge and experience required by the team to deliver the services. Although a vacancy will always reduce capacity, as there is one fewer person to do the work, the impact on team capability varies, depending on what service functions the vacant position contributes, and which other team members can provide the functions. Similarly, turnover in a position may have little effect on team capability if the new recruit has the same skills as the previous incumbent, or can have a significant impact (positive or negative) if the newly appointed clinician has a different skills set to their predecessor.

Examining the functions delivered by each position enables the team to assess how vulnerable the service is to the loss of a critical service function if there is a vacancy or turnover. If the team is small, with only one person in a clinical profession or key role (e.g., manager, educator, clinician-researcher), it may be necessary to look at the functions provided by both the position and the individual employee in that role. This can be the case where, through long-standing preference or custom, a single team member acquires sole responsibility for an area of practice that is unlikely to be replicated in a replacement e.g., rural generalist physiotherapist / occupational therapist and comprehensive lymphoedema care, or rural generalist pharmacist and anti-microbial stewardship, or an individual who delivers all or most of the team's student education.

Where possible, capabilities that relate to critical service functions should be possessed by multiple team members, or the team should have a 'back up plan' for accessing required skills if a position becomes vacant. Teams should strive to minimise the number of critical service functions that can be provided by just one role or worker. Risks associated with the limited distribution of capabilities across the team may be addressed through developing task substitution (e.g., delegation, skill sharing), model of care re-design such as adding telehealth service capability, developing service partnerships, or scope of practice expansion/ upskilling across the team through training and development or structured succession planning.

2.2 Drivers for service-critical workforce planning

Meeting the needs of communities and the performance outcomes of health services are key drivers for hospital and health services (HHSs) to optimise access, effectiveness and sustainability of allied health services. An allied health team that is assessing its workforce-related risks to its services will need to identify their performance targets and the factors that define and influence their service requirements.

2.2.1 Health service performance and outcomes

Service agreements and performance targets

Each Hospital and Health Service (HHS) has a service agreement with the Queensland Government for the provision of public health services. The service agreement defines the

healthcare, teaching, research and other services that are to be provided by the HHS and the funding the HHS receives for the delivery of these services. It also defines the outcomes that are to be met by the HHS and how its performance will be measured. Allied health services contribute to performance targets associated with inpatient, outpatient, primary and community care, and aged care as well as training, education and research, with performance measures specific to each HHS.

HHSs may also have service agreements with other state and non-government organisations (e.g., Department of Education, Primary Health Networks) for the delivery of allied health services. There may also be agreements with education providers for training and funding agencies for research. The HHS may have funding arrangements for specific service or workforce activities with Department of Health branches such as the Office of the Chief Allied Health Officer (e.g., rural generalist training positions, First Nations graduate positions, research fellows or projects, models of care projects) or Healthcare Improvement Unit (e.g., service improvement projects).

Service plans

Each HHS has a range of plans and strategies that describe the aims, targets, outcomes, context for service delivery and other factors that influence the type of services allied health teams deliver. These may include plans for specific clinical areas such as mental health, sub-acute or ambulatory care, or specific populations such First Nations Peoples.

Clinical Services Capability Framework

The Clinical Services Capability Framework (CSCF) defines the service requirements of Queensland public health facilities. Allied health services that contribute to maintaining the clinical services requirements defined in the CSCF are likely to be high priority for risk assessment and management strategies. However, most CSCF modules have limited specificity for allied health service requirements, particularly in smaller facilities. Consequently they may have limited value for planning purposes.

Patient flow

Rural and remote HHSs support the whole of Queensland Health goals for “transferring clients to smaller facilities in the sub-acute period to minimise displacement from home communities for clients and family, and to support system efficiency in large metropolitan hospitals” (State of Queensland (Queensland Health), 2018b). Allied health teams will generally deliver a range of clinical functions that support sub-acute care in rural and remote health services e.g., diagnostics, assessment, therapy, psychosocial support, medications. Functions that enable patients to receive care closer to home, and that support patient flow are likely to be high priority for managing workforce-related risks to services. HHS and local service plans can provide information on patient flow targets and procedures that may help to identify critical service functions for the allied health team.

2.2.2 Community needs and expectations

The delivery of allied health services in rural and remote services should be informed by, and responsive to the health needs of the community. Consumers expect equitable and timely access to public health services to prevent or mitigate the escalation of health issues.

To enable community access to care, allied health teams shall consider the availability and capacity to meet demand, the accessibility of their services including maximising the delivery of care as close to the patient's home as possible, the cultural safety and responsiveness of their services, affordability and cost barriers for clients, and the organisation of service delivery to support the patient journey through the system. The HHS's Local Area Need Assessments (LANA) can assist allied health teams to understand community priorities, along with consumer engagement plans, First Peoples Health plans / strategies, etc.

2.3 Assessing and managing risk

The Framework applies a risk lens to workforce and service planning. Implementing the Framework will supply an allied health team with the information and decision support tools required to identify and manage service risks associated with workforce instability. Key concepts in relation to risk that are used in the Framework are summarised below. The Framework reflects the broad approach to risk management used in clinical safety and quality, finance / business, HR / workforce, information technology and other Queensland Health activities. Consequently, extensive information on risk management theory and practices are not included in this explanatory section of the Framework. Teams may seek out HHS and Queensland Health risk management resources if further background information or tools are required.

2.3.1 Risk Assessment

Risk is the chance of something happening that will have a negative impact. The elements of risk are: risk sources, potential incidents or events, their consequences, and their likelihood (Australian Commission on Safety and Quality in Health Care, 2021).

The risk **source** for health services addressed in the Framework is the reliance on a suitably skilled and qualified workforce to deliver the activities and service functions required for patient care and to meet service outcomes and performance requirements.

The **event** addressed in the Framework is the loss of capabilities including knowledge, skills, and experience, and the loss of capacity required to deliver a service due to:

- an unfilled position - planned or unplanned leave, secondment out, redeployment or other temporary staffing change, or permanent separation producing a vacancy,
- staff turnover – loss / change in skills, knowledge and experience available to the team.

The **consequence** is the outcome of the event. Workforce instability may impact the service functions required to deliver patient care, produce service outcomes, and meet performance targets. Consequences for clinical activity and direct client care are a common focus for allied health teams but other impacts may be relevant e.g. clinical placement activity, service agreement KPIs / deliverables, accreditation or clinical governance requirements.

Likelihood is the chance of the event happening. In relation to the Framework, this includes both the chance that the team will:

- experience a position becoming unfilled or staffing turnover and
- this will disrupt the team's ability to deliver the functions required by the service.

The risk assessment process reflects the Queensland Health Workforce Planning Risk Matrix. The team should examine the likelihood and consequence of service disruption associated with the loss of a position and the service functions that the position provides. This is summarised in Figure 1.

Figure 1. Summary of risk assessment – risk of service disruption associated with vacancy/turnover in a position and associated loss of functions delivered by the role

LIKELIHOOD of service disruption if a position is unfilled or there is staffing turnover	History or predicted turnover/ vacancy in this position. This position is the only one in the team that delivers one or more service functions. Skills, knowledge and experience required to deliver the function cannot be quickly or easily acquired / replaced in the event of unplanned leave or vacancy.	Very likely	**Medium Risk** Explore and plan	**High Risk** Prepare (Service-critical risk)
	Stable staffing history and good anticipated employee retention. All / most service functions are currently provided by multiple team members. Skills, knowledge and experience required to deliver the function can be easily and quickly accessed (e,g., another team in the HHS).	Unlikely	**Low Risk** Note and monitor	**Medium Risk** Explore and plan
			Negligible	Extreme
			Limited disruption will occur or disruption will take a long time to manifest if functions are unavailable in the team	Immediate and serious disruption if functions are unavailable in the team
			CONSEQUENCE of a position vacancy / turnover for patient care, service outcomes or performance	

2.3.2 Strategies to manage risk

Managing service-critical workforce risk requires strategies that address one or more methods for risk reduction:

- avoid the risk
- remove the risk source
- change the likelihood
- change the consequence
- share the risk
- retain and monitor the risk by informed decision.

(United Nations Industrial Development Organisation, 2018)

There are a range of strategies to manage the risks of workforce instability and the consequent impact on critical service functions. The types of risks identified will influence the strategies that the team includes in a Service-critical Workforce Action Plan. The selection of strategies will also be influenced by a range of contextual factors including team size, structure and appetite for implementing change, the local service provider landscape and existing service relationships, the HR policy and funding environment, and the needs of the wider service and community.

Strategies employed by health services may include:

- workforce management solutions e.g., workforce structures and team composition,
- workforce development solutions e.g., work-based training, supervision, clinical education, succession planning, and
- service models and models of care solutions e.g., partnerships with other service providers.

The toolkit includes a strategy resource library and decision-support tool that links identified risks to potential management strategies.

PART 3. Using the Service-critical Workforce Framework

3.1 Indications and considerations for use

The Framework and associated toolkit are available to allied health teams that want to assess their workforce-related risks to service continuity and sustainability and develop a Service-critical Workforce Action Plan. Indications for use may include:

- a history of extended, persistent or repeated service restrictions related to workforce instability, or other evidence of service vulnerability related to vacancy and turnover in allied health roles,
- lack of team understanding or agreement, or inadequate documentation and implementation of service continuity strategies in the event of workforce instability, or
- expressed needs of the allied health team, wider HHS, service partners or community for improved service continuity that provides consistent consumer access to care.

The Framework does not focus on building a business case for more staff. The Framework primarily supports teams to examine strategies that can maximise the use of existing resources.

The outcomes for teams that implement the Framework are expected to include:

- improved clarity and ability of the team to address short-term, unplanned loss of key workforce / skill sets and maintain service continuity,
- a shared understanding and plan to guide incremental improvements in service and workforce capacity, stability and sustainability in the medium to long term, which may guide multi-stage strategies that are integrated into the team's quality and service improvement, workforce development or other plans, and
- expanded knowledge, skills and experience of team members in service and workforce analysis and planning.

To be most effective, teams implementing the Framework should be able to consider short-term / emergent service continuity strategies and also medium to longer-term capacity building. Teams that are currently experiencing high turnover or extensive vacancies may have difficulty allocating the time and resources to effectively implement the Framework and develop a comprehensive action plan for change. Similarly, a team under high stress or with significant change fatigue will have difficulty engaging with the Framework. In these situations, the team's time and efforts may be better allocated to managing short-term service stabilisation and recruitment / onboarding activities. Implementation of the Framework may be more beneficial at a later time.

3.2 Project management

The Framework provides a structure and resources to assist the team to complete the exploratory and action planning phases of a project to address workforce-related risks to

service continuity and sustainability. A general overview of project implementation activities is shown in Table 1, including a reference to relevant Service-critical Workforce Framework steps.

Table 1. Summary: phases and activities for service/workforce improvement projects, including reference to Service-critical Workforce Framework steps

Project phase	Key activities
Preparatory phase	Project concept approved by relevant delegate (project sponsor) Awareness raising and team support to participate in project Scope, aims and expected outcomes of the project are discussed and agreed by team and key stakeholders Project plan approved by project sponsor Project responsibilities agreed including project lead/s nominated Resource allocation to project (particularly time) agreed, documented in project plan and integrated into project lead and team members' schedule (e.g., meetings and project time allocated in calendars) Project support secured e.g., project management mentor / coach, evaluation expertise Project governance processes commence e.g., governance / working group convened, and terms of reference approved by project sponsor
Exploratory phase	***Service-critical Workforce Framework: Steps 1 – 5*** Team reviews Service-critical Workforce Framework and toolkit Gathering, processing, evaluating and interpreting information relevant to workforce and service risks
Planning phase	***Service-critical Workforce Framework: Steps 6 - 8*** Service-critical Workforce Action Plan drafted and endorsed by project governance group Service-critical Workforce Action Plan approved for implementation by project sponsor Implementation responsibilities and resources agreed in Action Plan, with timeframes, milestones and performance measures set
Implementation & monitoring phase	Strategies in the Service-critical Workforce Action Plan are implemented Implementation and outcomes of the Service-critical Workforce Action Plan are monitored and evaluated, with revisions to the plan if required Learnings and outcomes are disseminated e.g., Local or HHS presentations, conference presentations, newsletter, publications Strategies are embedded in 'business as usual' for the team including routine monitoring and scheduled review to ensure they remain effective and fit for purpose.

Project management resources

The Framework reflects but does not replace comprehensive project management processes. The team should apply relevant service improvement / change management approaches that are supported by the HHS. If the HHS does not have prescribed project management processes and templates, such as a project plan, risk assessment, Gantt chart / activity schedule, stakeholder analysis and engagement plan or evaluation plan, allied health teams can access resources from the Clinical Planning and Service Strategy Division, Clinical Excellence Queensland Project Management Assistant (PaM) QHEPS (intranet) site.

Resourcing considerations

The Framework is designed to be feasible for allied health teams to implement within existing staffing, skills and financial resources, potentially through integrating the work into routine quality improvement and service development cycles. Trialling of the Framework with two rural/remote allied health teams in 2022 provided the following learnings:

- Implementation of the eight-step Framework is feasible in approximately 12 weeks, from the point of project approval to the endorsement of the Service-critical Workforce Action Plan. Timeframes for implementing the Action Plan depend on the strategies selected.
- Team members require time to be allocated to project activities. To complete the implementation of the Framework in approximately 12 weeks, team members need time each week for project activities including participating in the project governance group or smaller working groups, and collecting and reviewing information. Time allocation in the trial varied by role in the project and phase of implementation. The project lead/s consistently required 1+ day per week to manage project activities, and other team members 1-4 hours per week, particularly during steps 4-7 of the Framework.
- Nomination of a project lead to manage and coordinate the project activities is critical. This may be one person or shared by a couple of staff (e.g., an experienced project manager mentoring and supporting an emerging clinical leader is a good model). During the implementation of the Framework the key responsibilities of the project lead include stakeholder engagement, drafting documents, collecting and collating information and working with the allied health team members to define risks and develop potential solutions. A project lead may be internal or external to the team, but it is important that the individual understands the core business of the team and service, the organisational context and the key stakeholders.
- Teams may need to access assistance and support for specific aspects of the local implementation of the Framework e.g., a workforce development officer to support project management, business analyst to support data sourcing or collation, or a research fellow to support evaluation planning.

Governance considerations

Sponsor

As implementation of the Framework will produce recommended changes to service, workforce, business and / or operational aspects of the team, the work should be sponsored by the position/s responsible for approving any recommended changes e.g., Director of Allied Health, Executive Director Rural Services.

Governance group

Implementation of the Framework should be supported by a project governance group to:

- provide oversight and coordination,
- contribute advice and feedback, and
- undertake the activities required to implement the Framework and to develop the Service-critical Workforce Action Plan.

Smaller working groups or a project leadership group may be formed to undertake specific activities, and a broad stakeholder network may be created to keep all interested people informed.

PART 4. Service-critical Workforce Framework

4.1 Structure

The Framework has eight steps, broadly grouped into three stages:

1. Understand the service
2. Assess the risks
3. Plan for the future

The outline of the Framework, including stages and the related steps, is shown in Figure 2.

The Framework provides a guide and tools to support objective and reasonable decision-making on priorities for change and strategies to address identified workforce-related service risks. The activities and tools in each step will enable this, but the Framework is not a strict recipe. The project team needs to have good understanding of the Framework purpose, concepts and tools, and match them to the aims and outcomes required of their project. No two teams will implement the Framework in the same way. Although presented in a linear sequence, trialling of the Framework in two rural / remote allied health teams in 2022 indicated that 'doubling back' to expand or refine information or decisions made in an earlier step is not uncommon. The need to revisit an earlier step sometimes becomes apparent if the team identifies a gap in information that is required to make a decision. Equally, a tool in the Framework may have limited relevance for a team, or not contribute much to decision-making. In this case, the team might elect to omit or hold over this work and move on to the next step.

4.2 Tools

Tools are associated with each step in the Framework. The tools provide guidance on sourcing, organising and interpreting information and prompts for making decisions. Most tools are templates in electronic (MS Excel) format that allow information, findings or decisions to be recorded. Using the tools on a MS Teams or One Drive platform (or similar) allows multiple team members to collaborate on the document in real time.

The suggested process for approaching each tool is:

1. Review the tool, ensuring the team understands its purpose and what it contributes to the team's understanding of their risks and challenges.
2. Determine what information is required to complete the tool. This may require some thinking on the extent of information that will be sourced. For example, how far back should the team collate vacancy data for: 1 year, 3 years, 5 years? Consider what is needed to provide the team with an understanding of workforce-related service risks, and also the time and resource investment required to source and process the data.

3. Make a plan to source the information including who is responsible for providing / sourcing / collating the information and the desired timeframe. This might involve the entire team, specific team members or people who are external to the team e.g., Division business analyst, HR unit.
4. When the tool is completed, review the outcomes as a team. What does the information indicate? What can you learn from it that is relevant to the Service-critical Workforce Framework and your project aims? Record these learnings and what it means for the Service-critical Workforce Action Plan.

Remember, the purpose of each tool is just to gather and arrange information so that the team can understand their risks and make good decisions on strategies to be progressed in the Service-critical Workforce Action Plan. Tools can be roughly presented, with comments and notes added, the structure changed, more or different information collected. The value of the tools is derived from the team interpreting and discussing the information that it collects to progressively build a plan for improvement.

Access the toolkit via the OCAHO website at https://www.health.qld.gov.au/ahwac/html/rural-remote or contact the Office via email for more information: allied_health_advisory@health.qld.gov.au.

4.3 Steps

The Framework's eight steps are presented in the remainder of Part 4 of this document. Each step has key activities, that generally relate to collecting / collating, analysing and interpreting information, discussing it as a team and making decisions. Outputs from each step build to produce a comprehensive Service-critical Workforce (SCW) Action Plan, which is the primary output of the Framework. The SCW Action Plan will present the strategies that the team have prioritised for implementation, based on the assessment of workforce-related risks to service continuity and sustainability that the Framework has highlighted.

Figure 2. Service-critical Workforce Framework implementation

Framework focus	Framework steps
Understand the service Overview: The team assesses their readiness and preparations for scoping, designing and implementing change. The team collects / collates and analyses information on: (a) resources including workforce establishment, capacity and capability, and (b) demands including service outcomes and performance requirements. Outcome: Through completing Step 1 - 3 activities, the team will have a clear understanding of their service, and determine or refine the scope of positions and functions that need to be risk assessed in Step 4 and 5, and considered for strategies in the SCW Action Plan.	**Step 1: Readiness Assessment** **Step 2: Service Profile** **Step 3: Workforce Profile**
Analyse the risks Overview: The team identifies critical service functions (clinical and non-clinical) and risks to the delivery of those functions. Outcome: Risks to critical service functions, including the impacts of loss of the functions, are identified, discussed and documented.	**Step 4: Role Analysis (Clinical)** **Step 5: Role Analysis (Non-clinical)**
Plan for the future Overview: The team sets priorities, identifies strategies and completes the SCW Action Plan. Outcome: SCCW Action Plan is prepared, endorsed and approved for implementation.	**Step 6: Priority Setting** **Step 7: Strategy Identification** **Step 8: Action Planning**

Step 1: Readiness Assessment

Purpose

To support the team to understand their readiness and capacity to implement the Framework, develop a SCW Action Plan, and progress the strategies. The team will consider who needs to be involved in the project.

Output

Readiness for the project is assessed, project risks are identified, and the project plan is refined and finalised.

Project governance and coordination processes commence and stakeholders are considered.

Key questions to be considered in Step 1

- Is there HHS support for examining and addressing service-critical workforce risks?
- Is the team ready, motivated and adequately skilled to assess and address workforce-related service challenges?
- Is there adequate project management capability (skills, experience) and capacity (time, resources) within the team? If not, how can this be addressed e.g., scheduling, sourcing skills or capacity from outside the team?
- Who needs to be involved in planning the project and implementing the Framework?
- What data is available for analysis and planning activities, and how can it be obtained?
- What workforce and service sustainability strategies have been tried before and what was the outcome?
- What are the team's main challenges to service continuity and sustainability currently and in the last 12 months?

Activities

Readiness Assessment

Stakeholder assessment

Project governance arrangements commence e.g., project governance group is formed

Reflection activity at end of stage is useful to check progress and refine the project

Resources

Tool 1.1 – Readiness assessment

Tool 1.2 - Stakeholder engagement tool

Reflection tool

Note: At the start of this stage, the team should have a project plan prepared. The plan may be in draft form, to be finalised for approval of the delegate shortly after the readiness assessment is completed. Project planning resources and templates are available in some HHSs or at https://qheps.health.qld.gov.au/cpss/workforce-strategy-branch/leadership/project-management-framework (Queensland Health only).

Step 2: Service Profile

Purpose

To understand the services provided by the team and to identify the critical services that will be the focus of the SCW Framework implementation.

Output

Service profile is completed, and the team determines the services that are in scope of the SCW Action Plan.

Key questions to be considered in Step 2

- What services does the team provide? Consider:
  - setting - inpatient, ambulatory care, community.
  - delivery mode - telehealth, outreach, in-person.
  - clinical groups e.g., diabetes, frail aged, maternal and child.
  - clinical pathways and patient flow relevant to specific professions or whole team.
- What are the team's service outcomes and performance requirements?

  This should consider relevant drivers of service scope and demand including: service and operational plans, performance indicators, Clinical Services Capability Framework (CSCF), service agreements, funding environment, referral trends, wait lists and wait times, community expectations and local indicators of service demand (e.g. compliments and complaints).
- What services are in scope for the SCW Framework implementation and planning processes?
- Which positions are in scope for the SCW Framework implementation and planning processes?

  The scope should describe what is to be included and excluded in the SCW planning project. Scope will be defined by the professions / positions, service / clinical areas and facilities / geographical locations included. The scope may be broad, such as all professions in a multi-disciplinary allied health team, or may be narrow such as inpatient services or a single profession. The team should consider its recent history and known threats to workforce stability and service continuity, workforce profile etc; as well as indicators of unmet service demand or service stress such as wait lists / wait times, existing service restrictions (e.g., clinical category or facilities serviced). The team's capacity and time available to invest in the project should also be considered.

Activities

Develop a profile of the service

Reflection activity at end of stage is useful to check progress and refine the project.

Resources

Tool 2.1 - Service Profile

Reflection tool

Step 3: Workforce Profile

Purpose

To identify the characteristics of the allied health team and indicators of workforce stability relevant to the SCW Action Plan.

Output

Workforce profile including indicators of workforce risks for the team.

Key Questions to be considered in Step 3

- Which positions deliver the services that are relevant to the scope of this project? Record details including position numbers, profession / discipline, classification, FTE, position status, work days and location, etc.
- What is the history of recruitment and retention for each position? This indicates the trends in turnover and also the approximate 'replacement time' for the position.
- What strategies does the team routinely use for workforce development, recruitment and retention? (e.g., structured orientation in team, introduction to community, formal supervision, mentoring, access to accommodation, flexible working arrangements, team-based professional development, professional development / conference / study leave or funding such as SARAS, HR Policy C42, Clinical Assistant Training Fund).
- What strategies does the team currently use to build the workforce 'pipeline'? That is, how are current and future health professionals exposed to the work of the team and encouraged to seek employment in the service? (e.g., clinical placement activity, traineeships and cadetships, graduate positions, rotations and secondments).

Activities

Document the workforce profile of the team including positions that are in scope of the project and descriptive information on each role.

Collect and collate information on recruitment and retention performance in the past two years (or an appropriate time period to identify a baseline / trend) including vacancies, locums, secondments, failed recruitment rounds etc.

Collect and collate student and practitioner 'pipeline' information including clinical placement activity, and use of workforce support strategies.

Reflection activity at end of stage is useful to check progress and refine the project.

Resources

Tool 3.1 - Workforce Profile

Tool 3.2 - Workforce Support

Tool 3.3 - Workforce Pipeline

Reflection tool

Step 4: Role Analysis (Clinical)

Purpose

To identify and describe service-critical clinical functions for positions in scope of the SCW Action Plan.

Output

Completed risk assessment for each critical clinical function for each position in scope of the project. Functions at high risk of causing service disruptions are identified.

Key Questions to be considered in Step 4

- What are the key functions for each position / profession in relation to clinical service requirements?
- What is the impact if that function is not provided? (i.e., what is the degree of disruption to service outcomes, patient care, patient flow and patient safety?)
- How likely is it that the function will not be available to the team (or significantly curtailed) if the employee is absents or the position becomes vacant? (i.e., capability and capacity)?
- How quickly can the function be sourced / replaced (i.e., replacement time from within the team, HHS or external unit / agency)? Note: this is replacement of the function, not necessarily recruitment to the vacant position as there may be other ways to deliver the function while a position is unfilled.

Activities

Map potential critical clinical functions of each position (or a small number of positions of the same profession as a group) that are characterised by:

- High volume / frequent delivery in the service.
- Support for high priority services (i.e., Category 1 and 2).
- Important enablers for patient flow in an episode of care (i.e., where delay to delivery of the clinical function will impact patient outcomes, transitions or service efficiency).
- lead to significant disruption to the service if the function is not available in the immediate / short-term, or significant / escalating disruption in the medium-term (e.g., waitlist / wait times, referrals and demand management).

Develop a list of potential critical clinical functions for each position.

Undertake a risk assessment through considering the likelihood and consequence for the service of the loss of the function due to absence, vacancy or turnover.

Reflection activity at end of stage is useful to check progress and refine the project.

Resources

Tool 4.1 - Role Analysis (Clinical)

Reflection tool

Step 5: Role Analysis (Non-clinical)

Purpose

To identify and describe service-critical non-clinical functions (operational, business, education or research) for positions in scope for the SCW Action Plan.

Output

Completed risk assessment for each non-clinical function for each position in scope of the project. Functions at high risk of causing service disruptions are identified.

Key Questions to be considered in Step 5

- What are the key functions of each position in relation to non-clinical service requirements (refer to Section 2.1 of the Framework for information on non-clinical service functions)?
- What is the impact if the function is not provided? (i.e., what is the degree of disruption to service operations?)
- How likely is it that the function will not be available to the team (or significantly curtailed) if the position was vacant? (i.e., consider the capability and capacity across the team)
- How quickly can the function be sourced / replaced (i.e., replacement time from within the team, HHS or external unit / agency)? Note: this is replacement of the function, not necessarily recruitment to the position.

Activities

Map potential critical non-clinical functions of each position (or a small number of positions as a group e.g., clinical educators) that will potentially cause significant disruption to:

- Patient care or safety if the function was not available in the immediate / short-term, or significant / escalating disruption in the medium-term (e.g., clinical governance requirements such as supervision or delegation, service improvement initiatives, equipment / consumables management such as maintenance or infection control).
- The service's capacity to meet its commitments or obligations (e.g., service agreements, KPIs, student deed or placement allocations, rural generalist training agreement, project grants / funding agreements, research grants / collaborative agreements).
- The service's capacity to maintain operational, administrative and business requirements (e.g., human resources, finance, occupational health and safety, information management and data systems).
- Education and training commitments including student education, staff development.
- Research commitments including funded projects and approved timelines.
- Leadership, strategic planning and reporting.

Develop a list of potential critical non-clinical functions for each relevant position. Not all positions included in Tool 4.1 Role Analysis (clinical) may need to be considered in this step.

Undertake a risk assessment through considering the likelihood and consequence for the service of the loss of the function due to vacancy or turnover.

Reflection activity at end of stage is useful to check progress and refine the project.

Resources

Tool 5.1 - Role Analysis (Non-clinical)

Reflection tool

Step 6: Priority Setting

Purpose

To categorise the identified risks and the outcome of the risk assessment into a priority list for action.

Output

Priorities for action are identified.

Key Questions to be considered in Step 6

- What are the team's greatest vulnerabilities? Reflect on the information from steps 1-5 and prioritise the identified risks for action.
- Which risks require immediate action due to their potential negative impacts for the service?
- Are there any risks that can be easily eliminated and should be prioritised for action in the near future? ("low hanging fruit")
- Which risks need to be further investigated?
- Which risks need to be addressed in the medium term but are not immediate priorities? This may include more complex risks or those that are likely to have more complex strategies, or those linked to external factors or timeframes (e.g., financial years, or budget build cycles).
- Which risks only require monitoring at this time? How will the risks be monitored and who is responsible?

Activities

Consider identified risks to critical clinical and non-clinical service functions and prioritise using information compiled in stages 1-5.

Resources

Tool 6.1 - Risk stratification and priority setting

Step 7: Strategy Identification

Purpose

To identify a range of strategies and that can be used to address the team's risks and vulnerabilities.

Output

Strategies identified that may address the priority risks. The team determines the strategies to be included in the SCW Action Plan.

Key Questions to be considered in Step 7

- Which strategies can be applied to address emergent or short term absence from a position (i.e., vacancy or leave)? This may include strategies that provide short term replacement options, and improve onboarding and induction for new employees.
- Which strategies may improve workforce stability and sustainability? This may include strategies that reduce turnover / increase retention and enhance attraction and recruitment.
- Which strategies can be used to maintain critical service functions when a position is vacant or the employee is absent? This may include strategies that use other team members or other services to deliver the function.
- What strategies may be used to further align the team's capabilities with critical service functions and service performance requirements? This may include expanding the breadth and depth of skills, knowledge and experience in the team, changing the way services are organised or developing partnerships.
- What would be required to progress the strategies including:
  - timeframes,
  - resources, and
  - changes required, agreement and approvals?
- What partnerships/ resources does the team already have to support the potential strategy and what needs to be developed? (review Readiness Assessment)

Activities

Use the Decision Support Tool to identify potential strategies to address identified priorities. Selected strategies will be recorded in the SCW Action Plan (Tool 8.1).

Resources

Tool 7.1 – Strategies decision support tool

Step 8: Action Planning

Purpose

To develop an achievable plan that will address the priority risks that the team has identified. The plan will be presented to the approving delegate for consideration.

Output

SCW Action Plan

Key Questions to be considered in Step 8

- Which strategies should be progressed in the Action Plan?
- For each proposed action, record what is required including:
  - brief description and objectives, main challenges and enablers,
  - key activities required to deliver the outcome,
  - responsibilities for activities and any resources required,
  - timeframes and milestones, and
  - measures / indicators of implementation.
- Is additional documentation required for an action, such as a detailed project plan or business case? Strategies that are complex, potentially sensitive or controversial, or that require significant resource allocation or reorganisation are likely to need more detailed implementation processes.

Activities

Finalise the SCW Action Plan using the template provided and in consultation with relevant stakeholders and decision makers.

Resources

Tool 8.1 – SCW Action Plan

References

Australian Commission on Safety and Quality in Health Care. (2021). National Safety and Quality Health Service Standards.

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Shoo, A., Stagnitti, K., Mercer, C., & Dunbar, J. (2005). A conceptual model for recruitment and retention: Allied health workforce enhancement in Western Victoria, Australia. Rural and Remote Health(5), 477. https://www.rrh.org.au/journal/article/477

World Health Organization. (2010). Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. World Health Organization. https://apps.who.int/iris/handle/10665/258734

United Nations Industrial Development Organisation. (2018). ISO 31000: 2018 Risk Management.

Additional resources

Strategic planning

- My health, Queensland's future: Advancing health 2026 (Advancing health 2026)
- Optimising the allied health workforce for best care and best value: A-10 year Strategy 2019-2029
- Queensland Heath Strategic Plans
- Hospital and Health Service Strategic Plans

Service planning

- Queensland Health Health service and system planning

Workforce planning

- Queensland Health Strategic Health Workforce Planning Framework
- Queensland Health Health Workforce Information Gateway (HeWI)
- OCAHO Workforce planning resources

Workforce policy

- Queensland Health awards and agreements

Glossary and acronyms

Acronyms and terms used in the Framework are shown below.

Note: The term for a health service user varies across the health system and includes 'client', 'patient' and 'consumer'. In this document, the terms are used interchangeably and have the same meaning.

Acronym	Meaning
AHP	Allied health professional
AHA	Allied health assistant
CSCF	Clinical services capability framework
FTE	Full time equivalent
HHS	Hospital and health service
KPI	Key performance indicator
OCAHO	Office of the Chief Allied Health Officer
SCW	Service-critical workforce

Term	Meaning	Source (if relevant)
Service-critical Workforce Action Plan	Documented information that guides an organisation to respond to a disruption and resume, recover and restore the delivery of services consistent with its strategic, operational and business continuity objectives.	
Business continuity	Capability of an organisation to continue to deliver products and services within acceptable time frames at predefined capacity during a disruption.	ISO: 22301:2019
Disruption	Incident, whether anticipated or unanticipated, that causes an unplanned, negative deviation from the expected delivery of products and services according to an organization's objectives.	ISO: 22301:2019
Incident	Event that can be, or could lead to, a disruption, loss, emergency or crisis.	ISO: 22301:2019
Prioritised activity	Activity to which urgency is given in order to avoid unacceptable impacts to the business during a disruption.	ISO: 22301:2019

Term	Meaning	Source (if relevant)
Resource	All assets (including plant and equipment), people, skills, technology, premises, and supplies and information (whether electronic or not) that an organization has to have available to use, when needed, in order to operate and meet its objective.	ISO: 22301:2019
Risk	Effect of uncertainty on objectives. (Note: Risk is often expressed in terms of a combination of the consequences of an event (including changes in circumstances) and the associated likelihood (as defined in ISO Guide 73) of occurrence.)	ISO: 22301:2019
Effectiveness	Care, intervention or action achieves the desired outcome from both the clinical and patient perspective, including as patient reported outcomes (PROMs). Care provided is based on evidence-based standards.	Australian Health Performance Framework (2017)
Safety	The avoidance or reduction to acceptable limits of actual or potential harm from health care management or the environment in which health care is delivered. Includes aspects of the safety of care delivered to health care providers and patients, including patient reported incidents (PRIMs).	Australian Health Performance Framework (2017)
Continuity of care	Ability to provide uninterrupted care or service across programs, practitioners and levels over time. Coordination mechanisms work for health care providers and the patient.	Australian Health Performance Framework (2017)
Accessibility	People can obtain health care at the right place and right time, taking account of different population needs and the affordability of care.	Australian Health Performance Framework (2017)
Efficiency and sustainability	The right care is delivered at minimum cost and human and physical capital and technology are maintained and renewed *while* innovation occurs to improve efficiency and respond to emerging needs. Members of the workforce receive appropriate support and report positive experiences.	Australian Health Performance Framework (2017)