Calderdale Framework: An Overview &
Calderdale Introduction Session Q&A Summary, May 29th 2018

What is the Calderdale Framework?

The Calderdale Framework (CF) is a workforce design tool that has the potential to support the development of new models of care, achieve more efficient and effective utilisation of the clinical workforce and provide safe quality care for patients. It was developed in the United Kingdom by Rachael Smith and Jayne Duffy, while working in Calderdale and Huddersfield NHS Foundation Trust. Smith and Duffy now own the rights to the Calderdale Framework (Effective Workforce Program). The main uses of the CF in a health service team are to scope, design, implement, evaluate and monitor:

- a delegation model for assistants and other support workers
- a workforce model for skill sharing across professions in the team.

Key principles of the Framework are:

- Patient focused – patient quality and safety central to the design
- The process is clinician and team led with engagement at all steps of the process
- Transparent and objective
- Systematic and sustainable change process
- Establishment of a Clinical Governance framework.

The Calderdale Framework has been used and evaluated in many allied health services in the United Kingdom and Australia. It is also being successfully implemented by the South Island Alliance through the South Island Workforce Development Hub.

The Calderdale approach is led by **trained Facilitators** who lead skill mix and/or delegation process changes within a team. The Facilitators are trained by credentialed **Practitioners** (who can also work as Facilitators). The overall intent is to create a Facilitator community to build capacity for change. Ultimately, health professionals would utilise skill sharing and skill delegation methodology in practice, as part of quality improvement and professional development.

How is Calderdale Training undertaken?

Attendance at a Foundation Day is a prerequisite for clinicians who may then progress to the Facilitator training course.

Facilitator training occurs over 4 days across a 12 month period and is in 2 parts – Part 1 is 3 face-to-face days and Part 2 is a single face-to-face day held 6 months later. In between these days the Facilitator trainees work on a project as part of their assessment which they report on during their Part 2 training day. The Practitioners provide support at least monthly during this time. Potential Facilitators can be clinicians at any level in the organisation and any person who is interested and put forward by the service. Support from senior decision makers and their direct manager(s) is essential. Basic skills in project management and facilitation would be provided from within the DHB. Peer support for Facilitators is also important and regular network forums are held.

There are currently **2 Calderdale Practitioners** in New Zealand: Hilary Exton, Director of Allied Health, Nelson Marlborough DHB and Vicki Prout, Clinical Team Leader, Physiotherapy, Canterbury DHB who would provide training to potential Facilitators.

What are the potential benefits for Northland?

The Calderdale Framework could provide a structured approach to support Northland to address key challenges of health service delivery. It is particularly relevant to the development, implementation and evaluation of sustainable workforce solutions and safe clinical practices enabling community allied health and nursing services to work at the top of clinical scope, thereby increasing patient access to timely community allied health service and nursing care.

Introduction to the Calderdale Framework May 29th

Questions&Answers

Q Is this open to nurses as well, or is it targeted to the Allied Health workforce?

A No, it's not limited, the methodology applies across nursing and allied health.

Q Is this leading to a reduction in 'body counts' or releasing time to care? It should be about releasing time to care.

A It's not about a reduction in the body count - it's definitely about releasing time to care, about addressing ongoing demand and reducing waitlists for patients.

Q Were your clinicians given time to develop this or were they expected to do this on top of their role?

A Yes and no. Yes, I do my best to backfill - if I can. But there is a challenge to that. Clinicians are already training allied health staff so do they need additional time to do this – they're already spending time training.

Q There is a difference between Health Care Assistants (HCAs) and Allied Health Assistants (AHAs). Do you have standard AHA training?

A No, not at this stage but there is a need to consider this. We are trying to purposely develop and align Clinical Task Instructions (CTIs) for cross-credit. There are slightly different modules for AHAs and HCAs. Occupational Therapy Assistants (OTAs) and Physiotherapy Assistants (PTAs) are also seen as two separate workforces at present and it's better to view them as a 'group' - not using AHAs *specifically* as PTAs or OTAs. It goes back to the consumer - they probably wouldn't want multiple different people involved in their care delivery. It's about having one Assistant for one client - in the community, one Assistant for one patient.

Q How does a more generic type workforce fit in with specialist community rehab and NASC?

A It's up to the profession to determine what works best in relation to delegated practice and what doesn't. The Service Analysis completed along with the Clinical Task Analysis*, can identify who is doing what, where any duplicated effort is, and what are the opportunities for delegation and for skills sharing as well as what needs to remain as specialised roles and tasks. The consumer needs are always central to this discussion.

(*Service Analysis and Clinical Task Analysis are 2 of the 7 key steps of the Calderdale Framework. These 7 steps are undertaken by trained Calderdale Facilitators)

Q Who leads out the competency task training?

A It's led by the profession within which it sits. Ultimately, it's the profession that must sign off a person as competent to do a task. The Calderdale approach fosters the development of clinical governance strategies and structures across local and regional governance groups to support this.

Q In relation to the MAU concept, there is a speech assessment, a swallow assessment- a package of training for dysphagia. Can you pick up Clinical Task Instructions from elsewhere?

A Yes, if your service has assessed the need - and the existing CTI fits. There is also a bank of existing CTIs which the trained Calderdale Facilitators can access. These provide a resource, so rather than reinventing the wheel, these can be adapted and adopted to fit the local context.