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| Victorian allied health assistant workforce recommendations |
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In this document, ‘Aboriginal’ refers to both Aboriginal and Torres Strait Islander people. ‘Indigenous’ or ‘Koori/Koorie’ is retained when part of the title of a report, program or quotation.

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Available at [Victorian Allied Health Assistant Workforce Recommendation and Resources](https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources) <https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources>

# Acknowledgement of Country

Artwork by Dixon Patten Jr showing the different stages of our lives. The coolamons (shallow dishes) represent women and children, and the connection between birth, life and death. Shields are the strength and resilience of the people and the large hands represent the elders who share their knowledge.
Boomerangs means returning to culture to find counsel and wisdoms.

**Artist**: Dixon Patten Jr (Gunnaim, Yorta Yorta and Gunditjmara).

**Title**: Ngarra-jarra-noun (Woi-Wurrung language), meaning ‘to heal’.

Commissioned by Monash Health

The authors of the *Victorian allied health assistant workforce recommendations* would like to acknowledge the Traditional Custodians of the lands in which we provide therapy and supports to the community. We acknowledge Aboriginal and Torres Strait Islander culture as the oldest continuing culture in the world. Aboriginal and Torres Strait Islander people never ceded sovereignty and we recognise the impacts colonisation continues to have on the health and wellbeing of Aboriginal and Torres Strait Islander people to date. We pay our respects to Elders, past and present, emerging and Aboriginal Elders of other communities.

We acknowledge the history of Aboriginal and Torres Strait Islander people in Australia and the barriers this has introduced to accessing timely therapy and supports with assured cultural safety. The workforce recommendations have undergone significant cultural safety consultation with local, state and national peak body representatives. The workforce recommendations aim to strengthen the allied health assistant workforce to meet the complex healthcare and wellbeing needs of Aboriginal and Torres Strait Islander peoples. This includes increasing the number of Aboriginal and Torres Strait Islander people participating in the allied health assistant workforce and strengthening the cultural responsiveness of all allied health assistant students and graduates.

# Acknowledgements

The *Victorian allied health assistant workforce recommendations* (workforce recommendations) were developed by the Monash Health Workforce, Innovation, Strategy, Education and Research (WISER) Unit in consultation with the project reference group.

Project reference group

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* Project steering committee (**Appendix 1: Project steering committee members**).

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# Summary of the recommendations

The Victorian Department of Health, in collaboration with Monash Health WISER have developed the following recommendations and accompanying resources to assist key stakeholders such as allied health workforce and employers and the VET sector in their utilisation of the Allied Health Assistant workforce.

## Pre-employment training

**Recommendation 1:**

The national skills service organisation (SSO) and local registered training organisations (RTOs) regularly review the Allied Health Assistance training packages in consultation with the health, disability and aged care sectors.

**Recommendation 2:**

The Vocational Education and Training (VET) sector should include an interview as a requirement of the pre-training review for allied health assistance courses. The interview should include an assessment of communication, literacy and numeracy capabilities.

**Recommendation 3:**

The VET sector should work collaboratively with relevant organisations to ensure the Certificate in Allied Health Assistance course curriculum is consistent across providers.

**Recommendation 4:**

The VET sector should increase clinical exposure and placement experience in pre-employment training for students of allied health assistance courses.

**Recommendation 5:**

The VET sector should give prospective and enrolled students clear and accurate information about the role of allied health assistants.

**Recommendation 6:**

Across all sectors, encourage people considering a career as an allied health assistant to complete the nationally accredited Certificates III and IV in Allied Health Assistance qualifications.

## Workforce planning and governance

**Recommendation 7:**

Workplaces should undertake robust workforce planning and redesign processes to increase and make best use of the allied health assistant workforce.

**Recommendation 8:**

Workplace governance structures should define allied health assistant roles and delegation practices to ensure safe, effective and evidence-based therapy and supports.

**Recommendation 9:**

Training, supervision and delegation between allied health professionals and allied health assistants should be informed by existing frameworks[1] to work together effectively.

**Recommendation 10:**

Workplaces should establish and maintain a culture of mutual respect, equal worth and collaboration to promote the value of the allied health assistant role.

## Consumer-centred therapy and supports

**Recommendation 11:**

Consumers should be given information about the:

* role of the allied health assistant in the treating team
* benefits of having an allied health assistant involved with their therapy and supports.

## Recruitment and induction

**Recommendation 12:**

When recruiting allied health assistants, the interview process should include behavioural scenarios to evaluate the candidate’s aptitude and capability to provide safe and effective consumer care.

**Recommendation 13:**

Workplace orientation should make clear the roles and responsibilities of allied health assistants and other professional staff to support a mutually respectful culture.

## Workplace training and development

**Recommendation 14:**

All workplace competency-based training development should align with the *Allied health: credentialing, competency and capability framework.*[2]

**Recommendation 15:**

Find opportunities for allied health assistants to work side-by-side with allied health professionals to:

* develop trusted working relationships
* create shared knowledge of roles
* complement workplace competency-based training.

**Recommendation 16:**

Workplace competency-based training and assessment should be undertaken by supervisors who meet relevant requirements.

**Recommendation 17:**

Keep competency attainment records for transferability between roles and settings.

**Recommendation 18:**

Allied health assistants’ learning needs should be formally identified and addressed to:

* foster life-long learning
* maintain performance standards
* support career development.

# 1. Introduction

An allied health assistant (AHA) is a member of the allied health team. AHAs support and assist allied health professionals (AHPs) by taking on a range of less complex tasks (both clinical and non-clinical). This lets AHPs focus on more complex clinical work. Together, they can provide therapy and supports to a greater number of consumers.

While the role of an AHA is not new, the full potential of this role has not yet been realised. Demand for allied health services is growing as skilled workforce shortages continue. Used well, and with delegation and supervision from AHPs, AHAs can help meet service demands in the health, disability and aged care settings.

Making best use of AHAs means:

* more consumers will have greater access to care
* AHAs work to the full extent of their skills and scope of practice
* AHPs can work at the top of their scope of practice.[3]

AHAs with a clear career pathway, appropriate role definition and associated delegations are more likely to remain in the vocation.

For consumers, making an informed choice to include an AHA in the treating team may allow more therapy and support needs to be met.

AHPs can benefit from the value and additional capacity of a delegate workforce to enrich patient care and streamline their own workflows.

United Victorian AHP and AHA workforces are essential for innovative, interdisciplinary models of care that promote high quality, efficient and effective consumer-centred therapy and supports across sectors. Appropriate governance and leadership are needed to ensure role expectations are understood and consumer goals drive service delivery.

The *Victorian allied health assistant workforce recommendations* (workforce recommendations) aim to create a shared understanding of the value the AHA workforce can offer consumers and AHPs working in the health, disability and aged care sectors. Underpinned by the core principles of Respect, Learn and Grow, the workforce recommendations offer individuals and workplaces realistic steps and measures to realise the full potential of AHA roles. They define AHA functions, capabilities and skills, differentiating them from other delegated workforces. The recommendations also include useful resources and indicators of progress. These should help various stakeholders (regardless of setting and governance structures) to measure their progress in implementing the recommendations.

Tested through broad consultation, the workforce recommendations aim to support:

* a supply of consistently-skilled AHAs whose role and competence are well understood by the sector
* a workforce culture with embedded supervision and delegation processes for the AHA workforce
* broad sector commitment to the ongoing planning, funding and development of the AHA workforce.

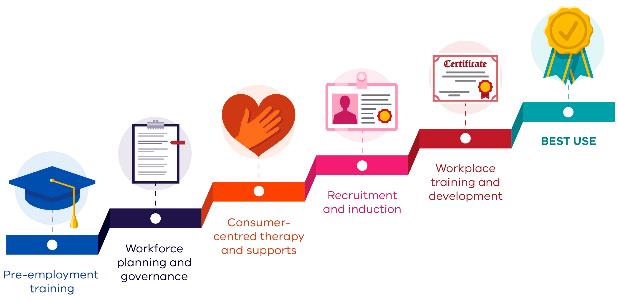
## About the recommendations

The 18 recommendations have been divided into 5 themes:

* pre-employment training
* workforce planning and governance
* consumer-centred therapy and supports
* recruitment and induction
* workplace training and development.

These themes are also the 5 steps needed to ensure the best use of AHAs (see **Figure 1**).

Figure 1: Steps to ensure best use of allied health assistants



Because career development for AHAs is a key interest, the workforce recommendations have been written with opportunities for career growth throughout.

The recommendations are applicable to all workplaces. They can also offer guidance to help ensure the right governance is in place. This includes the expectation that all workplaces will develop a culture of mutual respect and lifelong learning to optimise delegation practices.

The recommendations are directed at a range of stakeholders, including:

* AHPs
* AHAs
* Vocational Education and Training (VET) providers
* employers and managers of allied health staff and services
* funding bodies
* AHP peak bodies
* tertiary education providers
* consumers.

An outline of each stakeholder’s role and responsibilities is in **Appendix 2: Roles and responsibilities to ensure best use of AHA workforces**.

## How the recommendations and resources were developed

The workforce recommendations have been developed to support the Department of Health’s (the department’s) objectives for the AHA workforce of the future. They were informed by extensive sector consultation and feedback, with the input of a representative steering committee.

The project primarily used a consultative approach, supported by relevant literature, to ensure broad cross-sector input.

Each step of the consultation process was guided and endorsed by a representative steering committee (see **3. Consultation findings**). Consultation occurred across geographic, sector, employer and discipline workforce groups, including:

* allied health leaders, AHPs and AHAs
* consumers
* educators and students of AHA certificate courses.

Enablers and barriers to the best use of AHAs were identified in various work settings, including health, disability, aged care and private billing contexts.

As a basis for developing the recommendations, the following areas were explored:[4]

* pre-employment training of AHAs, graduate skills readiness and industry expectations
* governance and employment of AHAs, including recruitment, orientation, credentialing and workplace supports (such as cultural paradigms and procedural frameworks)
* on-the-job training, development and career pathways for AHAs.

Consultation findings and the development of the workforce recommendations are summarised in  
**3. Consultation findings**.

### Relevant Department of Health resources

The department has focused on developing the allied health workforce for more than a decade. The following publications have informed the workforce recommendations:

* *Supervision and delegation frameworks for allied health assistants*[1]
* *supervision and delegation framework for allied health assistants and the support workforce in disability*[5]
* *Allied health: credentialing, capability and competency framework*[2]
* *Victorian assistant workforce model* (VAWM)[6]
* *Victorian clinical governance framework*[7]
* *Victorian Allied health clinical supervision framework*.[8]

## How to use the recommendations and resources

The workforce recommendations include both recommendations and relevant resources to help achieve them.

The resources are designed to be used for both implementation and evaluation of the recommendations. The resources can be tailored to individual workplaces and their governance requirements.

Progress measurement tools and clinician checklists are available on the [department’s Victorian Allied Health Assistant Workforce Recommendation and Resources web page](https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources) <https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources>.

All 18 recommendations are relevant to AHAs, AHPs and employers working in the VET sector.

The following are the themes most relevant for the VET sector, and allied health workforce and employers respectively.

**VET sector:**

* pre-employment training
* recruitment and induction.

**Allied health workforce and employers:**

* pre-employment training
* workforce planning and governance
* consumer-centred therapy and supports
* recruitment and induction
* workplace training and development
* AHAs in the disability sector.

## Glossary

| Term | Definition |
| --- | --- |
| Allied health assistant (AHA) | A person working in health or aged care, and therapy assistants working in the disability sector, under the supervision and delegation of an allied health professional.  An AHA is a healthcare worker who has demonstrated competencies to provide person-centred, evidence-informed therapy and support to individuals and groups to:   * help protect, restore and maintain optimal function * promote independence and wellbeing.   An allied health assistant works:   * within a defined scope of practice and in a variety of settings, where they actively foster a safe and inclusive environment * under the delegation and supervision of an allied health professional.   The level of supervision may be direct, indirect or remote, depending on the AHA’s demonstrated competencies, capabilities and experience.[36] |
| Allied health professional (AHP) | A graduate of an allied health professional degree whose role, in part, is to delegate to allied health assistants. In Victoria, there are 27 allied health professions across the categories of therapies and sciences. |
| Best use (or optimal use) | Making best use of AHAs so consumer demand for allied health services is better met:   * AHPs can work to the full extent of their scope of practice, in a culture of ongoing learning that supports safe and effective care * AHAs are used to the full extent of their skills and scope of practice across all allied health therapy disciplines in health, disability and aged care.   Indicators of this:   * AHAs have greater than 70% clinical load (that is directly consumer facing) * AHPs delegate up to 25% of their consumer-facing work to AHAs.[9] |
| Brokered models of care | Third party models of care where the AHP or AHA workforce (or both) is subcontracted. The third party is responsible for governance, training and insurance arrangements. |
| Capabilities | Underpinning behavioural skills that characterise work being performed well.  Capabilities specify the expected behaviours and non-clinical attributes of clinicians as they progress through grading structures.  Capabilities reflect the expanding sphere of influence and control expected of individuals of a higher grading.[2, 10] |
| Clinical supervision | Formal process of professional support and learning that enables individual practitioners to:   * develop knowledge and competence * assume responsibility for their own practice * improve consumer protection and safety of care in complex clinical situations.[8] |
| Competency | Consistent application of knowledge and skill to the standard of performance required in the workplace.  It embodies the ability to transfer and apply skills and knowledge to new situations and environments.[11] |
| Competency-based assessment | A purposeful process of systematically gathering, interpreting, recording and communicating to stakeholders information on candidate performance against industry competency standards or learning programs.[11] |
| Competency-based training | An approach to training that places emphasis on what a person can do in the workplace as a result of completing training.[11, 12] |
| Competency standards | Competency standards describe the knowledge, skills and attitudes needed to perform a particular occupation. They define the essential work outcomes and performance level needed for effective performance of a work role or task in the workplace.[2] |
| Consumers | All people receiving allied health services across the health, aged care and disability sectors. |
| Cultural safety | Part of creating an environment that is safe for Aboriginal and Torres Strait Islander people and people of culturally diverse backgrounds. This encompasses creating shared respect, meaning and knowledge. |
| Department | Victorian Department of Health. |
| Department’s core competencies | Four competencies endorsed by the department as core for AHAs in Victoria:[13]   * individual therapy and supports * group therapy * communication of patient information * equipment and environment. |
| Free TAFE Initiative | Victorian Government initiative for priority courses. It covers tuition fees for eligible students to study one of more than 60 courses.[14] |
| Medicare Benefits Schedule (MBS) | List of Medicare services subsidised by the Australian Government. |
| National Disability Insurance Agency (NDIA) | The Australian Government organisation administering the National Disability Insurance Scheme. |
| National Disability Insurance Scheme (NDIS) | An Australian Government national scheme that provides funding directly to people with disability. |
| Peak bodies | Allied health and other professional associations with an interest in the governance of the allied health assistant workforce. |
| Performance criterion | Specifies the level of performance needed to demonstrate achievement of or competence in an element. |
| Performance evidence | When referring to workplace competency-based training, performance evidence is information gathered that offers proof of competence when matched against performance criteria. This may include prior formal learning, observed practice or other similar examples. |
| Priority groups | Vulnerable populations with medical, socioeconomic, cultural or communication needs who have a high risk of adverse health outcomes. To address this risk, these groups need culturally competent, culturally safe, accessible and appropriate care and services. |
| Scope creep | People working outside their scope of practice. This may lead to risks to consumer care through lack of competence and governance.  The risk of scope creep increases when roles are not well defined. |
| Scope of practice | The full spectrum of roles, functions, responsibilities and decision-making capacity that people in a profession are educated, competent and authorised to perform.[15] |
| Sectors | The different settings in which individuals or workplaces operate:   * **aged care** sector – providers of aged care services in aged care homes and multi-purpose services, providers of home-based care and support to the elderly * **disability** sector – health care workers or services that provide therapies and support to people with a disability * **health** sector – Victorian public and private hospitals, community settings, mental health settings and allied health professional peak bodies. * **vocational education and training** (VET) sector – registered training organisations (RTO) offering certificate training in Allied Health Assistance, and their regulatory bodies. |
| Skills and jobs centres (SJC) | Based in Victorian TAFEs and provide advice on training and employment opportunities. |
| Subject matter experts | Clinicians or people with the highest level of expertise in performing a specialised job, task or skill.[2] |
| TAFE | Technical and Further Education. TAFEs are government owned while RTOs are privately owned. Both operate under VET sector governance and accreditation standards. |
| The workforce recommendations | *Victorian allied health assistant workforce recommendations and resources* (this document). |
| Therapy and support | Allied health service provision of care in the health, aged care and disability settings |

# 2. Victorian allied health assistant workforce

## The value of allied health assistants (AHAs)

Delegating appropriate tasks to AHAs can increase the capacity of allied health professionals (AHPs) by up to 17%.[16, 17]

AHAs offer a way to provide timely and effective therapy and supports to more consumers.

AHAs work with a range of AHPs in a wide range of settings. Because of this, AHAs have a broad range of capabilities, technical skills and experience.

AHAs make the following important contributions to health, disability and aged care services:

* support the provision of consumer-centred therapy and supports
* enable AHPs to work to their full scope of practice
* provide administrative and day-to-day support to the allied health team
* provide orientation and support to both AHAs and AHPs
* take part in quality improvement and research initiatives
* enable the allied health team to provide more health services.

## AHA workforce landscape

An AHA is a member of the allied health team whose work is delegated by an AHP. This is unlike a disability support worker, a personal care attendant, a leisure and lifestyle assistant or other support workforce members.[1]

AHAs support and assist AHPs by taking on a range of less complex clinical and non-clinical tasks. This allows AHPs to focus on more complex clinical work. Together, they can provide therapy and supports to a greater number of consumers.

As indicated by the department’s workforce data source, the majority of AHAs working in the health sector are:

* female (86%)
* employed on an ongoing basis
* remain in the career for 10 to 20 years.

In rural and regional areas, it is more common for AHAs to be above 50 years of age (a trend that is not mirrored in metropolitan areas) with more varied lengths of service.

Data sources for AHAs working in disability and aged care are currently limited, preventing accurate reporting of similar workforce statistics for these sectors.

The department’s most recent health workforce data indicate that in June 2022 just over 1,300 AHAs were employed in Victorian public health services – up from 1,099 in May 2021. These additional AHAs are mostly young workers in metropolitan areas who are under 25 years old and have less than a year’s experience in the role.

A number of factors may be contributing to the recent increase in AHA recruitment, such as:

* Victorian Government Free TAFE initiative
* introduction of COVID-19-related ward support roles
* the need to address AHP workforce shortages.

While AHP workforce shortages have been seen in rural and regional areas and the disability sector for many years, shortages are now also in larger metropolitan health organisations. Using AHA workforces to address these shortages is an important consideration when undertaking workforce planning.

## Pre-employment training

The nationally accredited Certificate III and Certificate IV Allied Health Assistance courses are the accepted qualifications for an AHA across Australia. However, graduate outcomes vary considerably due to factors such as:

* the wide variety of people studying, in terms of factors like age, understanding of the AHA role and life experience
* inconsistent marketing of courses
* inconsistent course delivery
* a lack of robust industry consultation
* limited clinical exposure
* a teacher shortage.

The inconsistency in training and graduate outcomes leads to several issues:

* For graduates who wish to continue studies toward an allied health profession, the university sector struggles to recognise prior learning as course outcomes vary widely.
* AHPs report difficulties in understanding what tasks they can delegate to an AHA.
* For industry, as workplace competency-based training needs are unpredictable, resource intensive and highly individualised. This sometimes leads employers to prefer AHAs with more consistent and familiar alternate qualifications, like overseas trained AHPs or AHP students. This makes it harder for AHA certificate graduates to compete for jobs with other candidates with alternative or higher qualifications.

## AHA roles in the workplace

The AHA role has been developed to support the provision of allied health services, under the delegation and supervision of AHPs.

All AHAs work under the delegation of an AHP. Accountability for a consumer’s care remains with the AHP. The AHP completes an assessment, makes a diagnosis, prescribes and makes discharge decisions. The AHA performs delegated clinical and non-clinical tasks in line with the prescribed therapy and supports.

If an AHA identifies a clinical need, they tell the delegating AHP in a timely manner. However, AHAs may be supported and specifically trained to perform tasks that need clinical reasoning or help identify changes that affect the trajectory of care for a consumer. This is still done under the delegation of the AHP.

The role an AHA plays depends on the:

* competence and experience of the AHA and their grading
* competence and experience of the delegating AHP
* employer’s overarching organisational structure.

AHAs can work across single disciplinary, multi-disciplinary and interdisciplinary workplace structures.

While AHAs are not autonomous, the degree of supervision and monitoring needed will vary depending on:

* setting
* knowledge of the AHA
* experience of the AHA
* skills of the delegating AHP and the AHA
* grading of the AHA

AHAs have been used in different ways in different sectors. In Victoria, the grading and classification of the AHA role varies according to the sector and funding stream.

AHAs are currently underutilised.[3] This may be related to:

* a lack of standardised competencies and training for AHAs, limiting skills transfer and creating inconsistencies in knowledge and capability
* a lack of shared understanding and recognition of the current and future capabilities of the AHA workforce.

### Victorian health sector AHA role and classification

The health sector has traditionally employed AHAs in hospital and community settings to support single professions. The recent growth of multidisciplinary AHA roles, particularly in community health settings, has been beneficial to patient care and resulted in AHA career growth.

The following is a summary of the current AHA grading structure for the Victorian public sector. For the full description, refer to the current enterprise agreement. At the time of publishing, this is the *Health and Allied Services, Managers and Administrative Workers (Victorian Public Sector) (Single interest Employers) Enterprise Agreement*.

#### Grade 1 AHA

**Supervision and nature of work**:

* Required to perform work of a general nature under the direct supervision of an AHP.

**Education level entry criteria**:

* No formal qualifications needed.

**Duties may include**:

* Collect and prepare equipment.
* Maintain client contact details.
* Monitor clients to ensure they follow their programs.
* Complete basic delegated therapy interventions with patients or clients under the direct supervision of an AHP.

#### Grade 2 AHA

**Supervision and nature of work**:

* Required to perform work of a general nature under the supervision of an AHP.

**Education level entry criteria**:

* Holds an AHA qualification

**Duties**:

* Perform the full range of duties of a Grade 1 AHA
* Work directly with an AHP, work alone or in teams under supervision following a prescribed program of activity.
* Use communication and interpersonal skills to help meet the needs of clients.
* Accurately document client progress and maintain documents as required.
* Demonstrate a capacity to work flexibly across a broad range of therapeutic and program-related activities.
* Identify client circumstances that need more input from the AHP.
* Prioritise work and accept responsibility for outcomes within the limit of their accountabilities.

#### Grade 3 AHA

**Supervision and nature of work**:

* Required to perform work of a general nature under the supervision of an AHP.

**Education level entry criteria**:

* Formal qualification of at least Certificate IV in Allied Health Assistance or its equivalent.
* Three years’ experience (full time equivalent) as a Grade 2 АНА.

**Duties**:

* Perform the full range of duties of Grade 1 and Grade 2 AHAs.
* Understand the basic theoretical principles of the work undertaken by the AHP they support.
* Work with minimum or remote supervision to implement therapeutic and related activities, including maintaining appropriate documentation.
* Identify client circumstances that need more input from the AHP, including suggestions for appropriate interventions.
* Lead and contribute to quality initiatives
* Demonstrate proficient communication and interpersonal skills to help meet the needs of clients.
* Organise their own workload and set work priorities in the program set up by the АНР.
* If needed, help with supervising work being done by Grade 1 and 2 AHAs and AHAs in training.

### Disability sector AHA role and classification

AHAs are an emerging workforce in the disability sector. Here, AHAs are also known as therapy assistants.

The *NDIS national workforce plan: 2021–2025*[18] identifies a need to increase the allied health assistant workforce.

The National Disability Insurance Agency (NDIA) does not require AHAs to have any formal qualifications. There is currently no standardised definition of activities for therapy assistants working in the disability sector across Australia. There are only supervision structures and a requirement that therapy assistants be covered by the delegating AHP’s professional indemnity insurance.

The NDIA defines Level 1 and Level 2 therapy assistants as follows:[19]

* **Therapy assistant level 1**: An AHA ‘working under the delegation of and direct supervision at all times of a therapist’. The AHA must be covered by the professional indemnity insurance of the supervising therapist (or the therapist’s employing provider).
* **Therapy assistant level 2**: An AHA ‘working under the delegation and supervision of a therapist, where the therapist is satisfied that the AHA is able to work independently without direct supervision at all times.’ The AHA must be covered by the professional indemnity insurance of the supervising therapist (or the therapist’s employing provider).

Funding is used to encourage self-managed AHPs and support planners to find their own AHAs. However, there is no clear guidance around credentials or qualifications. This can create inconsistent expectations and mistrust between AHPs and AHAs.

There is significant confusion across the sector around:

* how the role differs from other support workforces
* appropriate qualifications
* insurance obligations
* brokered models and cost-effective business models for using AHAs.

In many instances, AHP students are being employed as AHAs. As a result, the difference between AHPs and AHAs is not clear to consumers and care planners. Consumers often are not given enough information on the role of AHAs in the disability sector.

### Aged care sector AHA role and classification

In aged care, people do not need certificate training to be employed as an AHA. Also, the AHA role has not been formally defined. This has led to some blurring of roles between AHA and other support workforces (such as leisure and lifestyle assistants, direct care workers or personal care attendants).

Aged care services rarely employ AHAs directly. When they have, the AHA role – often under the delegation of nursing – aligns more closely with a leisure and lifestyle assistant role.

AHPs are often contracted for residential and in-home aged care services. Some of these AHPs use AHAs to increase the reach of their service.

Outside of residential aged care, there are opportunities to use AHA workforces in the Commonwealth Home Support Programme[20] (CHSP) and Home Care Package[21] program (HCP). AHA services in these programs are mostly bundled with allied health services provided in community health settings.

The Royal Commission into Aged Care Quality and Safety[22] recommended increasing access to evidence-based allied health services for older Australians in residential and in-home settings. The Victorian Better at Home initiative[23] offers another opportunity to use AHA workforces to provide allied health services to older Australians.

### Private billing

Funding to more effectively use AHAs is somewhat limited in private billing contexts.

Currently, private billing for AHA services is only an option with NDIS funding.

The Medicare Benefits Scheme (MBS) does not provide funding for AHAs. This may be deterring the private sector from using AHAs to meet growing demand. When the MBS is next reviewed, it may be beneficial to consider funding for AHA governance, supervision and workplace training resources.

Compensating bodies like the Traffic Accident Commission (TAC) and Department of Veteran Affairs (DVA) may not yet realise the full potential of AHAs. This may be due to a lack of clear guidance around AHAs or updated pricing.

# 3. Consultation findings

## Pre-employment training

The Certificate III and Certificate IV in Allied Health Assistance courses are currently the accepted qualifications for AHAs across Australia.

There is an industry preference for graduates of Certificate IV in Allied Health Assistance, due to the higher competency level of this group compared to Certificate III graduates. However, industry representatives also highlighted that:

* good communication and other soft skills are highly desirable attributes among new graduate AHAs
* training courses should also focus on building these soft skills.

Consultation also revealed that graduate outcomes can vary considerably. Factors contributing to this include inconsistent student screening prior to commencement of the course and inconsistent course curriculum across providers.

The Certificate III and IV courses are currently part of the Victorian Government’s Free TAFE initiative. The courses have been included as part of an allied health and nursing priority pathway. This means people can complete a Certificate III, Certificate IV and Diploma in the same pathway without paying tuition fees. This has also meant some people have attempted the courses without a full understanding of the role or have discovered they are not suited to the role.

Pre-training assessments may identify people who are better suited to AHA careers and improve graduate outcomes. Currently, pre-training interviews are ad hoc rather than formally part of the assessment process.

Training and assessment strategy (TAS)[24] templates are often used to give students and regulatory bodies training and assessment information. These templates need to be adapted to include a well-rounded‑ assessment of candidates’ non-clinical attributes and suitability for health care roles or study. Registered training organisations (RTOs) have committed to a Free TAFE Minimum Service Standard, which requires students to complete a pre-training assessment. This strategy should improve the course completion rate of students who start Certificate IV in Allied Health Assistance training.

Variations in course curriculum have led to several issues for graduates, health care workers and employers:

* There is a wide range of elective units but the value or relevance of some units is not clear.
* AHAs wanting to continue studying and gain an AHP qualification noted problems having their prior learning recognised.
* AHPs reported difficulties in understanding what tasks they can delegate to AHAs due to the variations in training and scope of practice.
* For industry, workplace competency-based training needs are difficult to anticipate and need to be individualised. This makes training more resource intensive. It also means workplaces may need to create more competency assessments and training programs before they feel they can safely use AHAs as a workforce.

For these reasons, employers may prefer to recruit AHAs with alternative qualifications, like AHP students or AHPs trained overseas, as the baseline skill level is more consistent. This makes it harder for AHA certificate graduates to compete with other candidates with other or higher qualifications.

Students, the VET sector and industry all felt that current clinical placement hours and limited contact with clinical environments do not adequately prepare graduates for the workplace. Steps have recently been taken to increase clinical placement hours for the Certificate III Allied Health Assistance course from 80 hours to 120 hours. Certificate IV has not been increased from its current total of 120 clinical placement hours. Greater student exposure to workplace environments, coupled with contemporary course content, will ensure that graduates are better prepared to enter the healthcare workforce.

The workforce challenges raised could be addressed through increased collaboration with industry. By working with RTOs, relevant sectors and allied health representatives, the VET sector could ensure the certificate courses continue to be relevant and preferred. It may also improve the consistency of course content across RTOs. The recommendations in *Future skills for Victoria*[25] highlight the need to support the VET sector to ensure a strong post-secondary education and training system.

It was widely acknowledged that the pool of teachers available to give AHA training is limited, particularly in regional areas.[25] Particularly sought after are teachers with:

* current and relevant industry experience
* a Certificate IV in Training and Assessment (required to teach TAFE courses).

The cost of studying has been a barrier for many people. The Certificate IV in Training and Assessment is now included on the Free TAFE list. This should increase the number of people able to complete the Certificate IV qualification. By partnering and working with industry, the VET sector may be able to encourage more experienced AHPs and AHAs to complete the course.[26]

## Workforce planning and governance to prepare the workplace for an AHA

Consultation revealed that the difference between certain support workforces is not clear, notably:

* AHAs
* education aides
* lifestyle and leisure workers
* personal care attendants
* disability support workers.

This is particularly evident in private billing settings, where there can be multiple support roles involved with someone’s care and therapy. In brokered care models, devolved governance (transferring powers to local boards) can increase this confusion. Workplaces need to make the differences clear in terms of role, scope of practice, and function. This should be included in planning, management and marketing.

In the United Kingdom this issue has been partially addressed through enterprise agreements. AHAs are listed on the same progression as AHPs. AHAs have similar entitlements to training, leave and incremental pay increases.[27] By incorporating AHAs in the same classification structure as AHPs, the AHA role is clearly differentiated from other support workforces.

There is conflicting information around insurance and governance obligations in private billing contexts. Some AHP peak bodies are defining insurance obligations for their members as AHA use grows. In general, an AHA is covered by the AHP’s professional indemnity insurance or the workplace’s public liability insurance if working within the limits of the delegation.

As individual private billing contexts (such as the NDIS) increase, AHAs operating in these contexts may need their own professional indemnity insurance. Even with professional indemnity insurance for AHAs, AHAs and AHPs must still work within a supervision and delegation framework. As a non‑registered delegate workforce, AHAs rely on AHPs to meet regulatory body requirements. Also, AHAs are not endorsed to work as sole practitioners or without AHP supervision and delegation in any setting.

Governance structures are essential even though they may vary based on the size and context of the workplace. AHA workforce planning and governance principles apply to all workplaces that employ AHAs, regardless of workplace size and registration status.

Decision makers in workplaces employing AHAs do not always have an allied health background. To help these people or teams make informed decisions about AHA roles, clear governance and processes about how AHAs and AHPs work together must be in place.

The AHA workforce can play a role in maximising allied health workforces and relieving chronic personnel shortages when used in a tiered workforce model with appropriate:

* role definition
* professional representation
* governance.

A tiered workforce model creates a career path for AHAs, with set grade levels and designated responsibilities according to qualifications and experience. This model gives AHAs the capacity to improve the consumer experience and reduce wait times by significantly increasing the case load an allied health service can manage[28].

The importance of formal and effective supervision was raised during consultations. Effective supervision and delegation training, resources and practices help build professional relationships based on mutual trust and confidence. To ensure clinical supervision meets the needs of AHAs, it is important to recognise that:

supervision is the [clinician’s] most essential helping relationship. It is a necessity, not a luxury.[29]

When supervision is not formalised, it tends to be neglected in busy working environments. This can have a negative impact on the quality and safety of consumer therapy and supports. It can also affect workplace culture and limit ongoing learning.

## Consumer-centred therapy and supports

As a delegated extension of AHPs, AHAs increase the opportunity for consumers to access allied healthcare. AHAs may be included in a consumer’s billable hours to maximise a package and receive therapy and supports more frequently.

Consumers expect workplaces to manage AHA governance, credentialing, training and development.

It is important for consumers to understand the different roles of the people involved in their care team. Information about these roles, including the AHA, must be accurate, evidence based and accessible.

This information may also be used to educate:

* families
* students
* disability support workers
* disability support planners
* other relevant stakeholders.

While providing consumer-centred care, although AHAs must consider consumer rights and choice, they should still be mindful of the limits of their delegation. If the AHP has not assessed and delegated the task to them, the AHA should not perform the task.

## Recruitment and induction

During consultations, participants noted that workplaces are most confident that AHAs they recruit can provide safe and effective therapy and supports when candidates have relevant:

* attributes
* capabilities
* qualifications
* sector experience

AHAs may be recruited in different ways, such as:

* through grant funding
* local students
* traineeship programs
* education partners
* the local community.

Best practice for recruitment includes an interview to understand each candidate’s aptitude for a consumer-facing role. A mock documentation exercise during interviews has become popular across industry. This exercise is used to assess both comprehension and communication skills.

Growth in AHP student placements across sectors has not always resulted in a proportional growth in AHA placements. Allied health workforce shortages have been seen in:

* rural areas
* remote locations
* some metropolitan disability and aged care settings.

One way to address these shortages is through ‘locally grown’ traineeships for AHA roles. ‘Locally grown’ refers to employing someone in training (or prepared to complete training) from within the local community. This approach means teams better reflect the community they serve. It also allows workplaces to employ people who best fit the team and then train them accordingly, in partnership with the VET sector.

Some workplaces are employing AHP students as assistants, with a view to moving them to professional roles after graduation. This strategy may create a professional AHP workforce pipeline and enable new graduates to enter the workforce with a better understanding of consumer needs and the care environment. Organisations considering hiring AHP students as AHAs should ensure that recruitment practices, advertised role and published position descriptions are in line with the relevant enterprise agreement. Be mindful of the current enterprise agreement definition of equivalence when assessing equivalent qualifications during the recruitment process. This will also help grade AHAs accurately.

Clear governance and training can help define the scope of practice for AHAs, AHP students and overseas-trained AHPs. They all have different career goals and learning needs. Delegating AHPs require clarity on the expected competencies, capabilities and learning needs for each group to reduce ambiguity and streamline delegation practice.

A structured orientation and induction program can set the foundation for best practice by:

* consolidating AHAs’ skills
* creating broader team understanding of the different roles
* providing training in supervision and delegation
* involving AHAs in AHP orientation.

Including AHAs in AHP orientation can better explain the AHA role to newly employed AHPs and reduce any potential perceived power imbalances.

A graduate training program for new AHA graduates can build core knowledge and skills needed for the role. This can help AHAs:

* become competent, confident clinicians
* developing reflective practice
* foster lifelong learning.

As they enter practice for the first time, AHA and AHP graduates may have similar learning needs, like:

* education
* support
* peer networking
* professional development.

There may be benefits in combining AHP and AHA graduate programs. AHPs and AHAs work together closely in everyday practice. Increasing opportunities for professional learning and practice in a mixed graduate program may improve collaboration, communication and teamwork beyond the program.

## Workplace training and development

AHAs need access to documented competency-based workplace training and assessments to move from ’skills ready’ to ‘job ready’. Workplace competency-based training is training and assessment of clinical skills in the workplace, based on consumer need and service demand. It is distinct from professional development for AHAs. Competency-based training informs the minimum standards for safe and effective therapy and supports in a workplace.

Competency and learning needs are identified during the recruitment process and monitored continuously through clinical supervision and workplace performance appraisals. The level of autonomy (that is, less direct supervision) an AHA has when completing a task defines the level of capability and expectation. Autonomy is further developed with experience and training (see **Victorian health sector AHA role and classification**). Giving AHAs more opportunities to work side-by-side with AHPs may complement and reinforce competency-based training. This would also be a way to build strong working relationships between AHAs and AHPs.

The minimum standard an AHA needs to perform a skill or task safely and effectively is expected to be transferable between settings, with some tailoring depending on the role or setting. This is similar to ‘entrustable professional activities’[30] – tasks that can be fully entrusted to someone once they show they can complete the task without supervision.

AHAs noted that they often have to repeatedly explain their skills when they have a new delegating AHP or move roles. A documented competency-based training and assessment program, combined with side-by-side clinical practice, can increase understanding of AHA skills. This may also:

* enhance scope of practice
* reduce the amount of repetition needed
* improve transferability of AHA skills across roles and settings
* foster greater confidence in the capabilities of AHAs
* foster lifelong learning and development in AHAs.

During consultation, some participants noted that occasionally competency-based training was too complex or unnecessary for smaller workplaces. Because of this, some workplaces skipped the training completely.

Competency-based training and assessment should be prioritised based on risk – see the decision tool in **Figure 6**. Competencies should be tailored to the relevant consumer group and work setting but follow the same format and principles. That is, performance evidence is systematically gathered and mapped against documented performance descriptors or standards.

The range of training and recording mechanisms varies by workplace sector and size, depending on need. A smaller workplace may use a checklist and spreadsheet. Larger workplaces may use shared training packages and complex databases.

In some instances and at the request of industry, individual RTOs have run individual units of competency or skill sets, and provided a statement of attainment. This allowed AHAs to increase their scope of practice to include relevant units of competency. This has been well supported by workplaces with a clinical need.

Workplace competency-based training and professional development, supported by robust governance, work together to create safe and effective practices for AHAs (see **Figure 2**). Unlike workplace competency-based training, targeted professional development should focus on building capability, skills and attributes to maintain quality performance standards and aid career progression. Meeting demands for professional development in a structured and reviewed manner can foster an inclusive culture of learning for all. This can empower AHAs to take the lead in their own development.

In some instances, AHAs were using a continuing professional development (CPD) log to record ongoing professional development, just like their AHP colleagues.

Professional development that supports defined AHA career pathways may:

* attract and retain the AHA workforce
* encourage ongoing learning and development
* strengthen motivation and improve engagement of the AHA workforce.

Figure 2: The relationship between workplace competency-based training and professional development for an allied health assistant

Diagram of concentric circles describing the relationship between competency-based training and professional development.
Text description is in Appendix 4: Image descriptions.

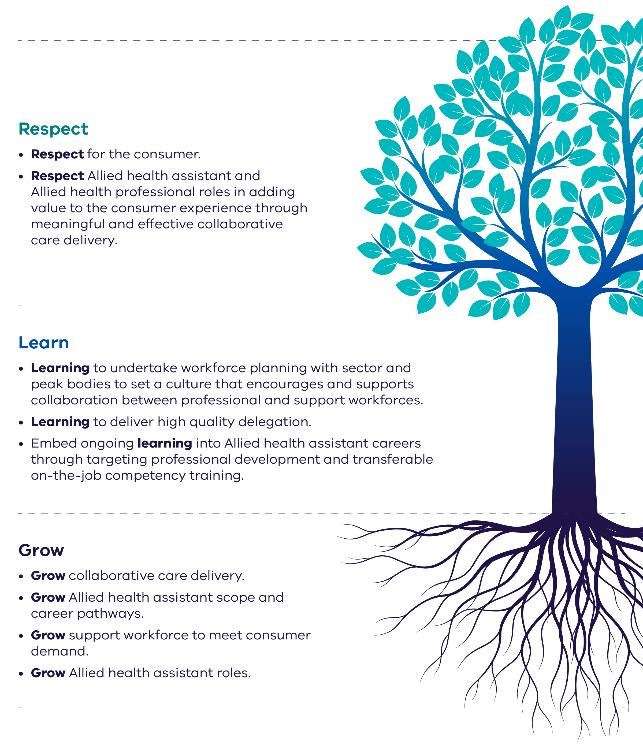
**Note**: Adapted from Lockyer, J., et al., Competency-based medical education and continuing professional development: A conceptualization for change. Medical Teacher, (2017) with permission from the authors.

# 4. Recommendations to best develop and use allied health assistants

The following recommendations were developed to ensure the AHA role can be used to its full potential.

To realise the recommendations – and best develop and use AHA workforces in health, disability and aged care sectors – all stakeholders will need to engage and invest in them. The recommendations were built on 3 core principles: respect, learn and grow.

Figure 3: The 3 core principles



These recommendations have been designed to support AHA careers across three tiers:

* career preparation
* career development
* career trajectory.

This tiered career path is summarised in **Figure 4**.

Figure 4: Factors contributing to the development and best use of AHA workforce

A flowchart in the form of a tree. Tier 1 career preparation is the roots, Tier 2 career development is the trunk and Tier 3 career trajectory is the branches.
Text description is in Appendix 4: Image descriptions.

## Pre-employment training

| Consumer benefit statement |
| --- |
| A consistently qualified workforce better supports safe and effective consumer care outcomes. |

### Recommendation 1

The national skills service organisation (SSO) and local registered training organisations (RTOs) regularly review the Allied Health Assistance training packages in consultation with the health, disability and aged care sectors.

#### Considerations for the VET sector

* Ensure skills service organisations (SSOs) consult with a broad representation of community and industry
* Ensure industry reference committees (IRCs) represent a broad cross section of industry
* Ensure local RTOs have broad representation in regular industry panels.

**Note**: Broad representation may include:

* consumers
* AHAs
* AHPs
* allied health leaders
* peak bodies for health, disability and aged care sectors, including Aboriginal and Torres Strait Islander people and other priority groups.

#### Considerations for workplaces

* Consult with SSOs, IRCs and RTOs to ensure industry needs are considered as part of course contextualisation.

#### Useful resources

Human Services Skills Organisation’s (HSSO) guide to the VET sector for human services employers:

* Includes information about the sector and advice on how to build and maximise relationships with RTOs.
* Available on [HSSO’s A guide to VET for human services employers web page](https://hsso.org.au/resources/view/a-guide-to-vet-for-human-services-employers) <https://hsso.org.au/resources/view/a-guide-to-vet-for-human-services-employers>.

### Recommendation 2

The VET sector should include an interview as a requirement of the pre-training review for allied health assistance courses. The interview should include an assessment of communication, literacy and numeracy capabilities.

#### Considerations for the VET sector

* Include suitable behavioural skills identified by industry consultation in training and assessment strategy (TAS)[24] templates
* Introduce a standard pre-training interview requirement
* Introduce a communication assessment in the withdrawal period of the course to evaluate capacity for interpersonal skills
* Incorporate demonstration of behavioural skills in assessment of clinical tasks.

Pre training interviews could involve:

* behavioural questions and scenarios
* values-based questions
* adapting existing templates to the RTO’s specific needs and requirements, ensuring a standard rubric for assessment is applied.

#### Useful resources

The department’s AHA-related resources:

* RTO pre-training review tool – designed to help complete pre-training reviews of course candidates.
* Available on the [department’s Victorian Allied Health Assistant Workforce Recommendation and Resources web page](https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources) <https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources>.

The National Disability Service (NDS) has a toolkit for values-based recruitment. The toolkit has several parts, covering areas like:

* how to use a values-based approach in interviews
* including people with lived experience
* behavioural interview questions (which can be adapted).

The toolkit is available on [NDS’ Values based recruitment toolkit web page](https://www.nds.org.au/value-based-recruitment) <https://www.nds.org.au/value-based-recruitment>.

### Recommendation 3

The VET sector should work collaboratively with relevant organisations to ensure the Certificate in Allied Health Assistance course curriculum is consistent across providers.

#### Considerations for the VET sector

**I**nclude the following in Certificate III and IV in Allied Health Assistance course curriculum:

* introduction to supervision and delegation models
* the department’s core units in individual therapy and supports, group therapy, equipment and communication[13]
* sector-specific skill sets for disability and aged care
* cultural safety training
* review the RTO Standards ([31]) to ensure quality assurance as well as compliance.

Collectively across Victoria:

* offer a consolidated list of limited electives that are relevant to the AHA role
* offer consistent placement hours and types across Victoria
* use standard teaching and assessment materials to develop a consistent set of core skills.
* provide placement preparation before starting placements (such as professional behaviour, time management, demonstrating initiative, asking appropriate questions and so on).
* develop and use a universal placement assessment tool in line with AHP counterparts like physiotherapy’s Assessment of Physiotherapy Practice (APP) or occupational therapists’ Student Practice Evaluation Form (SPEF).

To make teaching of certificate training more consistent:

* offer Certificate IV in Training and Assessment to experienced AHPs and AHAs interested in education career pathway, in partnership with industry
* employ teachers who are AHAs with at least 3 years’ industry experience
* employ teachers who are AHPs with at least 3 years’ experience working with AHAs
* offer joint appointments for teachers so they can continue clinical work while teaching
* establish communities of practice for teachers.

#### Considerations for workplaces

* partner with RTOs to support teaching pipelines through study leave, flexible working hours, education career pathway opportunities and scholarships
* support RTOs to develop teaching resources
* offering joint appointments for teachers so they can continue clinical work while teaching.

#### Useful resources

HSSO has guidance on preparing for work placements in disability and aged care. The work placement guide focuses on the capabilities needed to work in a consumer-facing environment.

Find the guide on [HSSO’s Mandatory work placements guide web page](https://hsso.org.au/resources/view/mandatory-work-placements-guide) <https://hsso.org.au/resources/view/mandatory-work-placements-guide>.

### Recommendation 4

The VET sector should increase clinical exposure and placement experience in pre-employment training for students of allied health assistance courses.

#### Considerations for the VET sector

**I**nclude early clinical exposure in the following ways:

* through industry guest speakers, consumer videos and observational placements in the first 4 weeks of training
* use simulated scenarios
* encourage students to volunteer in relevant clinical settings while studying to embed behavioural and soft skills needed for an allied health career

Improve graduate skills readiness:

* increase clinical placements to at least 200 contact hours for the Certificate IV in Allied Health Assistance, with potential to split placements across different care settings
* offer a variety of placement experiences, including aged care, disability and health settings, where possible.

Partner with industry to:

* offer AHA traineeships and clinical placement opportunities in regional areas, to improve access to training and address workforce shortages
* support the NDIS’ national workforce plan to increase the number of traineeships and student placements available in the disability sector.[18]

#### Considerations for workplaces

* partner with the VET sector to host placements for Certificate III and Certificate IV AHA students in line with:
  + the student placement agreement – see the [department’s Student placement agreement web page](https://www.health.vic.gov.au/publications/student-placement-agreement) <https://www.health.vic.gov.au/publications/student-placement-agreement>
  + where applicable, the standardised schedule of fees for clinical placement – see the [department's Fee schedule for clinical placement in public health services web page](https://www.health.vic.gov.au/education-and-training/fee-schedule-for-clinical-placement-in-public-health-services) <https://www.health.vic.gov.au/education-and-training/fee-schedule-for-clinical-placement-in-public-health-services>.
* Partner with RTOs to provide meaningful clinical exposure and placement experiences throughout training.

### Recommendation 5

The VET sector should give prospective and enrolled students clear and accurate information about the role of AHAs.

#### Considerations for RTOs

* Meet the *Standards for RTOs 2015*[31] when giving prospective and current students clear, accurate and accessible information about the RTO’s services and performance.
* Promote employment opportunities associated with completing Certificate III and Certificate IV in Allied Health Assistance to prospective student groups and help skills and jobs centres (SJC) to do the same.
* Include career preparation in the courses (such as preparing a curriculum vitae, preparing for interview, where to find relevant job opportunities).
* Evaluate student experience in certificate training.
* Develop processes to track graduate employment outcomes to ensure courses meet industry needs.

#### Useful resources

The department’s AHA-related resources:

* Position description templates – example position description templates for Grade 1, Grade 2 and Grade 3 allied health assistant roles.
* *Allied health assistants and you* – flyer for consumers to help them understand the role and decide who they want in their care team.
* Available on the [department’s Victorian Allied Health Assistant Workforce Recommendation and Resources web page](https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources) <https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources>.

### Recommendation 6

Across all sectors, encourage people considering a career as an AHA to complete the nationally accredited Certificates III and IV in Allied Health Assistance qualifications.

#### Considerations for workplaces

* Partner with the VET sector to ensure there are enough placements with an appropriate number of hours (at least 200 hours) available for students of allied health assistance courses (in line with VET sector considerations in **Recommendation 4**).
* Offer priority placements to RTOs and students who have undertaken a pre-training review. Use this as a basis for assessing learning needs while on placement (in line with VET sector considerations in **Recommendation 4**).
* Reduce the risk of breaches of AHA scope of practice by adopting the considerations outlined in recommendations 7, 8 and 9.
* Where workforce shortages exist, consider setting targets or quotas for employing AHP students and AHAs with certificate qualifications. This will both develop a stable AHA workforce and create entry pathways for AHP roles.
* When employing Grade 1 or unqualified AHAs, explore pathways with employee to **complete** an AHA qualification through apprenticeship and traineeship. See the [Victorian Skills Gateway's Apprenticeships and traineeships web page](https://www.skills.vic.gov.au/s/apprenticeships-and-traineeships) <https://www.skills.vic.gov.au/s/apprenticeships-and-traineeships>.

#### Considerations for the VET sector

* Implement recommendations 1 to 5 to maintain and increase the credibility of certificate training.

#### Considerations for disability and aged care peak bodies

* Take part in VET sector consultation.
* Endorse AHA certificate training.
* Advocate for AHA student placements in their sector.

### Progress indicators for recommendations 1 to 6

RTOs that teach allied health assistance courses in Victoria:

* Undertake substantial industry consultation with allied health representation from the health, disability and aged care sectors.
* Conduct pre-training interviews to determine candidates’ aptitude for future AHA roles.
* Run core units aligned to the department’s AHA competencies.
* Create a consolidated list of relevant elective units.
* Use uniform course materials, tools, and assessment processes.
* Employ teachers with suitable industry experience (working as or with AHAs for at least 3 years).
* Partner with industry to help appropriately-experienced AHAs and professionals complete Certificate IV in Training and Assessment.
* Work with industry to provide greater opportunities for early and extended clinical placements in a variety of work environments.
* Provide clear messaging to prospective and current students on expected employment options.
* Conduct student experience evaluations and use graduate employment tracking measures.

#### Useful resources

The department’s AHA-related resources:

* *Progress measurement tool for RTOs* – helps RTOs track their progress against these recommendations.
* Available on the [department’s Victorian Allied Health Assistant Workforce Recommendation and Resources web page](https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources) <https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources>.

## Workforce planning and governance recommendations to prepare the workplace for an AHA

| Consumer benefit statement |
| --- |
| United allied health teams, where team members have clear role delineation and are supported by governance structures, to provide safe and effective therapy and supports for better consumer experiences and outcomes. |

### Recommendation 7

Workplaces should undertake robust workforce planning and redesign processes to increase and make best use of the AHA workforce.

#### Considerations for workplaces

* Take time to understand the full breadth of AHA roles in the workforce landscape.
* Perform regular workforce reviews to remain responsive to changing operational and consumer demands and ensure delegated tasks make best use of AHAs.
* Refer to existing tools and frameworks for workforce planning (see **Useful resources** for this recommendation).
* Include both AHPs and AHAs in workforce planning consultations.
* Establish an AHA governance role to represent, plan and advocate for the AHA workforce at the allied health leadership level.
* Apply cost-benefit analyses to AHA roles to ensure value against role requirements.

#### Useful resources

The department’s AHA-related resources:

* *Progress measurement tool for health, aged care and disability sectors* – helps track progress against these recommendations.
* *Clinician’s checklist for AHPs and AHAs* – to assess if AHAs are being used effectively and to their full potential.
* Available on the [department’s Victorian Allied Health Assistant Workforce Recommendation and Resources web page](https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources) <https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources>.

The department’s workforce planning information and resources:

* *Victorian assistant workforce model toolkit.*[6]
* Available on the [department’s Victorian assistant workforce model toolkit page](https://www.health.vic.gov.au/victorian-assistant-workforce-model-toolkit) <https://www.health.vic.gov.au/victorian-assistant-workforce-model-toolkit>.

*Guidelines to scope and introduce new allied health assistant roles*:[32]

* Helps analyse your allied health workforce.
* Available on the [department’s Guidelines to scope and introduce new allied health assistant roles web page](https://www.health.vic.gov.au/publications/guidelines-to-scope-and-implement-new-allied-health-assistant-roles) <https://www.health.vic.gov.au/publications/guidelines-to-scope-and-implement-new-allied-health-assistant-roles>.

*Calderdale framework*:

* A way to review skill, role and service design.
* [The Calderdale Framework website’s The framework page](https://calderdaleframework.com/framework) <https://calderdaleframework.com/framework>.
* *Evaluation of the state-wide implementation of an allied health workforce redesign system: utilising aspects of the Calderdale framework*[6, 7, 8] – [Calderdale framework article on the Asia Pacific Journal of Health Management website](https://journal.achsm.org.au/index.php/achsm/article/view/121) <https://journal.achsm.org.au/index.php/achsm/article/view/121>.

*NDIS national workforce plan: 2021–2025*:[18]

* Available on the [Department of Social Services’ NDIS national workforce plan web page](https://www.dss.gov.au/disability-and-carers-publications-articles/ndis-national-workforce-plan-2021-2025) <https://www.dss.gov.au/disability-and-carers-publications-articles/ndis-national-workforce-plan-2021-2025>.

*The allied health assistant good practice guide:*[33]

* Evidence-based guide for disability employers on introducing AHAs to the workforce
* Created by Community Services Industry Alliance (CSIA) on behalf of WorkAbility Queensland
* Available on [CSIA’s The allied health assistants good practice guide web page](https://csialtd.com.au/major-programs/workforce/allied-health-good-practice-guide) <https://csialtd.com.au/major-programs/workforce/allied-health-good-practice-guide>.

Boosting the Local Care Workforce Program (BLCW) workshops and resources:

* BLCW partnered with CINCH Transform on 2 workshops:
  + Financial sustainability of the AHA role in your workplace
  + Human resources issues to consider when using AHA workforces
* Available on [CINCH Transform’s Learning resources web page](https://cinchtransform.my.canva.site/learning-resources) <https://cinchtransform.my.canva.site/learning-resources>.

### Recommendation 8

Workplace governance structures should define AHA roles and delegation practices to ensure safe, effective and evidence-based therapy and supports.

#### Considerations for workplaces

* Tailor AHA position description templates, including capabilities according to grading, and clinical and non-clinical support functions.
* Ensure position descriptions for AHAs are in line with current enterprise agreements.
* Establish the grade of AHA needed for a role, based on position requirements and the availability of supervision.
* Establish partnerships with other local providers to share governance resources and create peer networking opportunities.
* Distinguish an AHA’s scope of practice from an AHP and other delegated workforces within health, disability and aged care settings in terms of delegation procedure, delegation training and credentialing practice.
* Establish private-public partnerships (contracting care) in disability and aged care settings to support shared governance and retain local AHP and AHA workforces.

When employing AHP students or overseas qualified AHPs as AHAs in the Victorian public sector:

* Clearly define employer-accepted equivalent qualifications in line with current enterprise agreements.
* Employers should check that the core competencies of equivalent qualifications align with Certificate III and Certificate IV in Allied Health Assistance. It is up to employers to decide whether to accept the alternative qualification.
* Ensure the position grade aligns with the current enterprise agreement’s classification descriptions and qualifications requirements.
* Identify individual on-boarding requirements and career pathways.

A summary of accountabilities and responsibilities in the care team is in **Figure 5**. Specifically, the AHP is accountable for:

* planning, monitoring and providing safe and effective delegated therapy and supports
* conveying any changes to the original delegation in a timely manner.

The AHA is responsible for:

* completing safe and effective delegated tasks
* identifying risks while undertaking delegations
* giving feedback to the delegating AHP in a timely fashion.

Figure 5: Accountabilities and responsibilities of members of the care and therapy team



#### Considerations for AHPs

To better understand their accountabilities in working with AHAs and the difference between AHA’s role and scope of practice and other delegated workforces:

* Liaise with peak bodies and use their resources on how to work effectively with AHAs in their work setting.
* Get to know the background and clinical experience of the AHAs they work with.

#### Considerations for AHP peak bodies

* Work with sector funding bodies to define the role and scope of AHAs.
* Give their membership consistent messaging on AHA scope of practice.

#### Considerations for sector funding bodies

* Work with allied health peak bodies to define the role and scope of AHA and associated billing and pricing tiers.

#### Useful resources

The department’s AHA-related resources:

* Position description templates – example position description templates for Grade 1, Grade 2 and Grade 3 allied health assistant roles.
* *Allied health assistants and you* – flyer for consumers to help them understand the role and decide who they want in their care team.
* Available on the [department’s Victorian Allied Health Assistant Workforce Recommendation and Resources web page](https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources) <https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources>.

The department’s supervision and delegation resources:

* *Supervision and delegation framework for allied health assistants.*[1]
* *Supervision and delegation framework for allied health assistants and the support workforce in disability.*[5]
* Available on the [department’s Allied health assistant workforce web page](https://www.health.vic.gov.au/allied-health-workforce/allied-health-assistant-workforce) <https://www.health.vic.gov.au/allied-health-workforce/allied-health-assistant-workforce>.

### Recommendation 9

Training, supervision and delegation between AHPs and AHAs should be informed by existing frameworks[1] to work together effectively.

#### Considerations for workplaces

* Regular audit of AHP and AHA practice to ensure it meets clinical supervision and delegation procedures and training requirements.

Delegation:

* Develop procedures, training and tools to ensure shared understanding of the processes that underpin effective delegation from an AHP to an AHA in the local context.
* Provide guidance that delegation should be given in writing and verbally, in line with the principles of best practice clinical communication.[30]
* Work with other local services to run supervision and delegation training when unable to do so internally.

As part of AHA supervision:

* Supervise AHPs and AHAs in line with the *Victorian clinical supervision framework*[8] to ensure regular training and access to appropriate and ongoing[1, 5] clinical supervision.
* Embed supervision from a Grade 2 or more senior AHP in service delivery and agreements, where necessary.

#### Considerations for the university sector

* Include an introduction to the AHA role, as well as supervision and delegation training, in pre‑employment teaching for AHPs.

#### Considerations for peak bodies

* Include links to free supervision and delegation training modules in AHA online resources.
* Play a role in providing and sharing tools and resources on how to work effectively with an AHA.

#### Useful resources

The department’s AHA-related resources:

* *Allied health assistant delegation tool* – to help AHPs delegate effectively to AHAs.
* *Clinician’s checklist for AHPs and AHAs* – to assess if AHAs are being used effectively and to their full potential.
* Available on the [department’s Victorian Allied Health Assistant Workforce Recommendation and Resources web page](https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources) <https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources>.

Monash Health eLearning modules about delegation to AHAs in health:

* Need to create a login to access the 4 modules.
* [Monash AHA eLearning module 1: The allied health team](https://elearning.easygenerator.com/4579f9a9-474e-4f2b-aee8-c7ed21585c2d) <https://elearning.easygenerator.com/4579f9a9-474e-4f2b-aee8-c7ed21585c2d>
* [Monash AHA eLearning module 2: Role and Competencies of an allied health assistant](https://elearning.easygenerator.com/88a414c6-9a03-4fb6-a2e0-dce25de95197) <https://elearning.easygenerator.com/88a414c6-9a03-4fb6-a2e0-dce25de95197>
* [Monash AHA eLearning module 3: Delegation](https://elearning.easygenerator.com/5354a42a-b665-4ba9-966e-2200844954b9) <https://elearning.easygenerator.com/5354a42a-b665-4ba9-966e-2200844954b9>
* [Monash AHA eLearning module 4: Supervision](https://elearning.easygenerator.com/48f6a9a1-8c8d-4545-b052-14a6de0899cb) <https://elearning.easygenerator.com/48f6a9a1-8c8d-4545-b052-14a6de0899cb>.

Monash Health eLearning modules about delegation to AHAs in disability:

* Need to create a login to access the 5 modules.
* [Monash AHA in disability module 1: The allied health team](https://elearning.easygenerator.com/15355cff-2369-47e3-afc5-4d1493f4f59c) <https://elearning.easygenerator.com/15355cff-2369-47e3-afc5-4d1493f4f59c>
* [Monash AHA in disability module 2: Delegation, identification and training](https://elearning.easygenerator.com/b1b47e6a-1257-44f8-8289-382ff0ebdad9) <https://elearning.easygenerator.com/b1b47e6a-1257-44f8-8289-382ff0ebdad9>
* [Monash AHA in disability module 3: Supervision](https://elearning.easygenerator.com/ccb5a0ee-272a-42eb-b134-757ff9173e85) <https://elearning.easygenerator.com/ccb5a0ee-272a-42eb-b134-757ff9173e85>
* [Monash AHA in disability module 4: Communication](https://elearning.easygenerator.com/78d2c96d-5798-4b7b-853c-d6d9ecaa54aa) <https://elearning.easygenerator.com/78d2c96d-5798-4b7b-853c-d6d9ecaa54aa>
* [Monash AHA in disability module 5: Training, education and instruction](https://elearning.easygenerator.com/65f915f4-d1af-43ec-8dec-5430d1ac92a8) <https://elearning.easygenerator.com/65f915f4-d1af-43ec-8dec-5430d1ac92a8>.

Decision making around delegation of tasks:

* **Health** settings – *Supervision and delegation framework for allied health assistants*[1] (figure 4.1)
* **Disability** settings: *Supervision and delegation framework for allied health assistants and the support workforce in disability*[5] (Appendix A: Allied health professional considerations for delegation)
* Both are available on the [department’s Victorian assistant workforce model toolkit page](https://www.health.vic.gov.au/victorian-assistant-workforce-model-toolkit) <https://www.health.vic.gov.au/victorian-assistant-workforce-model-toolkit>.

*Victorian allied health clinical supervision framework*:[8]

* Includes clinical supervision training, templates, tools and resources.
* Available on the [department’s Victorian allied health clinical supervision framework web page](https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-clinical-supervision-framework) <https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-clinical-supervision-framework>.

Peak body resources for professional members working with AHAs:

* Speech Pathology Australia’s ‘Working with allied health assistants' from the June 2021 edition of *Speak out*. Registered members can access [Speech Pathology Australia’s Speak out archive](https://www.speechpathologyaustralia.org.au/spaweb/Document_Management/Restricted/Speak_Out.aspx) <https://www.speechpathologyaustralia.org.au/spaweb/Document\_Management/Restricted/Speak\_Out.aspx>
* [Exercise and Sport Science Australia’s Compensable work for an AES web page](https://www.essa.org.au/AES/Compensable_Work/AES/Compensable_Work.aspx) <https://www.essa.org.au/AES/Compensable\_Work/AES/Compensable\_Work.aspx>.

Monash University AHA resources for physiotherapy students:

* Two Monash University videos to help physiotherapy students increase their knowledge of AHAs in the workplace before starting clinical placement.
* [Monash video: Roles and responsibilities of an AHA](https://monash.au.panopto.com/Panopto/Pages/Embed.aspx?id=6ede0311-285d-4606-abd7-afa301862946) <https://monash.au.panopto.com/Panopto/Pages/Embed.aspx?id=6ede0311-285d-4606-abd7-afa301862946>
* [Monash video: Supporting effective delegation](https://monash.au.panopto.com/Panopto/Pages/Embed.aspx?id=7fbea842-f26f-4927-a7c8-afa301862947) <https://monash.au.panopto.com/Panopto/Pages/Embed.aspx?id=7fbea842-f26f-4927-a7c8-afa301862947>

### Recommendation 10

Workplaces should establish and maintain a culture of mutual respect, equal worth and collaboration to promote the value of the AHA role.

#### Considerations for workplaces

* Evaluate workplace culture and inclusivity.
* Set up communities of practice for AHAs in leadership roles.

Ensure AHAs:

* are empowered to understand and describe their competence and learning needs
* are supported to identify and find appropriate learning opportunities to meet their individual learning needs
* have a valued role in setting goals with the consumer through case conferences, multidisciplinary meetings, planning meetings, resident reviews and care planning
* participate in or lead quality improvement initiatives, depending on classification
* are included in leadership roles and meetings.

### Progress indicators for recommendations 7 to 10

Workplaces that provide safe and effective therapy and supports through a well-governed and integrated team of AHPs and AHAs have:

* dedicated workforce planning for AHA workforces
* the AHA workforce included in workforce planning processes and activities
* policies and procedures designed to ensure allied health employees are suitably trained to provide delegated therapy and supports throughout their employment
* regular auditing of practice to ensure it meets supervision and delegation procedures
* standard position descriptions that clearly define the AHA role and scope of practice appropriate to the setting and sector
* policies and procedures stating that allied health workforce undertakes and provides suitable supervision during their employment
* an inclusive culture that values all team members’ skill sets, with measures to assess this.

The AHP workforce clearly understands how to supervise and work with an AHA when they have:

* consistent, peak body-endorsed resources on how to effectively work with an AHA
* training on how to effectively work with AHAs
* regular supervision and delegation training
* an understanding of the differences between the AHA’s role and scope of practice and that of other delegated workforces in health, disability and aged care.

## Consumer-centred therapy and supports recommendations

| Consumer benefit statement |
| --- |
| Understanding the different roles of the care team empowers consumers, families or carers to engage in the informed choice and control of their therapy and supports. |

### Recommendation 11

Consumers should be given information about the:

* role of the AHA in the treating team
* benefits of having an AHA involved with their therapy and supports.

#### Considerations for workplaces

* Centre consumers, families and carers in the planning of individual therapy and supports, as experts by experience.
* Involve consumers in workforce planning and selecting the treating team, when feasible.
* Provide accessible consumer resources to inform decision making.
* Request and assess consumer feedback regularly to inform ongoing development and improvement of delegated therapy and supports provided by AHAs.
* Use supervision and delegation models where the consumer is part of the process, including in service agreements, where applicable.
* Ensure practice allows consumers to see trusting relationships between AHAs and AHPs.
* Ensure consumers know the available escalation options if a service is not meeting their goals or expectations.

#### Considerations for. disability and aged care peak bodies

* Actively promote accurate information about the roles of AHPs and AHAs as part of a therapy and support plan.

#### Useful resources

*Allied health assistants and you*:

* Flyer for consumers to help them understand the role and decide who they want in their care team.
* Available on the [department’s Victorian Allied Health Assistant Workforce Recommendation and Resources web page](https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources) <https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources>.

Speech Pathology Australia’s *Working with an Allied health assistant: Information for speech pathology clients, including NDIS participants*:

* Information on how AHAs work with speech pathologists and can add value to speech pathology programs.
* Available on [Speech Pathology Australia’s Allied health assistants web page](https://www.speechpathologyaustralia.org.au/SPAweb/Resources_for_the_Public/Allied_Health_Assistants/SPAweb/Resources_for_the_Public/Allied_Health_Assistant/Allied_Health_Assistant.aspx?hkey=a177611d-77aa-45a4-a623-08be92822c7f) <https://www.speechpathologyaustralia.org.au/SPAweb/Resources\_for\_the\_Public/Allied\_Health\_Assistants/SPAweb/Resources\_for\_the\_Public/Allied\_Health\_Assistant/Allied\_Health\_Assistant.aspx?hkey=a177611d-77aa-45a4-a623-08be92822c7f>.

### Progress indicators for recommendation 11

Workplaces that support consumer-centred therapy and supports:

* place the consumer (and families or carers, where appropriate) at the centre of decision making for their therapy and supports
* encourage informed choice by providing consumer resources that clearly communicate the role of an AHA in the allied health team
* use consumer feedback to inform service changes.

Consumers are informed to make collaborative decisions about the therapy and supports AHPs and AHAs provide when:

* there are clear consumer feedback mechanisms
* accessible resources tell the consumer about treating team roles
* consumers are involved in workforce planning and selecting the treatment team
* there are opportunities for candid conversations about differences with service planners or treating team members.

## Recruitment and induction recommendations

| Consumer benefit statement |
| --- |
| When a workforce represents the community, therapy and supports will be better suited to individual and community needs. When AHPs clearly understand the role of AHAs, trust and mutual respect increases – which helps provide cohesive therapy and supports. |

### Recommendation 12

When recruiting AHAs, the interview process should include behavioural scenarios to evaluate the candidate’s aptitude and capability to provide safe and effective consumer care.

#### Considerations for workplaces

* Include clinical scenarios with a focus on behavioural skills.
* Include a written comprehension task in the interview.
* Ensure interview processes are culturally safe.
* Include senior AHAs in recruitment of more junior AHAs.

#### Useful resources

The department’s AHA-related resources:

* AHA position description templates:
  + Grade 1 AHA and allied health trainee
  + Grade 2 AHA and Level 1 therapy assistant
  + Grade 3 AHA and Level 2 therapy assistant
* *Allied health assistant interview guide*:
  + Guide to running interviews for AHA or therapy assistant roles.
  + Includes an interview assessment template that workplaces can adapt to their needs.
* Available on the [department’s Victorian Allied Health Assistant Workforce Recommendation and Resources web page](https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources) <https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources>.

Behavioural interviewing (worked example), *Allied health: credentialing, competency and capability framework*[2]:

* Examples of behavioural-based interview questions for a range of domains
* See *Resource kit 3: Capability*, available on the [department’s Credentialling, competency and capability framework web page](https://www.health.vic.gov.au/allied-health-workforce/credentialling-competency-and-capability-framework) <https://www.health.vic.gov.au/allied-health-workforce/credentialling-competency-and-capability-framework>.

### Recommendation 13

Workplace orientation should make clear the roles and responsibilities of AHAs and other professional staff to support a mutually respectful culture.

#### Considerations for workplaces

* Develop orientation procedures, which may include checklists, role descriptions or duty statements.
* Include information on AHA delegation processes in AHP orientation.
* Include information on other team members’ roles and responsibilities as part of orientation when a staffing change occurs (such as a new recruit or rotation).
* Provide new AHAs with a buddy AHA, where capacity allows.
* Allocate an appropriately-credentialed clinical supervisor during orientation.
* Start credentialing and defining scope of practice once person has been recruited to confirm competency and identify learning needs in line with local processes and, where needed, including the department’s four AHA core competencies[13] in local credentialing processes.
* Provide opportunities for more frequent supervision when new to a role, in line with the *Victorian clinical supervision framework*[8]
* Assign a supervisor or mentor to provide appropriate cultural support, if needed.
* Give AHAs access to an early graduate program designed to help them transition from student to assistant in their first year of practice (while AHAs may have different transition to practice needs, there may be opportunities for shared content with AHP graduate programs).
* Clearly set out professional indemnity insurance provision and requirements.

#### Useful resources

*Aboriginal workforce strategy 2021–2026:*

* The department promotes culturally responsive recruitment processes and culturally safe onboarding as part of the *Aboriginal workforce strategy 2021–2026*.
* The strategy is available on the [department’s Aboriginal employment web page](https://www.health.vic.gov.au/careers/aboriginal-employment) <https://www.health.vic.gov.au/careers/aboriginal-employment>.

### Progress indicators for recommendation 12 to 13

Workplaces that successfully recruit suitable candidates for AHA roles and support inclusive induction processes:

* have appropriate governance structures to ensure defined scope of practice for all AHAs
* take part in VET sector consultations to ensure course content remains relevant
* consistently offer appropriate placement location and duration (at least 200 hours) for RTO partners delivering certificate training for AHAs
* recruit AHAs with appropriate qualifications (aligned to industrial agreements) and experience in line with the role’s classification and performance requirements
* use behavioural-based interview questions to assess candidates’ aptitude and capability for roles
* have a structured and supportive orientation program for AHAs and AHPs to promote clear understanding of roles
* give new allied health employees more frequent supervision
* complete credentialing and define scope of practice early (within first 6 weeks of starting a new role) to establish learning needs
* give AHA graduates access to early graduate programs and resources, where possible.

## Workplace training and development recommendations

| Consumer benefit statement |
| --- |
| When AHAs are supported to complete workplace training for lifelong learning, it expands the therapy and supports that AHPs can delegate to them. This provides more opportunities for consumer choice and better access to high quality therapy and supports. |

### Recommendation 14

All workplace competency-based training development should align with the *Allied health: credentialing, competency and capability framework.*[2]

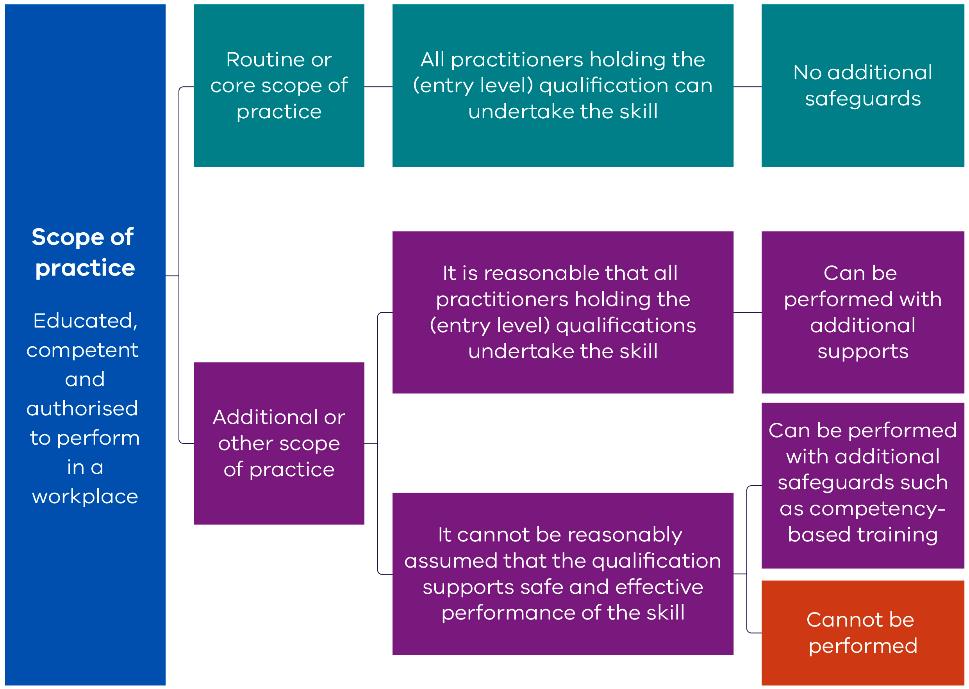
#### Considerations for workplaces

* Evaluate whether a specific task needs education or a competency-based training and assessment program, in line with the department’s *Allied health: credentialing, competency and capability framework*[2] and the assessed risk of the task. Lower risk tasks may be addressed as part of general professional development. Higher risk tasks need a competency-based training and assessment program before delegated practice can begin. See **Figure 6**.
* Use the department’s AHA core competencies[13] as the basis for developing competency standards and training for all AHAs.
* Use a reference group to develop competency-based training programs for AHAs. Include people with:
  + educational expertise (to help develop competency-based training)
  + best practice performers or subject matter experts (for skill-specific technical input and to contextualise the program) – such as a clinician experienced in the area of competency.
* Share resources and work with workplaces and sectors, with local contextualisation, to provide competency-based training when it cannot be run internally.
* Partner with the VET sector to run recognised competency units (found on the [training.gov.au website](https://training.gov.au/))[33] and provide certificates of attainment to:
  + upgrade from Certificate III to Certificate IV in Allied Health Assistance, or
  + upskill in areas of competency related to a specific allied health profession.

#### Considerations for AHP peak bodies

* Support competency-based training relevant to their profession for this workforce.
* Evaluate the need for an AHA membership category.

Figure 6: Categorising scope of practice to inform risk control measures



**Note**: presented to Victorian Allied Health Assistant Workforce Recommendations Steering Committee October 2020 by Monash Health Professional Practice Advisor. This decision tool was based on work of the Professional Standards Authority[34] and the Australian Commission on Quality and Safety in Health Care.[35] Safeguards may include activities like self-reflection, orientation, access to patient education material and competency-based training.

#### Useful resources

The department’s core AHA competencies training modules and learning guides:

* Good starting point for developing learning activities for new AHA competency-based training.
* Each competency has its own training module and learning guide.
* Includes case scenarios and templates that can be used for different workplaces.
* Available on the [department’s Core allied health assistant competencies web page](https://www.health.vic.gov.au/victorian-assistant-workforce-model-toolkit/core-aha-competencies) <https://www.health.vic.gov.au/victorian-assistant-workforce-model-toolkit/core-aha-competencies>.

*Allied health: credentialing, competency and capability framework*:

* Includes the framework, resource kits and self-assessment tools.
* Resource kit 2 covers competency (resources 2.2 to 2.11 are particularly relevant).
* Available on the [department’s Credentialling, competency and capability framework web page](https://www.health.vic.gov.au/allied-health-workforce/credentialling-competency-and-capability-framework) <https://www.health.vic.gov.au/allied-health-workforce/credentialling-competency-and-capability-framework>.

### Recommendation 15

Find opportunities for AHAs to work side-by-side with AHPs to:

* develop trusted working relationships
* create shared knowledge of roles
* complement workplace competency-based training.

#### Considerations for workplaces

* Establish and prioritising opportunities for side-by-side working, where possible.
* If side-by-side work is not possible (such as remote supervision or brokered AHA services), review the frequency of supervision and communication to ensure learning is consolidated.
* Dual billing for the time taken to train or supervise an AHA to complete consumer-specific tasks in private billing contexts.

### Recommendation 16

Workplace competency-based training and assessment should be undertaken by supervisors who meet relevant requirements.

#### Considerations for workplaces

Supervisor requirements, as stated in *Allied health: credentialling, competency and capability framework*:[2]

* tacit knowledge of the assessment area (at least Grade 2 AHP or Grade 3 AHA)
* recent and broad experience in the area being assessed
* working knowledge of the competency standard content
* working knowledge of the assessment plan, tool and process
* working knowledge of an assessor’s responsibilities, including cultural safety
* relevant clinical competencies at an appropriate level due to qualification, training or experience.

### Recommendation 17

Keep competency attainment records for transferability between roles and settings.

#### Considerations for workplaces

* Set up a central register for AHA competency attainment. This may be in electronic or specialty software form depending on the requirements and scale of the workplace.
* Support AHAs to document performance evidence of competencies. This will improve transferability of their skills across settings and workplaces (for example, to market their skills or as evidence for prospective employers).
* Audit clinical practice to ensure AHAs are working within their defined scope of practice.
* Use a skills recognition process when an AHA moves roles. Skills recognition may include orientation, clinical supervision and a review of performance evidence to meet the needs of the new role.
* Set up a skills passport to transfer skills across AHA roles and across sectors, as recommended by the *NDIS national workforce plan: 2021–2025*.[18]

#### Useful resources

*Allied health: credentialing, competency and capability framework*:

* Includes guidance on collecting evidence.
* Available on the [department’s Credentialling, competency and capability framework web page](https://www.health.vic.gov.au/allied-health-workforce/credentialling-competency-and-capability-framework) <https://www.health.vic.gov.au/allied-health-workforce/credentialling-competency-and-capability-framework>.

### Recommendation 18

AHAs’ learning needs should be formally identified and addressed to:

* foster life-long learning
* maintain performance standards
* support career development.

#### Considerations for workplaces

* Set a key performance indicator of annual CPD hours for AHAs.
* Formally identify individual AHA learning needs every year.
* Monitor progress of meeting identified learning needs through clinical supervision and performance appraisal.
* Help allied health educators target learning to AHA needs and in an appropriate format, where possible.
* Evaluate professional development targeted to AHAs.
* Include AHAs in existing training where relevant to learning needs.
* Give AHAs opportunities to attend relevant internal and external professional development activities related to their individual learning goals.
* Help AHAs keep a record of their professional development. For example, a CPD log that they can use as part of annual performance review and to identify ongoing learning needs.
* Audit AHA access to and attendance at professional development sessions and events.
* Help AHAs develop and take part in a community of practice to develop peer networks and improve cross-region and sector learnings. For example, support the development of a care and support worker professional network in the disability sector, as recommended by the *NDIS national workforce plan: 2021–2025*.[18]
* Provide interdisciplinary and single discipline roles for AHAs, where feasible.
* Work with other local services to provide professional development if the workplace cannot run an internal program.
* Allow grade reclassification, informed by role and experience.
* Explore transferability of AHA skill set to other roles in health, disability and aged care sectors.

#### Considerations for AHAs

* Push for targeted professional development relevant to learning needs.
* Show a willingness and commitment to ongoing learning and development.
* Commit to a key performance indicator of annual CPD hours (such as 15 hours each year for each person).
* Develop and take part in communities of practice or regional networks. This will encourage peer learning, information sharing, professional development and cross-region and sector learnings.
* When applying for positions outside traditional AHA roles, describe transferable skills gained from workplace experience.
* Find opportunities to promote, advocate for and contribute to the growth of the AHA workforce.

#### Considerations for the university sector

* Include allied health assistance certificate training programs, competencies gained and work experience as part of recognised prior learning. Use these, combined with personal attributes and academic performance, when selecting people for graduate-entry AHP degree programs.[25]

#### Useful resources

The department’s AHA-related resources:

* *AHA learning needs assessment tool* – to help AHAs identify training and development goals and opportunities.
* Available on the [department’s Victorian Allied Health Assistant Workforce Recommendation and Resources web page](https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources) <https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources>.

### Progress indicators for recommendations 14 to 18

Workplaces that help AHAs build workplace competency and undertake meaningful professional development:

* Evaluate the need for competency-based training and assessment programs.
* Use documented competency-based training and assessment programs, developed using the *Allied health: credentialing, competency and capability framework*.[2]
* Explore opportunities to partner with the VET sector on workplace competency-based training programs.
* Prioritise opportunities for side-by-side working in allied health teams (directly or remotely).
* Have processes to ensure workplace training supervisors have appropriate knowledge and skills.[2]
* Have a central workplace register and individual records of AHA competencies gained to ensure transferability of skills.
* Help AHAs achieve their individual learning needs and career goals.

AHAs are supported to progress their career within allied health when:

* the workplace acknowledges an AHA’s skills and work experience
* the relevance and transferability of an AHAs skills to other roles in health, disability and aged care sectors is explored
* the university sector includes an AHA’s skills and work experience in their recognition of prior learning requirements.

# 5. References

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# 6. Appendices

## Appendix 1: Project steering committee members

| Name | Title | Organisation |
| --- | --- | --- |
| Alison Cliff | Allied health assistant team leader (February to November 2020) | Central Bayside Community Health |
| Angela Ellis | Executive Manager Support, Therapy, Education and Prevention (February 2020 to August 2021) | Gippsland Lakes Complete Health |
| Annette Davis | General Manager, Therapy Services | SCOPE |
| Annie Pearce | * Professional Practice Advisor * Subject Matter Expert – Credentialing and scope of practice | * Monash Health * State-wide Equipment Program |
| Catherine Wolters | Allied Health Clinical Interface Leader and Speech Pathologist | Alfred Health |
| Claire Hewat | Chief Executive Officer (February 2020 to July 2022) | Allied Health Professions Australia (AHPA) |
| Courtney Ward-Jackson | Manager of Speech Pathology and Allied Health Assistants (February 2020 to April 2021) | Northeast Health Wangaratta |
| Dianne Hardy | Project Lead, Disability Workforce Innovation | National Disability Services |
| Dimitri Diacogiorgis | Clinical Manager, Podiatry and Allied health assistants | Ballarat Health |
| Emma McAuley | Allied health assistant (November 2020 to present) | Peninsula Health |
| Fiona Still | State Manager (February to June 2020) | National Disability Services |
| Greta DeVincentis | Allied health assistant | Monash Children’s Hospital |
| Heidi Manson | Allied Health Clinical Educator | South West Healthcare Warrnambool |
| Helen Garard | Education Manager (February 2020 to November 2021) | Holmesglen Institute |
| Jill Walsh | Senior Policy Advisor (February 2022 to October 2022) | Department of Health |
| Jim Sayer | Director of Allied Health | Northern Health |
| Kat Habel | Clinical Lead Allied health assistants and Physiotherapist | Gateway Health Wangaratta |
| Kate MacRae | Chief Executive Officer | * Able Australia (February 2020 to February 2022) * Scope (March 2022 to present) |
| Kirsty Hearn | Clinical Lead Physiotherapist | Eastern Health |
| Laura Browning | Allied Health Tertiary Education Lead | Western Health |
| Leanne deVos | Australian Physiotherapy Association Representative | Access Health and Community |
| Lesley Rieveley | Allied health assistant (February to October 2020) | Peninsula Health |
| Michelle Sargent | Head of Speech Pathology and Allied Health Assistant Advisor | Peninsula Health |
| Mitchell Dunn | * Trainer Assessor Allied Health Assistance (February to November 2020) * Associate Lecturer, Rural Placement Coordinator (November 2020 to September 2021) * Manager, Allied Health (September 2021 to present) | * Goulbourn Ovens TAFE * The University of Melbourne * Shepparton Private Hospital |
| Nicole Mahar | Director, Market Development South, NDIA (February 2020 to December 2021) | National Disability Insurance Agency |
| Paula Cooke | Occupational Therapy Manager | Mercy Health Werribee |
| Reece Adams | * Head, Centre for Developmental Disability Health * Occupational Therapy Manager and Allied Health Research and Innovation Lead * Senior Clinical Lead - Therapy | * Monash Health * HEARTH Support Services * SCOPE |
| Robyn Ingram | Senior Policy Advisor, Department of Health, Workforce Branch (March 2022 – May 2023) | Department of Health |
| Ruchika Rawat | * Allied health assistant (February 2020 to July 2021) * Public Health Officer (August 2021 to September 2021) * Project Lead (Health Programs) Health/Trauma Branch (September 2021 to present) | * Barwon Health * Department of Health * Transport Accident Commission |
| Scott Miller | Allied health assistant | Eastern Health |
| Sean Kinnaird | * Allied health assistant (February 2020 to January 2021) * Teacher Certificate in Allied Health Assistance (January 2021 to present) | * Monash Health * Holmesglen Institute |
| Sharon Downie | Manager, Allied Health Workforce (February 2020 to February 2022) | Department of Health |
| Shilpa Smith | * Head of Department (Aged Care, Disability, Allied Health and Health Services) (February 2020 to August 2021) * Head of Learning – Community and Health (September 2021 to present) | * All Health Training * IVET institute |
| Simone Motton | Director, Allied Health | Northern Health |
| Stephanie Allan | Allied health manager (Nov 2020-present) | Central Bayside Community Health |
| Tilly Waite | Teacher Allied Health Assistance | Wodonga TAFE |

## Appendix 2: Roles and responsibilities to ensure best use of AHA workforces

| Stakeholder | Role and responsibility | Relevant recommendation |
| --- | --- | --- |
| Consumers | * Make informed choices in therapy, supports and services. * Actively take part in prescribed therapy plans. * Work with care team to set goals. * Escalate concerns when therapy, supports or services are not in line with consumer goals. | 11 |
| Allied health assistants (AHAs) | * Maintain knowledge of role and defined scope of practice in setting. * Uphold a culture of ‘respect, learn and grow’ by taking part in activities like team support, workforce planning, leadership, orientation and workforce representation. * Actively work with delegating professionals and broader consumer care teams to ensure safe and effective therapy and supports within defined scope of practice. * Identify risks within scope of delegation and escalate accordingly. * Complete documentation in line with workplace requirements. * Actively participate in clinical supervision. * Actively identify learning needs through participation in delegation, professional development, competency-based training and clinical supervision. * Engage in culturally safe practice with priority groups of peers and consumers. * Support VET sector and industry partnerships. * Support student clinical placements. | All |
| Allied health professionals (AHPs) | * Uphold a culture of ‘respect, learn and grow’ through working collaboratively with the allied health workforce. * Help with orientation of AHAs to role and workplace. * Uphold accountability for consumer diagnosis and overall therapy and supports plans, including when the task is delegated. * Establish clear two-way communication with AHAs. * Maintain knowledge of the AHA role and scope of practice and consider individual capabilities, competencies (knowledge and skills) and learning needs. * Analyse clinical practice to identify tasks that can be delegated. * Actively take part in supervision and delegation training. * Provide appropriate delegated tasks along with supervision and delegation in line with the AHA’s level of competency and capability. * Provide workplace competency-based training and assessment or professional development to meet AHA learning needs, where appropriate. * Support endorsement and recording of AHA competencies. * Regularly give AHAs clinical supervision. * Engage in culturally safe practice with priority groups of peers and consumers. * Ensure AHAs are covered by the supervising therapist’s professional indemnity insurance, when directly employing an AHA. | 1, 3, 6, 7, 8, 9, 10, 11, 13, 14, 15, 16, 17 |
| VET sector (including private and public providers) | * Work with other education providers to give AHA students a consistent student experience and industry a consistent graduate experience. * Conduct interviews as part of pre-training reviews. * Prepare skills ready graduates in Certificate III and Certificate IV Allied Health Assistance, in consultation and partnership with industry. * Ensure graduates undertake cultural awareness training and understand differences in cultural communication styles. * Provide alternate modes of delivery and placement and consider traineeship partnerships. * Partner with industry to provide skilled and qualified teaching staff. * Partner with industry on meaningful placement models across sectors. * Partner with industry to support and provide training after Certificate IV graduation as elective modules for competency-based training in the workplace. * Work with the university sector to provide appropriate and accessible education pathways for AHAs who want to pursue university study. | 1, 2, 3, 4, 5, 6, 14 |
| University sector | * Prepare AHP students with an introduction to the AHA role, delegation knowledge and skills. * Provide appropriate and accessible education pathways for qualified and experienced AHAs who want to pursue university study. | 6, 8, 18 |
| Employers and managers | * Instil and uphold a culture of ‘respect, learn and grow’ in the allied health workforce. * Ensure clear policies and resources are in place to guide the way the team works around:   + cultural safety   + consumer information   + clinical supervision   + delegation practice   + workplace competency based-training and professional development. * Regularly evaluate models of care, team performance and use of AHA roles against best practice recommendations and service demands. * Clearly define role and AHA scope of practice, including in position descriptions. Ensure they are in line with current enterprise agreements. * Recruit, on-board and induct new AHA staff into positions with appropriate supervision and delegation processes in place. * Instil an expectation of ongoing learning and development in AHAs. * Ensure the workforce is representative of the wider Australian population. * Support AHA student training and placement opportunities through partnerships with RTOs. * Provide traineeships for AHA where workforce shortages indicate the need. * Ensure AHAs are covered by the workplace’s professional indemnity insurance. | 1, 4, 6, 7, 8, 9, 10, 11, 12, 13, 14, 15, 16, 17, 18 |
| AHP peak bodies | * Consult on or develop, support and distribute guidelines for the defined scope of practice and use of AHAs. * Give members continuing professional development to support effective use of and appropriate delegation to AHAs, in line with their profession and setting. * Offer AHAs membership categories and learning opportunities. * Liaise with the tertiary education sector and Allied Health Professional Registration Association, where indicated, to inform supervision and delegation training for undergraduate AHP students. * Inform course content for AHA students through VET sector consultation activities. | 1, 6, 7, 8, 9, 10, 14 |
| Disability peak bodies (NDS and NDIA) | * Actively take part in consultation with the VET sector on appropriate course content for certificate training for AHAs (therapy assistants). * Endorse certificate training of AHAs (therapy assistants) working in disability. * Ensure AHP and AHA accountabilities and scope of practice are clearly defined, endorsed and supported by workplaces. * Ensure accurate and appropriate consumer, carer and planner resources are available to inform choice and control over therapies and supports. * Ensure advice on using AHPs and AHAs (therapy assistants) in disability is clear and distinct from other support roles like disability support workers. * Ensure the AHA role is clearly defined for planners and consumers as one that works under the delegation and supervision of an AHP and not as an independent trader. * Support the growth of AHA (therapy assistant) roles, as outlined in the *NDIS national workforce plan*. | 1, 6, 7, 8, 9, 10, 11, 15, 16, 17, 18 |
| Disability support package planners | * Ensure participants’ plans have adequate access to allied health therapies. * Ensure AHP accountabilities in assessment, diagnosis, therapy planning and prescription are upheld in a supervision and delegation model with AHAs (therapy assistants). * Ensure that the consumer understands the AHA is an appropriately qualified person who is delegated and supervised by an APH, whenever an AHA (therapy assistant) is included in a plan (including with dual billing). * Support AHA (therapy assistants) roles, as outlined in the *NDIS national workforce plan*. | 6, 7, 8, 10, 11 |
| Aged care peak bodies | * Actively take part in consultation with VET sector on appropriate course content for Certificate training for AHAs working with older persons. * Endorse Certificate training of AHAs working in aged care. * Ensure AHP and AHA accountabilities and scope of practice are clearly defined, endorsed and supported by workplaces. * Ensure advice on using AHPs and AHAs in aged care is clear and distinct from other support roles (such as lifestyle assistants, personal care attendants, diversional therapists). * Ensure the AHA role is clearly defined for consumers and families as one that works under the delegation and supervision of an AHP. * Support funding models to continue AHA input into therapy programs for older adults. | 1, 6, 7, 8, 9, 10, 11, 17, 18 |
| Department of Health and industry leaders | * Include AHAs in workforce planning through consultation. * Provide workforce planning options so AHAs can be best used in collaborative allied health teams or by sole practicing AHPs, regardless of work setting. * Ensure tools provided are reviewed regularly, considering contemporary practice, evidence base and funding implications. * Support training options to train workplaces on how to best use AHAs. * Advocate for funding for dedicated AHA workforce support. * Advocate for extension of training and development funding to include AHAs in early graduate programs. | 6, 7, 8, 9, 10, 11, 18 |
| Compensable bodies (like Traffic Accident Commission, Department of Veteran Affairs) | * Consult with peak bodies to maintain support for contemporary allied health practice and effective models of care. * Maintain contemporary funding of the AHA role * Endorse AHA Certificate training through eligibility criteria for funding. | 6, 7, 8, 10, 11 |

## Appendix 3: AHA-related departmental resources

The following resources are available on the [department’s Victorian Allied Health Assistant Workforce Recommendation and Resources web page](https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources) <https://www.health.vic.gov.au/allied-health-workforce/victorian-allied-health-assistant-workforce-recommendations-resources>.

### Recruitment

* Registered training organisation pre-training review
* Allied health assistant role grading flow chart
* Position description: Grade 1 Allied Health Assistant or Allied Health Trainee
* Position description: Grade 2 Allied Health Assistant or Level 1 Therapy Assistant
* Position description: Grade 3 Allied Health Assistant or Level 2 Therapy Assistant
* Allied health assistant interview guide

### Progress measurement

* Clinician checklist for allied health professionals and allied health assistants
* Progress measurement tool for registered training organisations
* Progress measurement tool for health, aged care and disability
* Allied health assistant delegation tool

### Training and professional development

* Allied health assistant learning needs
* Allied health assistant continuing professional development log

### Business and consumer information

* Allied health assistants and you

## Appendix 4: Image descriptions

### Figure 2: The relationship between workplace competency-based training and professional development for an allied health assistant

At the centre is a skilled AHA supported in ongoing learning and development

The AHA develops two areas (including through CPD learning cycles):

* **Capability**: Professional development
* **Skills and knowledge**: On-the-job competency training.

Capability is informed by:

* productivity
* competency frameworks.

Skills and knowledge are informed by:

* scope of practice
* industry need.

Supporting and overseeing the AHA is ‘supervision and delegation in place’.

Return to **Workplace training and development**.

### Figure 3: The 3 core principles

#### Respect

* Respect for the consumer.
* Respect allied health assistant and allied health professional roles in adding value to the consumer experience through meaningful and effective collaborative care delivery.

#### Learn

* Learning to undertake workforce planning with sector and peak bodies to set a culture that encourages and supports collaboration between professional and support workforces.
* Learning to deliver high quality delegation.
* Embed ongoing learning into allied health assistant careers through targeting professional development and transferable on-the-job competency training.

#### Grow

* Grow collaborative care delivery.
* Grow allied health assistant scope and career pathways.
* Grow support workforce to meet consumer demand.
* Grow allied health assistant roles.

Return to **4. Recommendations to best develop and use allied health assistants**.

### Figure 4: Factors contributing to the development and best use of AHA workforce

#### Tier 1: Career preparation

Individual factors:

* Professional and workforce influences external to workplace
* AHA capabilities for AHA role
* Personal attributes and aptitude for AHA career.

Workplace and workforce preparation

* Workforce planning and redesign
* Workplace governance
* Workplace culture
* Allied health workforce orientation and training to extend knowledge and skills
* Resources to implement allied health workforce frameworks and guidelines
* Sector, workforce and funding influences external to training programs.

Training factors:

* Consistent AHA pre-employment training.

All factors lead to Tier 2.

#### Tier 2: Career development

Progress from Grade 1 to Grade 3:

* Grade 1: AHA student or traineeship
* Grade 2: Certificate III in AHA or accepted equivalent course
* Grade 3: Certificate III in AHA or accepted equivalent course and 3 years’ experience.

Surrounding the 3 grades is a continuous cycle with 4 elements:

* AHA targeted continual professional development
* AHA competency-based training assessment program
* Respectful allied health team relationships
* Continuous performance improvement.

Grade 3 leads to Tier 3.

#### Tier 3: Career trajectory

* Education pathway: VET qualified teacher
* Training into another career (such as AHP or nursing)
* Broadening of clinical practice and leadership roles
  + Sector: health, disability, aged care
  + Allied health professions: single or multidiscipline
  + Leadership: team leader, student coordinator, quality and service improvement
  + Setting: public or private, community or hospital.

Return to **4. Recommendations to best develop and use allied health assistants**.

### Figure 5: Accountabilities and responsibilities of members of the care and therapy team

Figure made up of three concentric circles.

#### Inner circle

Safe and effective care.

#### Middle circle

Divided into 4 quadrants:

* **AHAs**: **Responsible** for carrying out delegated tasks within defined scope of practice and reporting back to AHP
* **AHPs**: **Accountable** for effectively delegating tasks to and appropriately supervising competent AHAs
* **Broader team**: **Informed** of AHA role and activity as relevant
* **Consumers**: **Consulted** on their goals and role of AHA in their care and therapy.

#### Outer circle

Continuous cycle of 2 elements: supervision and delegation.

Return to **Recommendation 8**.

### Figure 6: Categorising scope of practice to inform risk control measures

Flowchart for categorising scope of practice.

Scope of practice: Educated, competent and authorised to perform in a workplace

Divided into two paths:

* Routine or core scope of practice
* Additional or other scope of practice.

**Routine path**:

* All practitioners holding entry level qualification can undertake the skill
  + Result: No additional safeguards.

**Other scope path**:

* It is reasonable that all practitioners holding the entry level qualification undertake the skill
  + Result: Can be performed with additional safeguards.
* It cannot be reasonably assumed that the qualification supports safe and effective performance of the skill – leads to two options
  + Result: Can be performed with additional safeguards like competency-based training, or
  + Result: Cannot be performed.

Return to **Recommendation 14**.