Empowering EU health policies
on Task SHIfting

D5.1 CASE STUDIES OF IMPLEMENTATION SITES

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Table of contents

List of figures

List of tables

1. Executive summary

The EU co-funded project “Empowering EU health policies on Task Shifting” (TaSHI) aims to provide a novel understanding and up-to-date knowledge on task shifting, and on transferability and uptake of good practices in implementation.

TaSHI performs pilots at five European implementation sites (Estonia, Italy, Lithuania, the Netherlands and Norway), to gather evidence and data on different types of task shifting implemented in different health care systems. This deliverable presents case studies from the implementation sites, aiming to demonstrate the value of task shifting both for patients and for health professionals. They describe the activities for the task shifting that are taking place in the pilot sites in order to achieve the defined objectives and provide useful information on the results that can be extended to wider professions, levels and countries by various stakeholders.

The introductory chapter highlights the added value and potential advantages of task shifting, underlining the possibility of implementing different types of it, and recognizing the existence of several barriers and obstacles to a sustainable and effective implementation.

The “Objectives and Methods” chapter describes the stepwise approach to guide the pilot projects in the implementation sites. Seven steps used as a general guide for planning and executing the different phases of implementation. In addition, each pilot project presents the phases they have deployed according to their specific needs and the level of readiness to task shifting.

The “Results” chapter includes an overview, and then the case studies in details developed in the five European countries:

1) Research of the tasks' delegation from family physicians and psychiatrists to nurses, psychologists and nursing assistants at two primary care providers in Lithuania (in Vilnius and Kaunas districts);

2) Analysis of task shifting potential in wound care using videoconferencing at Vestre Viken Hospital Trust (Norway) to connect the municipal staff with the more experienced and competent hospital staff at the outpatient wound care clinic, and with General Practitioners (GPs);

3) Joint care for the stable glaucoma patient nearby: the case of an optometrist centre at the Rotterdam Eye Hospital (the Netherlands) and task shifting in eye care in the region of Twente in the Netherlands, where ophthalmologists and optometrists organised explore new ways to work together.

4) Analysis of task shifting potential between general practitioners and family nurse practitioners in the primary care sector in Lombardy Region (Italy) and related training.

5) Improving mental health care in Estonia by shifting tasks from psychiatric care and family physicians to nurses: Bringing mental health nurses to primary care.

Each case study describes the background and context of the task shifting implementation, the scope of the pilot project, the analysis of the tasks to be shifted, a real-life story about a task shifting event happened in the implementation site, the competences needed to succeed in the task shifting implementation and the learning opportunities within the lifespan of the TaSHI project and, finally, the opportunities and limitations of the task shifting experience. Finally, some suggestions for successful implementation are given.

2. About the TaSHI project

In March 2020, the European Commission published a call for project proposals within the third Health Programme (HP3) to support reforms in the health workforce field, targeting initiatives in three specific areas:

1. Initiatives on 'task shifting';
2. Initiatives on retention policies;
3. Initiatives on so-called 'medical deserts'.

The European Commission emphasised the following aspects in the call for proposals:

- Europe's health workforce is facing major challenges due to an ageing population, increased demand for new models of primary care and better-integrated and more patient-centred care, and an increase in chronic diseases, in a broader context of persistent budgetary constraints.
- Moreover, the health workforce itself is ageing rapidly, while financial cuts are adding to wider migration patterns and causing severe shortages of health workers in several Member States (MS). Several regions of the EU are facing the problem of so-called 'medical deserts' with declining numbers of doctors.
- It becomes more than urgent to promote evidence-based reforms to address the challenges that the European health workforce is facing, through actions focusing on retention policies, medical deserts and task shifting.

The European Commission approved five projects in November 2020, which were then started in early 2021, under the three selected topics:

1. TaSHI, aimed at analysing and promoting EU health policies on Task Shifting;
2. METEOR , focused on policies on health workforce retention;
3. OASES, ROUTE Health Workforce and AHEAD dedicated to the analysis of "medical deserts" and the promotion of mitigation policies.

The main objectives of the TaSHI project are to provide a novel understanding and up-to-date knowledge on task shifting, and on the transferability and uptake of good practices in task shifting implementation. TaSHI applies different methods of analyses in order to provide added value on the concept, notion, and implementation of task shifting at EU-, national- and regional levels.

TaSHI performs pilots in five European countries to gather evidence and data on the different types of task shifting in primary care, mental health care, wound care and ophthalmology, including the role of telemedicine and digital health.

TaSHI also aims to facilitate dialogues and knowledge exchanges between the relevant stakeholders. Strengthening governance and stakeholder engagement for transferring and upscaling task shifting practices plays a crucial role in policy-making supporting health reforms for workforce development, as well as in enhancing cultural sensitivity, flexibility, readiness, and organisational adaptation to task shifting.

TaSHI delivers a collection of good practices, useful tools and methods, a guidebook on task shifting supporting the real-life implementation, case studies on the pilots' experiences, practical training materials and curriculum, and a set of recommendations. The deliverables on tangible solutions and practical products support EU Member States at policy and organisational level to initiate and implement their own actions tailored to the local settings.

ABOUT THE "IMPLEMENTATION" ACTIVITIES IN TASHI AND THE DELIVERABLE 5.1

TaSHI aims to manage the implementations of task shifting initiatives in five European countries: Italy, The Netherlands, Norway, Lithuania, and Estonia. Specifically, TaSHI supports implementers in a mix-match approach to blend objectives and activities related to core features from different task shifting tools and practices. Moreover, a specific TASHI objective is to describe processes and results of the task shifting initiatives performed during the pilot exercise and, consequently, to support the exchange of knowledge and experiences of implementation by implementers including webinars and online thematic workshops. Finally, as an important outcome, the TaSHI project will identify general principles and individual characteristics of successful implementation of task shifting initiatives in each pilot site to facilitate the sustainability and scalability of the practice by strategy and plans for actions at local/ regional/national levels. In addition, TaSHI will generate a set of recommendations and guidance for uptake of the pilot task shifting initiatives with new knowledge and understanding, based on the results of implementation.

The present report 5.1 "Case studies of implementation sites" describes the case studies, outlining the specific national and local context of each site, the adopted framework of implementation, the action plan and the main phases of the ongoing experience.

3. Introduction

The health workforce (HWF) in Europe is facing significant challenges. Ageing of the population and of the HWF, shortages and unequal or maldistribution of HWF and other healthcare resources, growing population demands, need for better-integrated and patient centred care, as well as the rise of multi-morbidity and non-communicable diseases represent some of the challenges we are facing.

A possible solution that can help the HWF in tackling the various challenges is represented by Task Shifting (TS). According to WHO (WHO, 2008), task shifting occurs between different health professional groups and has the potential to alleviate these challenges by:

- Reducing staff shortage contributing to the sustainability of the health workforce;
- Increasing the skills of the staff improving quality of care, where evidence shows that activities are performed better by one group than another;
- Increasing collaboration between healthcare workers enhancing the resilience of the health system, especially where different professional groups can substitute for one another in emergencies;
- Facing the costs contributing to the financial sustainability of the health system, taking into account that many health professionals tend to spend a considerable amount of time performing activities for which they are overqualified.

According to the report of the EU Expert Panel (EU, 2019), task shifting is defined broader as delegation and (re)sharing of roles between health professions or shifts from professionals to patients and their carers or machines. Task shifting can be a way to regulate informal practices but it can also be a way to respond to an unmet demand of the population. Different types of task shifting exist: changing roles, job enhancement (increasing the depth of the job by extending the role or skills of a particular group of workers), job substitution/delegation (exchanging one type of work from one profession to another profession, breaking traditional professional silos), job innovation, i.e. creating new jobs by introducing a new type of worker or technology.

Technology, and specifically the digitalisation of the health care sector, is offering new solutions and new ways of delivering the health care and new ways of sharing the responsibilities among the health professionals (i.e. new skill mixes and new task shifting or

task sharing possibilities). New ways of delivering care deal, however, with several barriers and risks:

- Legal and regulatory constraints;
- Resistance and reluctance of the professionals and occupational groups involved to change;
- Lack of clear definition and regulation on task shifting (or task sharing, delegation, task re-distribution);
- Lack of skills to actually execute task shifting opportunities in practice.

Most of the barriers arise from the hierarchical organisation between different health professionals, as a consequence of the regulatory frameworks established in health systems, institutionalised by law, governed by professional organisations, and underpinned by a historical background. This is, first of all, a cultural issue that goes back to the tradition of (health) professional groups to create boundaries, closed shops and silos or arenas (Abbott, 1988). Hence, a cultural change must be implemented with a view to circularity of skills and responsibilities that can be shifted or shared among different health professional roles, Also the reconfiguration of scope of practices and healthcare teams should be revised (Lehmann, 2009). A good example of this is the adaptation happening during the COVID-19 pandemic. The COVID-19 pandemic highlighted the shortages or maldistribution of the HWF and speeded up the change process, pushing the health systems to find new ways of collaboration and sharing responsibilities among the health care staff, patients and caregivers in emergency situation (Orkin et al, 2021) as well as primary care (Groenewegen et al., 2022).

This report will describe task shifting on a continuum from planning to implementation illustrated by pilot cases from five European countries: Estonia, Italy, Lithuania, the Netherlands and Norway.

4. Objectives and methods

The implementation of task shifting as a possible solution to critical issues of the HWF consists of complex and delicate change interventions. To succeed, these need to be carefully planned taking into account the implications both for the actors involved (whether they are health professionals, patients or caregivers) and for the health system, in which this change takes place (both locally and nationally).

For this reason, it is important to use an action framework that considers the different aspects to be managed during the implementation of the task shifting. The report "Task shifting and health system design" written by a panel of experts and published in 2019 by the European Commission [1] suggests the use of a framework such as the Calderdale Framework (https://www.calderdaleframework.com/).

The pilot cases of the TaSHI project will not completely follow the Calderdale framework, due to the different levels of maturity of the pilot sites with regard to acceptance and the level of implementation of task shifting interventions. Nevertheless, the steps suggested by the Calderdale framework have been used as a general guide for planning and executing the different phases of implementation. As will be described below, each pilot project has deployed the proposed phases according to its needs and its level of readiness to task shifting.

STEP 1. Awareness raising

In this phase, each pilot project described the purpose of the intervention and identifies the key actors to be involved at managerial level as well as the main stakeholders to be involved. It is important to create and share a vision of the pilot project with the stakeholders.

All TaSHI pilots initially defined the scope of their intervention. The sharing with stakeholders took place subsequently and was in some cases repeated several times (iterative process) to reach a common understanding and finalising the scope.

STEP 2. Service analysis

This phase aimed to describe the service object of the task shifting in terms of "who does what" in the current setting and to identify potential barriers and enablers to change of practice.

[1] Available here: https://data.europa.eu/doi/10.2875/42878

A scientific literature review, a review of EU-projects and a Delphi process with stakeholders was conducted by TaSHI to identify barriers and facilitators to task shifting. The main findings indicate that the main facilitators of task shifting are open culture, a well-structured organisation and willingness to give away tasks, while internal disagreements, lack of supporting leadership, the resistance of professional bodies and working habits are the main barriers. (See more detailed in "Collection of useful tools and practices in task shifting" available from https://tashiproject.eu/tashi-outcomes/).

In addition, some pilot sites conducted surveys among stakeholders and professionals working in the involved services to evaluate and analyse the knowledge about task shifting, their level of awareness, as well as the barriers and facilitators. Further, the laws and regulations governing the provision of the service at present and any necessary changes to allow task shifting to be implemented were also analysed.

STEP 3. Task analysis

This phase aimed at identifying and agreeing with stakeholders about the risks associated with the performance of a specific task by another professional, or directly by the patient or his caregiver, or by a technological device. For each risk identified, mitigation actions were agreed.

STEP 4. Competency identification

In this phase, the pilots identified the skills necessary to carry out the task shifted in the new setting, whether they were necessary skills for the health professional / patient / caregiver, who receives the task or the health professional who gives the task while implementing supervision and coordination. The need for knowledge, skills and competences for each pilot site were identified.

STEP 5. Supporting systems

In order to enable task shifting as a sustainable change - not only confined to a moment of experimentation - , it is important to ensure the presence of leadership and management mechanisms of new ways of working and new roles. The pilots analysed in their respective contexts on the possible and necessary leadership and management mechanisms.

STEP 6. Training

In this phase, the health professionals involved in the pilot project may be involved in specific training activities with the support of the training materials produced by TaSHI, designed

according to the needs of knowledge / skills / competencies identified in step 4 and piloted in each implementation site subsequently.

STEP 7. Sustainability

In this last phase, the pilot projects will evaluate the benefits of task shifting and define a governance plan for future development, uptake and sustainability.

5. Results

In the TaSHI project, pilot projects have been launched in five European countries:

1) Research of the tasks' delegation from family physicians and psychiatrists to nurses, psychologists and nursing assistants at two primary care providers in Lithuania (in Vilnius and Kaunas districts);
2) Analysis of task shifting potentiality in wound care using videoconferencing at Vestre Viken Hospital Trust (Norway) to connect the municipal staff with the more experienced and competent hospital staff at the outpatient wound care clinic, and with General Practitioners (GPs);
3) Joint care for the stable glaucoma patient nearby: the case of an optometrist centre at the Rotterdam Eye Hospital (the Netherlands) and task shifting in eye care in the region of Twente, in the Netherlands, where ophthalmologists and optometrists organised explore new ways to work together.
4) Analysis of task shifting potentiality between general practitioners and family nurse practitioners in the primary care sector in Lombardy Region (Italy) and related training.
5) Improving mental health care in Estonia by shifting tasks from psychiatric care and family physicians to nurses: bringing mental health nurses to primary care.

Each pilot project is described below as a case study. Before presenting the specific case studies, the following section provides an overview for all the pilots.

5.1 Overview of the case studies of the implementation sites

In the TaSHI project the following implementation sites were identified:

A. Lombardy Region (Italy);
B. Estonia;
C. Kaunas and Vilnius District (Lithuania);
D. Rotterdam Eye Hospital (The Netherlands)
E. Twente Region (The Netherlands);
F. Viken County (Norway).

In each site, the task shifting analysis focused on different health care settings and facilities:

- primary care in Lombardy;

- primary care and mental health care, in Lithuania and in Estonia
- specialist eye care and primary care in the Netherlands;
- wound care and primary care, with digital support linking municipal and specialist staff in Norway.

Health professions involved in the implementation are manifold and diverse:

A. GPs and "family and community nurses" in Lombardy, Italy;
B. Mental health nurses, family doctors, primary care nurses, psychologists and psychiatrists in Estonia;
C. GPs, psychiatrists, nurses working with GPs and nurses working with psychiatrists in Lithuania;
D. Ophthalmologists and optometrists in the Rotterdam Eye Hospital and ophthalmologists, optometrists and GPs in the Twente Region, the Netherlands;
E. Home care staff, GPs and outpatient wound care staff in Norway.

During the different steps of the analysis, different types of task shifting were identified. Next to task delegation and task shifting from one profession to another including responsibilities, the pilots address job crafting[2], job carving[3] and creating new professions and roles. In the analysis of reconsidering services, tasks and competences, the pilots also focus on various professional and non-professional groups involved in task shifting: a) from health professionals to patients, b) from health professionals to informal caregivers; c) from health professionals to volunteers and informal caregivers; d) from health professionals to community workers; e) from health professionals to administrative/managerial staff; f) from health workers to technology; and g) between different types of health workers.

In most pilots, task shifting concerns from one profession to another (including or excluding responsibilities) or includes task delegation between different types of health workers. In Estonia and Lombardy a new health profession's role is the key subject, mental health nurse in Estonia, and family and community nurse in Lombardy; and their relationship with the other health professionals' tasks and responsibilities. In Norway, it's analysed how the task shift between health professionals is facilitated by the use of technology.

[2] Job crafting is about the influence of work on personal needs and wishes. Which aspects of the work can be changed, so that they better match the wishes and needs of the employee.
[3] Job carving is based on adapting tasks, or parts of those tasks, that are not directly related to the core of the job. Job crafting starts from the employee, while job carving starts from the position.

For each pilot site, the level of maturity to task shifting showed differences:

- In the Dutch and Norwegian sites, task shifting experiences are already ongoing, so the TaSHI pilots analysed
    - the effects, the learning needs, and the potential scalability/sustainability of task shifting practices already taking place in the eye care (the Dutch pilot sites);
    - the implications for task shifting by utilising a new digital wound service bringing health professional staff, patients and caregivers to new forms of collaboration, sharing of knowledge, skills-learning, and building of expert competence (the Norwegian pilot site).
- While in Estonia, Lithuania and Lombardy, the scope of the TaSHI pilots was
    - to analyse the maturity levels of health professions working in the primary care sector;
    - survey their readiness and openness to task shifting;
    - and consequently engage them in learning activities with the final aim of providing evidence and creating task shifting opportunities among health professionals

Because of the different stages in task shifting, some pilots have already evaluated the specific tasks or activities that were shifted, while for other pilots the identification of the tasks to be shifted were part of their objectives.

A. In Lombardy, the tasks potentially to be shifted are related to the new functions in primary care;
B. In Estonia, the tasks to be shifted are going to be analysed during the project and will relate to mental health nurse activities for working in primary care;
C. In Lithuania, some activities potentially to be shifted are: prescribing medical devices (wheelchairs etc.), issuing prescriptions etc. Other tasks that could be shifted will be identified through discussions with stakeholders during the project.
D. In the Rotterdam Eye Hospital, the shifted tasks are related to glaucoma monitoring and care and in the Twente Region site, the shifted tasks are related to standard and advanced eye/vision disease and impairment diagnoses and monitoring;
E. In Norway, the tasks shifted are related to advanced wound care.

Each pilot site explored evidence and the added value of implementing task shifting practices, both for the patients, the healthcare professionals involved, and for the healthcare system.

- For the patients, the main benefit could be the improvement of the quality of care;
- For the healthcare professionals: increasing health workers' motivation, improving career opportunities of new occupations, upgrading occupations, solving unequal workload or work pressure within a workforce group or an organisation;
- For the healthcare system and health care providers: meeting increased or unmet population needs, mitigating health workers shortages, saving time and money.

5.2 Case study description: Tasks Delegation from Family Physicians and Psychiatrists to Nurses, Psychologists and Nursing Assistants in Lithuania

Abstract

The Ministry of Health of the Republic of Lithuania (hereinafter – MoH) is working with the two largest primary care providers in the pilot project ("Centro poliklinika" and "Kauno miesto poliklinika"). Data collection methods involve an online survey and focus group discussions with healthcare workers from the primary sector.

The main aim of the Pilot Project is to increase the accessibility and quality of primary health care services (provided by family medicine doctors and psychiatrists) through task shifting to other health care professionals in Lithuania. Also, the aim is to save doctors' and nurses' time; shorten waiting times; increase health care professionals' motivation and social recognition; upgrade occupations; solve unequal workload or work pressure within the health care professionals or organisations.

The expected outputs of the Pilot Project are: recommendations and guidelines on task shifting; report of the best practices; the summarised experience of how nurses felt about performing tasks which were delegated from doctors; the list of tasks which could be effectively delegated; the list of competencies of nurses and nurse's assistants which should be strengthened; and suggestions for legislation improvement (if needed).

The GPs are performing the following tasks relevant for task shifting: "prescribing health-care supplies/medical equipment for home care (wheelchairs etc.)", "patient consultation", "management of healthcare prevention programmes", "writing referrals for tests or scans/referring to specialists", "prescribing medications", "prescription extension", "follow-up", "wound care", "home visits", "education and promotion". These tasks are possible subjects to task shifting from doctors to nurses. Considering the results of the focus groups' discussions and the survey, which reflect doctors' and nurses' readiness to the changes related with the task shifting, we see that it is feasible to start taking steps not only at these two health care institutions level but also nationally.

Background and context

The Lithuanian healthcare system faces several challenges in terms of HWF:

- Overall high number of service providers and doctor specialists, GP's services consumption without clear decrease in the number of amenable deaths rate;
- Uneven distribution of doctors, nurses in primary care across regions;
- Regional inequalities in service provision and service quality;
- Long waiting times, limited access to doctor specialists and GPs.

Considering this, a few years ago Lithuania incentivised nurses to uptake new roles. Also, the MoH is planning to implement the transformation of the network of health care institutions which is a perfect opportunity to implement evidence-based health service innovations including task shifting and building in the Pilot Project results. The task shifting could be one of the solutions to combating the underlying challenges, which are mentioned above. The task shifting could help with prevention programs, it could reduce shortage / unequal distribution of doctors, improve quality of services etc.

Scope of the pilot project

The overall ambition of the Pilot Project is to analyse task shifting feasibility and potentiality between family doctors / psychiatrists and nurses / mental health nurses.

The Pilot Project objectives are:

- Identification of the tasks that could be delegated from family doctors to nurses and from nurses to nursing assistants;
- Identification of the tasks that could be delegated from psychiatrists to psychologists and mental health nurses in primary care setting;
- Identification of the tasks in which IT solutions could decrease health professionals' workload;
- Identification of the most effective ways of delegating tasks from family medicine doctors and psychiatrists to nurses, nurse assistants, psychologists;
- Identification of the competencies which should be additionally provided to nurses and nurse's assistants;
- Recommendations will be provided to institutions, which are implementing the policy (if needed, legislative changes will be initiated).

The Health sector of the Pilot Project is primary care. As already mentioned, the MoH is working with two largest primary care providers in Lithuania ("Centro poliklinika" and "Kauno miesto poliklinika") that cover over 200 000 persons in their patient records. Health care professionals working in the selected institutions also have the most intense schedule in Lithuania.

Task analysis

A few years ago, the MoH provided more responsibility and tasks to general practice nurses and now the MoH wants to see if the nurses are ready to do even more and take more responsibilities (readiness mapping). In February and March of 2022, the MoH organised focus group discussions with healthcare professionals (family doctors, psychiatrists, general practice nurses, and mental health nurses). The goal of the focus group discussions was to gain an in-depth understanding of healthcare workers' views on task shifting, its feasibility and potentiality. Focus group participants included both general physicians and nurses in two separate groups (in total, focus group discussions were attended by 18 respondents).

In the focus groups' discussions, we identified:

- Activities potentially to be shifted (according to legal acts, these tasks are assigned to GPs):
    - Prescribing health-care supplies/medical equipment for home care (wheelchairs etc.);
    - Patient consultation;
    - Management of healthcare prevention programmes;
    - Writing referrals for tests or scans/referring to specialists;
    - Prescribing medications;
    - Prescription extension;
    - Follow-up;
    - Home visits.
- Barriers for task shifting:
    - Regulatory, legal constraints;
    - Lack of competencies;

- Patients' expectations (patients generally feel nurses cannot be able to deal with simple conditions and prefer to consult with a GP for more “complex” conditions);
- Lack of training.

- Measures suggested:
  - Development of a nursing education program;
  - Legislative changes (medicine norms of family medicine doctors, psychiatrists, nurses);
  - Training programs (wound care, reporting an ECG, etc.).

In June 2022, the MoH launched a survey for nurses and mental health nurses in two primary health care institutions (Vilniaus Centro poliklinika and Kauno miesto poliklinika) about task shifting. Overall, 83 out of 100 of respondents have completed the survey. The aim of the survey was to explore knowledge, perception and attitudes of general practice nurses and psychiatric - mental health nurses toward task shifting experiences and practices in primary care. In the survey design (see figure 1), several issues that can have an impact on task shifting in primary care were considered – previous task shifting experiences, ability to perform delegated tasks, ways to develop the competencies, facilitators and barriers for task shifting etc.

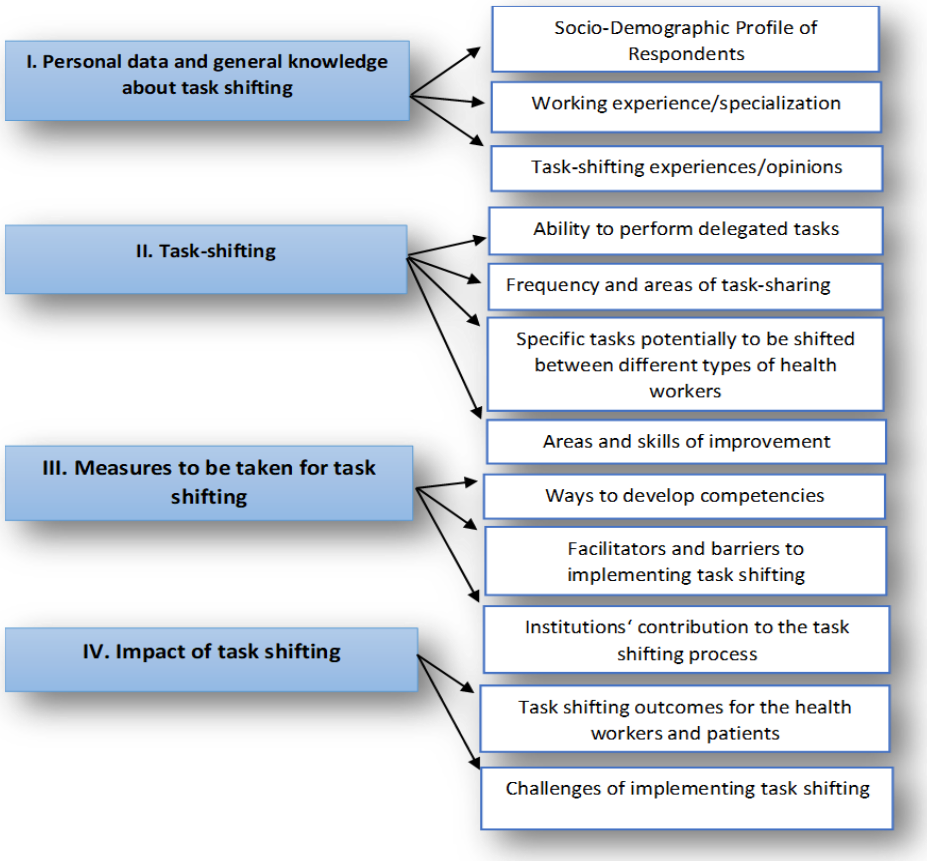

Figure 1 – Structure of the survey in Lithuania

The representatives of the MoH also surveyed nurses' readiness to take more responsibility for more and new tasks. Therefore, the following questions were asked:

- "In your opinion, could you perform certain functions assigned to a GP/psychiatrist" – 56 of 83 nurses answered yes.
- "In which processes of your work do you see a possible task shifting implementation?" – 61 of 83 answered "Clinical practice (prevention)", 55 answered "Organisational sector (registering patients)", 43 of 83 answered "Administration sector (filling medical records, writing referrals, prescribing medication)".
- "Please indicate which tasks could be shifted from GP to GP nurses?" 68 of 83 answered "Prescribing health-care supplies/medical equipment for home care", 57 of 83 answered "Prescribing medication/prescription extension", 56 of 83 answered "Management of healthcare prevention programmes", 50 of 83 answered "Wound care", 44 of 83 answered "Education and promotion", 37 of 83 answered "Health promotion".

Several respondents mentioned that they want to take on new tasks and see huge opportunities of task shifting. However, the respondents also stressed that training (including "Development of nursing education programs", "Strengthening teamwork activities", "Work environment changes") is the key factor to success.

To summarise, task shifting is acknowledged and nurses demonstrate readiness to accept more responsibility in their work.

TASK SHIFTING IS ALREADY HAPPENING

In Autumn 2022, the representatives of MoH interviewed the nurse working in the Primary Care office (Family Health Team) to share his experience about true task shifting stories. Task shifting events occurred between GP and nurse and were a consequence of the increased workload of the GP and excessive amount of medical documentation. Task shifting events occurred several times per shift, mainly in the administrative areas. The nurse took up on activities such as filling medical records, prescribing medical equipment, document management, writing referrals, patient consultation etc. It is important to note that relationship dynamics occurring between the professionals involved in the task shifting process were based on mutual respect and support. Accordingly, the GP fully trusted the nurse and continued transferring a part of his functions to him: writing prescriptions, filling out documentation, writing out medical equipment for technical support, filling in the patient's medical history, managing patients' appointments, writing referrals for tests, follow-up tests etc. The impression of the nurse was that patients did not feel the difference, as the quality of services provided by the nurse remained the same.

As task shifting occurred informally, the task shifting events were not reported officially. According to the respondent, the main reason why task shifting events were not reported is because complementary tasks (delegated to the nurse) are not regulated/ established in the Medicine Norm.

Learning needs

Survey demonstrated that the majority of nurses were open to learning opportunities as 45 of 83 respondents answered that proper training is important for effective task shifting from family doctors / psychiatrists and nurses / mental health nurses.

Opportunities and limitations

The table below shows overview and estimation of opportunities and limitations associated with task shifting potentials in the two primary care providers.

ACTIVITIES POTENTIALLY TO BE SHIFTED	BARRIERS FOR TASK SHIFTING	MEASURES TO BE TAKEN
• Prescribing health-care supplies/medical equipment for home care (68/83); • Prescribing medication/prescription extension (57/83); • Management of healthcare prevention programmes (56/83); • Wound care (50/83); • Education and promotion (44/83); • Health promotion (37/83).	• Patients prefer/want to consult with GP (67/83); • Patients generally feel nurses are not able to deal with simple health conditions (53/83); • Lack of communication (34/83); • Lack of training (30/83).	• Financial/material promotion (45/83); • Increased demand for healthcare (39/83); • Lack of human resources (39/83); • Health emergencies (e.g., COVID-19) (38/83); • Developments in legislation on nurses' competencies (34/83).

Table 1 - Opportunities and limitations in Lithuania

5.3 Case study description: Task shifting in wound care using videoconferencing in Norway

Abstract

Chronic wounds represent a major burden for the affected patient, their family, as well as the healthcare system. Caregivers employed in homecare services have varying wound care competencies and advanced wounds are typically treated at specialised outpatient clinics. For some patients, this entails travelling long distances to hospitals and spending many hours of their time in public transportation, private cars and in waiting rooms. Further, there is a general lack of collaboration between municipal and hospital staff when they are sharing responsibilities for the same patient. Using videoconferencing technology as means to connect them, sharing of competence and consequently tasks, represent a novel solution to increase the quality of wound management and to achieve more efficient health care services. The pilot project aims to describe a digital wound care service (telemedicine) in terms of task shifting potential, assess learning needs among stakeholders and test a learning module based on knowledge, curriculum and learning materials created in the TaSHI project, as well as specific learning materials on how to guide home care nurses by video link (telemedicine).

Background and context

In 2019, Vestre Viken Hospital Trust received regional funding to initiate a service innovation project *"The digital wound service project"*. The idea was to improve the quality of wound care in the municipal home care services by using videoconferencing technology to connect the municipal staff with the more experienced and competent hospital staff at the outpatient wound care clinic, and with General Practitioners (GPs). The service innovation involves the municipal staff wearing a voice-operated head-mounted tablet during wound care, enabling communication with hospital staff and real-time "outpatient consultations at the patient's home". The patient communicates with the hospital staff and/or GP by using a tablet (for example an iPad) connected to the same virtual room (Cisco Webex Desk), and the hospital staff and/or GP use a computer and provide specialist advice and guidance in the process of clinical assessment and wound management.

A group of three researchers from the Science Centre Health and Technology at the University of South-Eastern Norway (USN), as well as a senior consultant (and PhD student) at Sunnaas

Rehabilitation Hospital, was engaged to conduct research during the initial phases of implementation. Four focus group interviews were performed (March and October 2021); two interviews with the physicians, nurses, and auxiliary nurses at the outpatient clinic. A GP representative participated in the first of these interviews; and two interviews with leaders, nurses and auxiliary nurses working in home care (March and May 2021). Researchers were also observers in workshops and project meetings. The outlines of the main findings of the study, as well as recommendations from the team, are published in a report in Norwegian (Solli et al., 2022).

In the TaSHI project, USN has selected this service innovation as a case to further investigate the potential for task shifting through the attainment of effective collaboration, sharing of knowledge, skills-learning, and building of expert competence.

There are several reasons for choosing this case to explore task shifting. The prevalence of chronic wounds is increasing, posing increasing demands on health services. Venous ulcers, diabetic foot ulcers, arterial ulcers, and pressure ulcers are the most common groups, but cancer, autoimmune ulcers, infected acute wounds, and surgical wounds may also require long-term and advanced treatment. The peak prevalence of chronic venous leg ulcers occurs in the age group 60 to 80 years. These ulcers are a particular threat to older individuals as increased age is a major risk factor for impaired wound healing. They may take months or years to heal and are prone to recurrence because the underlying and wound-provoking factors have not been, or cannot be, adequately addressed (Agale, 2013).

Digital transformation has priority in today's political agenda worldwide. The WHO vision in the global strategy for digital health 2020-2024 is to improve health for everyone, everywhere by accelerating the development and adoption of appropriate, accessible, affordable, scalable, and sustainable person-centric digital health solutions (WHO, 2020). The Norwegian National Health and Hospital Plan (Meld. St. 7, 2019–2020)[4] emphasises task shifting as a strategy to deal with the increasing competence-need in the future and that eHealth technologies/telemedicine provide great opportunities to share knowledge and information between health professionals in new ways. The WHO describes telemedicine as "The delivery of health care services, where distance is a critical factor, by all health care professionals using

[4] https://www.regjeringen.no/en/dokumenter/meld.-st.-7-20192020/id2678667/

information and communication technologies for the exchange of valid information for the diagnosis, treatment, and prevention of disease and injuries, research and evaluation, and for the continuing education of health care providers, all in the interests of advancing the health of individuals and their communities" (WHO Global Observatory for eHealth, 2010, pp. 8-9).

In areas where there is a shortage of specially trained nurses or nurse assistants in wound care, telemedicine, such as videoconferencing technology, can help patients obtain safe and high-quality services by providing staff with targeted and knowledge-based advice and guidance. Another important and related aspect is the potential for increased competence-building through the collaboration between highly qualified healthcare workers and municipal healthcare workers with less training and qualifications in advanced wound management.

Relatively few health professionals have however been formally trained to deliver professional services using these devices. In the same vein, few health professionals have received specific education or training in communication and supervision skills using digital technologies.

Scope of the pilot project

The pilot project aims to describe the digital wound care service (telemedicine) in terms of task shifting potential between wound care specialists and municipality health workers, assess learning needs among stakeholders and test a learning module based on generic knowledge, curriculum and learning materials developed in TaSHI project, as well as specific learning materials on how to guide home care nurses by video link (telemedicine). The pilot project will not involve a comprehensive testing and evaluation of the TaSHI eLearning model.

Task analysis

Hard-to-heal wounds require specialised competence in wound care. Many patients are successfully treated by their general practitioner or by home care nurses, but some need frequent follow-up in specialised outpatient clinics. A transfer and sharing of competence between wound care specialists at outpatient clinics and municipal health personnel using novel videoconferencing technology may reduce the burden for patients suffering from hard-to-heal wounds and increase the overall quality of wound care in home care services.

In the short run, we propose that in this case study, tasks are first being shared, rather than shifted, meaning that tasks are not taken away from a set of healthcare workers and given to another, but shared by making tailored learning resources readily available, as well as the collaboration and peer learning happening during the digital wound-care consultations. From a more long-term perspective, particular wound-care tasks relevant to advanced wound care management can be shifted and delegated from outpatient specialist healthcare workers to municipal healthcare workers having now obtained the necessary knowledge and skills. Consequently, freeing up resources and increasing the capacity to deliver more emergent and specialised wound treatment can be realised.

The task identification is based on clinical assessment of chronic wounds and management of chronic wounds (Armstrong, D., & Meyr, A. J, 2021; 2022).

TASK SHIFTING IS ALREADY HAPPENING

In September 2022, a key partner of "The digital wound management project" was interviewed to collect true task shifting stories, including examples and perspectives on the potential for or actual task shifting happening in collaboration and knowledge-sharing between the specialist and municipal healthcare staff using the videoconferencing technology.

The key partner described the overall aim of the project as

I. to establish a collaboration model for all involved actors in wound care services; the patient and next of kins, municipal health services (home care nursing, long-term care facilities), general practitioners, and wound care outpatient clinics – and

II. to achieve successful implementation of the collaboration model to realise a sustained change in the healthcare services. A pertinent challenge, however, is that these actors are not used to collaborate at this level, beyond using electronic text messages and phone calls.

A typical digital wound consultation was described as follows:

1. An appointment is made between the patient, home care and the outpatient clinic. Often there is only one wound care nurse participating from the wound clinic, but sometimes an orthopaedist also takes part depending on the type of wound, assessment needs, the status of the wound at the previous consultation and so on. A vascular surgeon

may be called upon when required. Also, from the perspective of learning and implementation, a resident physician may participate. In other words, health personnel who are undergoing training are also engaged.

2. At the appointment, the participants join a virtual meeting room. The virtual meeting room is connected to the Norwegian Health Network ('Norsk helsenett'). The home care nurse travels to the patient with a small suitcase containing the head-mounted camera, and a tablet or smartphone can also be used as an alternative. At the patient's home, the home care nurse rigs the setting by preparing the wound (removing bandages and making it ready for assessment). At this point, the home care nurse puts on the head camera and starts the consultation via the voice-controlled app. You simply say, "call the wound clinic", and then you are straight into the same virtual meeting room where the hospital staff are waiting. The patients' next of kin may also be present, as well as other municipal staff undergoing training. One challenge has been that when you use the head-mounted camera, the patient is not able to hear or see the outpatient staff, as only the nurse who operates the camera does. A solution is that the patient is equipped with a tablet connected to the same virtual room. Now there are at least 3 people in the virtual meeting room – the outpatient nurse, the home care nurse, and the patient.

The potential for achieving task shifting through peer learning and competence development has often been raised in discussions among the participants. Home care staff express learning a lot about wound management principles and developing new skills that enable them to perform more advanced assessments and procedures. However, there is a great variation in specific procedures done across different municipalities. An example is that some perform vacuum treatment while others do not. Another example is related to debridement. A clear goal seems to qualify municipal nurses to perform more advanced wound care procedures, hence taking over new tasks and procedures that patients previously had to travel to the hospital to receive.

Active involvement of patients' GP has been a great challenge. It seems that wound care is not a prioritised area among GPs and that participation in service innovation projects has low priority due to a lack of an appropriate financial system for this type of service, time constraints, lack of resources and other factors. The GP representative involved in the project phase has shown great

interest and has tried to engage and motivate colleagues in the municipalities to participate. There is general agreement that the GP has an important role for the patient, but when it comes to chronic wound management, it seems unclear what the GP can and should be responsible for beyond referring the patient to specialist health services if necessary.

The home care nurses have expressed some concerns when starting up the digital wound service. They are afraid of becoming overburdened and that the services become financially burdened. They already have problems recruiting qualified staff as they suffer from a personnel shortage in the municipalities with too little wound expertise. Not all municipalities have wound-trained nurses, so there is a general paucity of wound expertise. The first issue that typically comes up is: "Are we going to get a lot more burden now, with more wound care than we otherwise have? Another expressed concern is: "is this going to be financially worse for us?" This is because of the financial model of home healthcare services in which they cannot charge any fees for the service as compared to the GPs and outpatient clinics who charge fees for their work. A previous attempt at establishing a wound care service had in fact been stopped some years ago by a municipality because of financial and capacity concerns raised in connection to task shifting from specialist to municipal healthcare services. However, in the current project, the municipalities involved have realised and endorsed the true potential for competence building and how patients' burden is decreased because they benefit from receiving high-quality wound care at home and not needing to travel to the hospital.

Learning needs

Through a co-creation process including mapping existing digital learning materials and assessing the needs of the stakeholders in a regional workshop and network meetings in advanced wound care, the following learning opportunities and learning outcomes are identified.

The pilot project has identified and chosen the following learning opportunities to be piloted:

- Advanced wound assessment and management: acquiring knowledge, skills, and competencies as described above.
- Facilitation of learning through videoconferencing: develop professional communication and supervision skills used to facilitate learning and competence development.

The pilot project will contribute to the development and testing of the learning material developed for TaSHI curriculum Module 2 - Tailoring task shifting to context and conditions, Knowledge and Process, including the following learning outcomes:

- has evidence-based knowledge about the specific condition relevant for task shifting, diagnosis and treatment
- understand the relevant qualifications, legislations, guidelines, and protocols for management of the specific condition relevant for task shifting
- uses specific digital technology
- applies evidence-based assessment, makes clinical decisions and justifiable documentation for effective and appropriate pathway management for specific conditions for task shifting.

More specifically, the learning outcomes tailored for and to be tested in advanced wound care:

- Knowledge about evidence-based practice on prevention, assessment, and management of wounds;
- Knowledge about person-centred communication and professional communication and guidance;
- Knowledge about relevant qualifications, legislations, guidelines, and protocols for wound care;
- Apply evidence-based knowledge in prevention, assessment, and management of wounds;
- Make clinical decisions and justifiable documentation in wound care;
- Utilise digital technology in wound care assessment and documentation;
- Use person-centred and professional communication and guidance in wound care.

Opportunities and limitations

A more complete overview and estimation of opportunities and limitations associated with task shifting potentials in the digital wound service will be further assessed. Below are some factors identified so far.

OPPORTUNITIES	CHANGE MECHANISMS		RISKS AND MIRIGTIONS
	ENABLERS	BARRIERS	
Increased competence, skill transfer and quality of care in wound management	1. Novelty of adopting new technology 2. Perception of improved wound treatment 3. Understanding of the patient's daily living 4. Role models; motivated and competent staff 5. Readily available learning material 6. Effective peer-learning processes 7. No need for the patient to travel	1. Lack of resources for training 2. Lack of allocated time for learning 3. Communication with and involvement of the patient	1. Ambiguous leadership 2. Funding for developing learning resources 3. Sustained motivation in the workforce 4. Resource-intensive for the staff to get to know the technology and become familiar with using it 5. More home care nursing resources required 6. Financing wound-care at municipality settings
Professional cooperation between municipal and hospital healthcare staff	1. Understanding each other's working methods and areas of expertise 2. Appropriate communication platforms and routines 3. Interest to learn about each other's scope of practice; boundaries and possibilities	1. Systems not working together 2. Lack of mutual acknowledgement and trust 3. Limited opportunity for collegial discussion and feedback 4. Lack of direct communication, infrastructure, and flexibility for video consultations 5. Lack of professional support from GPs.	1. Involving GPs 2. Misunderstanding of roles and responsibilities 3. Varying light conditions and internet access in the patient's home affect image quality and the quality of the video consultation. 4. Time-consuming procedures for referral and potential delay in wound treatment
Freeing up resources at hospitals to deliver more emergent/ specialised wound treatment	1. Successful use of the service in the management of suitable patients	1. Lack of a responsible service coordinator	1. Obtaining insufficient volume 2. Sustainability criteria not achieved

Table 2 - Opportunities and limitations in Norway

5.4 Case study description: Task shifting in eye care at Rotterdam Eye Hospital

Abstract

The Rotterdam Eye Hospital (REH) has taken an initiative to increase the outflow of patients from a specialised ophthalmic professional to an optometrist through the foundation of an optometrist centre in 2020. The centre focuses on Vitreoretinal Surgery (VR) and glaucoma patients, where patients are monitored by advanced-trained optometrists that act independently, i.e. under their own responsibility and without the supervision of the ophthalmologist. This task shifting initiative creates room for ophthalmologists in the REH to see new and more patients, and to ensure the accessibility for patients that require (top) specialist ophthalmology care. The first evaluation of the optometrist centre is positive. Optometrists meet the requirements formulated at the start of the optometrist centre, the VR and glaucoma patients monitored are highly satisfied, and so are the REH ophthalmologists. Optometrists see challenges in combining their work in the optometrist centre and the hospital.

Background and context

Ophthalmology is one of the top three medical specialties in the Netherlands with the fastest rising demand for care until 2040. As a top specialist centre with an essential 'last resort' function, it is important that the REH keep sufficient resources to treat the growing group of patients that need specialised eye care. At this moment, the REH outpatient clinics increasingly deal with patients who have been treated by a specialised ophthalmic professional, but actually do not require the expertise from an ophthalmologist in the follow-up phase of the care path. This goes at the expense of the capacity needed for patients who definitely need the expertise of an eye doctor.

In 2022, initiatives were taken to set-up an optometrist centre as an in-between primary and specialised (eye) care, where patient groups are monitored by high quality eye care. The aim was to realise a controlled outflow from the REH outpatient clinics, and offering optometrists a new opportunity to expand their expertise, capacity of scope of practice at the same time. The optometrist centre fits with the general aim in Dutch health policy known as 'organising the right care in the right place'. Here, it follows the general trend in the Netherlands in which

optometrists run independent consultation hours on a demarcated part of the ophthalmic concern.

Optometry and optometrists in the Netherlands

The profession of optometrist has been officially included in the 'BIG Act' (Act Professions in Individual Healthcare), under article 34 since 2000. Based on this, the optometrist is legally recognized as a healthcare professional. An individual can call him/herself an optometrist if he/she meets one of the following requirements:

He/she has graduated from the 4-year higher professional education program in Optometry at Hogeschool (University of Applied Science) Utrecht;
He/she is in possession of the certificate of the transition course Optometry of the Hogeschool Utrecht;
He/she has a foreign diploma, with a Certificate of Professional Competence for optometry.
Most optometrists are affiliated with the professional association: the Optometrist Association of the Netherlands (OVN). The OVN keeps optometrists abreast of developments in healthcare and optometry. For example, conferences and further training activities are organised for members. The OVN also secures contacts with the government, the optometry training, patient and consumer organisations, the Dutch professional association of ophthalmologists (NOG), general practitioners (NHG), orthoptists (NVvO), contact lens specialists (ANVC) and the trade association of optical companies (NUVO). The OVN is a member of the World Council of Optometry and the European Council of Optometry and Optics. Optometrists who are members of the OVN work according to the Code of Conduct for Optometrists and often carry a nameplate with the OVN logo. All optometrists listed on the OVN website meet the above conditions. This also applies to optometrists who are registered in the quality or diploma register of the Paramedics Quality Register.

Organisation and requirements

The optometrist centre, based at the locations of the REH, focuses on enabling more outflow from the REH outpatient clinics by eye doctors referring patients to the clinical optometrist.

The centre supplements a number of national initiatives in the Rotterdam region, where optometrists active in the primary care sector are mobilised to reduce the influx in specialised eye care by higher levels of triage. Before 2020, an 'outflow project' was already piloted as a collaboration between the REH, optometrists in the Rotterdam region (organised in an Optometrists Collective), opticians and health insurers. This pilot project focused on glaucoma patients, with an average ocular hypertension and patients of a positive family history of glaucoma by ophthalmologists. These patients were referred to the Optometrists Collective.
The patients that are at scope in the optometrist centre in the REH are referred from the REH to optometrists. Not to opticians, because of the relative complexity (present risk) and the specific equipment needed. The target groups of the centre are patients treated by the departments of glaucoma and Vitreoretinal Surgery (VR) of the REH. The capacity that hereby is saved at these departments will be used for specialist consultation hours. To organise and govern the referral (i.e. task shifting) process, the two patient groups were demarcated as follows:

<u>For glaucoma patients, the referral criteria are:</u>

- The optometrist is familiar with the diagnosis glaucoma or glaucoma suspect
- The optometrist is familiar with diagnosis of ocular hypertension or a family history for glaucoma
- The patient cannot be referred to an optometrist in the residence area (zip-code level)
- The patients' ophthalmic situation is deemed stable, a revision period from > 6 months is possible
- The patient has no advanced glaucoma (i.e. VFI > 80%, no fringe papillary excavation)

<u>For VR patients, the referral criteria are:</u>

- Patients with uncomplicated vitreous humor or retinal surgery would need to be followed-up after 6 weeks or more, and who are not seen by an eye doctor.
- Patients with diagnoses, after surgical treatment, idiopathic macular pucker, vitreomacular traction, macular hole, rhegmatogenous retinal detachment, vitreous opacities, after dropped IOL or dropped nucleus, vitreous haemorrhage.

- Patients with idiopathic macular pucker, lamellar hole, vitreomacular traction without surgery indication but risks of progression and without a referring ophthalmologist.
- Patients have no ophthalmic comorbidities for which the patient is still under treatment by another department of the REH.

In initiating the optometrist centre at the REH, the following conditional requirements were formulated:

1. Quality should be guaranteed by well-trained optometrists

Starting point is that patients are monitored by optometrists with a high level of knowledge and broad clinical experience, so that patients are secured by appropriate care quality and ophthalmologists can trust the optometrists when they refer. This knowledge level is achieved by training optometrists at the REH. Their level of knowledge is maintained by 'rotating' optometrists in the REH and the optometrist centre within the relevant subspecialties. For optometrists this also means an enrichment of their work through task variation.

2. Optometrist are ultimately responsible

Patients are referred to optometrists in the optometrist centre that performs their tasks independently. The optometrists bear the full responsibility for the eye care provided, as ophthalmologists cannot be responsible for professionals they do not supervise. The optometrists in the centre are aware of this position, i.e. to deliver care independently, i.e. without the formal supervision by eye doctors. The care delivered within the optometrist centre is scoped within the current (national, Dutch) job profile of the optometrists.

3. Continuity of care

To ensure quality and continuity of care and patient data, optometrists perform their tasks with the same equipment and same patient record system as in the REH. This allows optometrists to monitor the patients' care path and, vice versa, eye doctors in the REH can monitor patient data added by the optometrist in case the patient would be referred back to the hospital for specialist consultation. The joint use of the same patient records is desirable for training purposes (i.e. interdisciplinary intervision), as well to guarantee reliable patient outcome data for research purposes.

4. Prevention of unnecessary referrals and early consultation of eye doctors

To sustain the quality of care and by making sure, that patients are not referred back to the eye doctors unnecessarily, optometrists are able to receive fast and early advice from a specialist ophthalmologist through the electronic patient record.

5. Only patients in need for specialised care are referred to ophthalmologists

The optometrist centre will contribute to the goal that ophthalmologists only see patients who need specialist care or consultation. Patients who are not in need of specialised care, but cannot be referred back to their general practitioner, remain under the care of the optometrist centre. They can eventually be referred to the Rotterdam Optometrist Collective, in the case from the selective group within glaucoma.

6. Use of patient volume in front of outcome registration and scientific research

The REH is a unique research institute with a high volume of complex patients that drive scientific research in a 'single centre' structure. The optometrist centre will ensure follow-up patient registration so that no research data is lost. The centre will use the same privacy statement of the REH that governs the collection and analyses of anonymized data from patients for scientific research.

In addition, the following legal requirements were formulated:

1. The optometrist works according to the protocols of the REH. In the protocols it is stated by the optometrist centre for what tasks the optometrist is and is not authorised and competent.
2. The optometrist endorses the 'Code of Conduct' for optometrists' from Optometrists Association of the Netherlands (OVN).
3. The optometrist is familiar with, and follows, the relevant applicable practice guidelines and - documents:
    - OVN guideline in front of optometric Base Research
    - OVN guideline in front of Glaucoma research
    - OVN guideline action instruction Red Eye
    - NHG (Dutch Association of General Practitioners) and STILL Standard Red eye and eye trauma
    - NHG and STILL Standard visual complaints
    - NOG guideline Diabetic retinopathy.

4. The optometrist has experience administering diagnostic pharmaceuticals (tropicamide, oxybuprocaine, cyclopentolate).
5. The optometrist has knowledge of/ experience of multidisciplinary collaboration (including file management and Handover) and endorses the care and collaboration of others to coordinate.
6. The optometrist is communicatively skillful and can act as a focal point of contact for patients.
7. The optometrist independently makes decisions and executes these.

These requirements were also documented by:

- A protocol for referral at the optometrist centre, containing a clear division of tasks and responsibilities at and after handover from eye doctor to the optometrist. In this protocol, objective referral criteria are defined (see above).
- A protocol for monitoring in the optometrist centre, in which the activities are described as well as the skills and responsibilities of the optometrist to ensure that tasks are executed within their own area of expertise. This also includes the working method on consultations and prescriptions, including what to be reported by the optometrist in the patient record file.

Aim and advantages

In general, increasing patient outflow from the REH to the optometrist centre is defined as the aimed 'win-win' situation for all stakeholders involved. This strategic goal is considered as a necessary and 'inevitable' choice, and was further broken down by the following predefined advantages to be achieved:

<u>Advantages from the patient perspective</u>

- One physical, small-scale place for monitoring without (much) change in health care providers and with less waiting time for imaging and research, i.e. ensuring constant medical quality of care.
- Equal or even better accessibility for patients that are referred to the optometrists centre.
- Better accessibility for new patients in need for specialised care (reduced waiting time).

- Given these advantages, a possible disadvantage is that some patients, who only trust the expertise of an eye doctor, may prefer not to be checked by an optometrist. With careful information and communication, patients are made aware that only highly educated and clinically experienced optometrists qualify to work in the optometrist centre. It is also communicated that in the centre optometrists deliver person-centred and high-quality care, and optometrists will become their coordinating health professional healthcare.

Advantages from the perspective of health insurers

- Better access for insured patients in need for specialist eye care.
- Preservation of the high-quality eye care from patients that are monitored in the optometrists centre.
- More efficient care (fewer cost per patient)

Advantages from the perspective of the REH

- More resources to deliver specialist care in line with strategic objectives of the REH.
- Contribution to shifting care from the hospital to other health services.
- Retention of clinically experienced optometrists working in the REH, by providing more varied and challenging work.

Advantages from the perspective of the ophthalmologists

- More time for patients in need for specialist eye care, that require the key expertise of eye doctors.

Advantages from the perspective of the optometrists

- More task variation, more job satisfaction and more challenging work, by means of doing independent consultations; working at the optometrist centre and at the same time in the specialist environment of the REH.

Task analysis and competency identification

The initiative of the optometrist centre was explicitly aligned with two demarcation guidelines that are defined by Dutch law as the area of expertise of optometrists:

- Screening of patients on eye conditions using appropriate equipment or required research, as defined by the Minister of Health with regard to pharmaceuticals to diagnose eye conditions, and referring to a family doctor or eye doctor.

- By referral of a family doctor or eye doctor, using appropriate equipment, required research and pharmaceuticals, to carry out follow-up investigations of eye disorders in patients with chronic diseases.

With regard to the optometrist centre, it was agreed that optometrists are not allowed to perform procedures or perform independent laser treatments. Neither are they allowed to change or initiate pharmaceutical therapy independently. For this, the optometrist will ask the ophthalmologist for advice and then ask the family doctor (GP) to prescribe the prescribed medication or modified medication. If progression of the existing condition or the discovery of a new condition necessitates the care of an ophthalmologist, the optometrist refers back to the GP to the ophthalmologist.

Above, a number of specific competences were formulated as requirements for optometrists working in the optometrist centre:

- The optometrist has experience administering diagnostic pharmaceuticals (tropicamide, oxybuprocaine, cyclopentolate).
- The optometrist has knowledge and experience of multidisciplinary collaboration (including file management and handover) and endorses the care and collaboration of others to coordinate.
- The optometrist is communicatively skillful and can be the point of contact for patients and allied or colleague professionals.
- The optometrist independently makes decisions and executes these.
- The optometrist is familiar with the diagnosis of glaucoma or glaucoma suspicion.
- The optometrist is familiar with diagnosis of ocular hypertension or a family history for glaucoma.

Learning needs

Optometrists working at the optometrist centre all fulfilled the task, competence and organisational/legal requirements that were defined at the beginning of the centre. After one year (2021), they are satisfied with their position, have a high job satisfaction and are positive about their own responsibility. The main learning opportunity is to sustain ‘challenges’ in their position, i.e. the added value of combining working in the optometrist centre and the REH.

Opportunities and limitations

A first evaluation of the optometrist centre at the REH, after one year (2021), can be summarised by the following points. All points show both the opportunities and the limitations of this task shifting initiative.

- It takes time to get the care process well organised, cultivating confidence among optometrists in independently run consultation. During the year, this improved self-confidence of the optometrists grew. At the end of the year, the optometrist centre felt to optometrists as their ‘own shop’.
- VR and glaucoma ophthalmologists are satisfied. At the beginning, there was some confusion among glaucoma doctors and optometrists when to seek advice and when to re-refer patients. The protocol has been tightened up after discussions with both groups, resulting in more uniform policy, which ensures more space and confidence for optometrists and ophthalmologists.
- Optometrists are also very satisfied, but they feel that they need to work harder and longer hours. The optometrist centre has been expanded with two experienced optometrists.
- At the start, there were occasionally patients with 'fear of cold feet', despite an information letter. As expected, these were patients who actually wanted to be seen by an (ophthalmologist) doctor. After the first visit in the centre, they were convinced.
- Patients are very satisfied; (Patient Reported Experience Measure) PREM scores for optometrists were 9.0 on a 10-point scale for all questions. No complaints have been submitted. The majority of patients aim to come back and be monitored by the optometrist centre.

TASK SHIFTING IS ALREADY HAPPENING

Main results of an interview with an optometrist at the REH.

The task reallocation process was stimulated by the support of the ophthalmologists. This was further stimulated by the government policy 'right (eye) care in the right place'; and by the health insurer who wants to purchase ‘cheaper care’. The interviewee indicates that the reallocation of tasks has yielded advantages for the optometrist, in the sense that they now do not always have

to wait (‘in the corridor’) for supervision from the ophthalmologist, but run outpatient clinics independently. She also sees disadvantages: the care for stable patients is somewhat monotonous and not very challenging. Another limitation is a shortage of optometrists, in general, and of optometrists willing to work in this way.

The optometrist centre (as a task reallocation initiative), which originated from waiting list problems, under the influence of policy and the desire for cost reduction, is now standard practice in the Rotterdam eye hospital.

The ambition is to formalise a second process, in which the optometrist is given the role of gatekeeper for eye care and thus also takes over the 'influx of patients' as well. The Dutch Society of Ophthalmologists and the Dutch Association of Optometrists have established a patient history framework, which has created clarity about which patients are involved (e.g. vision change, dry eyes), and this method can, in principle, be put into practice. However, the interviewee indicates that ophthalmologists have resistance to the implementation of this trajectory. Questions are: What will the triage look like? Are only the heavy patients left for the ophthalmologist? What about the fee for service? The interviewee sees that the older generation of ophthalmologists in particular still has little confidence in the knowledge and skills of paramedics such as optometrists. She sees this less with young ophthalmologists. She thinks it is a matter of getting used to and trusting.

The expectation is that GPs have a positive attitude towards this far-reaching form of task reallocation. The interviewee does not foresee any problems with the referral from the GP to the ophthalmologist or optometrist at the eye hospital.

The interviewee sees that two things are needed to successfully complete this process:

- A standard rate for the optometrist, over which the ophthalmologist does not have to have a say
- More trust / cooperation between both healthcare professionals.

There is a need to create more awareness and awareness among all parties about the need for further task shifting in eye care, in order to keep care accessible and affordable.

Possibilities that could help this are:

- Sharing good examples of initiatives from other fields / countries / regions

- Supporting cooperation, in which the tension around hierarchy and trust are central. This must also be safeguarded at management level.

The interviewee does not immediately see opportunities for more integration of ophthalmologist and optometrist training as a driver, because internships and exchanges are already embedded in the training. This is how they work in a 'cell context': one ophthalmologist to three optometrists. Finally, the interviewee has some advice for others who want to get started with task reallocation: it is important to determine at an early stage what type of patients / care is involved. This immediately creates clarity and a basis for mutual trust.

5.5 Case study description: Task shifting in eye care at Twente region, The Netherlands

Background and context

In the region of Twente in the Netherlands, and nation-wide the recent years, more and more people with eye disorders have been seeing their general practitioner (GP). And the demand for eye care will double or even triple in the next three years. This is mainly due to ageing. There is a chance that general practitioners and specialists in Ophthalmology – who are already in short supply – cannot cope with the increasing flow of patients, resulting in waiting lists.

In the Netherlands, GPs generally refer their patients to an ophthalmologist. GPs do this because they cannot properly diagnose all eye complaints, as they (1) are not specifically trained for this and (2) they do not have the equipment for it. Ophthalmologists from regional hospital 'Medisch Spectrum Twente' and the 'Hospital Group Twente' have concluded that many of these referrals are unnecessary. And that many non-complex eye complaints can be treated by a qualified optometrist.

Organisation and requirements

The cooperation project between GPs and optometrists was set up by a regional organisation for General Practices in Twente region (Twentse Huisartsen Onderneming Oost Nederland, THOON) in collaboration with ophthalmologists from the regional hospital 'Medisch Spectrum Twente' (MST) and the 'Hospital Group Twente' (ZGT). THOON is an organisation that supports general practitioners in organising sensible care in general practice. The GPs in the THOON region work together with nine optometrists with a higher vocational education who meet the strict requirements of the Optometrists Association of the Netherlands (OVN). The general practitioner is and remains the main practitioner.

Patients are referred to a participating optometrist for diagnosis and treatment of simple ophthalmic complaints. GPs refer patients to an optometrist who will contact them to make an appointment for an ophthalmological examination. This examination usually takes place within two weeks. After the examination, the optometrist informs the GP about the results. After this, patients may still be referred to an ophthalmologist. Patients with an ophthalmological complaint can only go to the optometrist with a referral from their general practitioner. The referral is digital. The treatment is not incurred by the patients' deductibles.

The Dutch eye patient organisation is committed to solutions for high-quality eye care with short waiting times, together with the professional organisations of ophthalmologists and optometrists and other parties involved. They advocate shifting tasks from the ophthalmologists or general practitioners to other care providers such as optometrists who work outside the hospital or eye clinic. The Dutch eye patient organisation advocating the project in Twente is a good example of this.

Aim and advantages

The most important advantages defined by the project are:

- Provision of ophthalmological care close to home;
- Appropriate care is provided by a specialist, i.e. an experienced optometrist;
- Patient costs are lower, as the optometrist treatment through the GP referral is no deductible;
- Unnecessary referrals to the hospital are reduced;
- Patients are helped faster and need to spend less time on visits;
- Ophthalmologist only see patients who really need specialised hospital care;
- General practitioner, optometrist and ophthalmologist work together, and communicate in the same language to the patient;
- Shorter waiting times for the patient;
- The 'right care in the right place' is realised, i.e. deployment of a qualified optometrist for the diagnosis of specific ophthalmic complaints;
- GPs receive feedback in the usual way via a return message;
- GPs can declare a double consultation if they see the patient again after the diagnostic consultation with the optometrist.

Task analysis and competency identification

Patients are referred by GPs that have gradually loss of vision, have dry or red eyes, are between 8 and 12 years with orthoptist complaints, or have high eye pressures. More than 75% of all patients that were referred to the optometrists did not need to be referred to an ophthalmologist. Optometrists take over tasks from the general practitioner and the ophthalmologist, as they are well trained in examining eyes with, among other things, a slit

lamp and an OCT scan. Based on their diagnosis, it is determined whether it is necessary to refer to the ophthalmologist. Optometrists always refer to the ophthalmologist for serious conditions, but this is not always necessary. In the case of red eyes, for example, it may be advisable to keep the eye clean. In case of dry eyes, optometrists advise GPs to prescribe drops.

The optometrists participating in the project have extensive work experience, and are registered in the Paramedics Quality Register, and have OCT equipment at hand. They also meet regularly to discuss clinical cases and patients in order to guarantee quality.

In 2020, the Dutch Society of Ophthalmologists and the Dutch Association of Optometrists agreed on the following requirements for optometrists in the national guideline 'the right eye care at the right place'
Symptoms and complaints for which it is expected that diagnosis and treatment can take place by optometrists: ● Gradual loss of vision ● Screening for glaucoma with familial burden and with increased eye pressure measured at the optician < 30mmHg ● Dry eyes/sandy feeling/tired eyes ● Complex refractive error or complex measurement from age 8 ● Unassessable fundus photo in Diabetic Retinopathy ● Screening for Diabetic Retinopathy Quality assurance of the optometrists; the quality of the care provided by the optometrist is guaranteed by: ● Quality registration via the Paramedics Quality Register (this guarantees volume norms and professional development and peer consultation) ● Quality assessments within the professional group ● Client Satisfaction Survey ● Following guidelines

Opportunities and limitations

Since 2019, more than 4,200 patients are referred to the participating optometrists. 80% of these were treated in primary care. The most common referral complaints to the optometrist were gradual loss of vision, flashes and spots and persistent dry eye.

According to an involved ophthalmologist of regional hospital Medisch Spectrum Twente (MST), this working method has made eye care more efficient. “We can now see more people who really need our care. The optometrist sees people with complaints that can be handled very well by him/her or can go to the doctor with advice.” Other advantages are that GPs can offer their patients care at short notice, mostly within two weeks. About eighty percent of the patients in this project ultimately did not have to go to the hospital; they could be helped by optometrists or they just had to be checked regularly.

It is expected that waiting lists will eventually become shorter as a result of this working method. Support from the regional health insurer company contributed to the projects’ success.

There is room for improvement however, as still not every GP makes ‘optimal’ referrals. Due to this, patients are still seen by ophthalmologists unnecessarily. Another complicating factor is that patients find it unsatisfactory or confusing for to be seen by an optometrist instead of an ophthalmologist, in particular if optometrists are an unknown profession to them. Hence, there is progress to be made if more GPs would actively explain what an optometrist can do and that an ophthalmologist is not always necessary. This way, more patient referrals can be ‘filtered’. In the end, only people who have to undergo surgery or who need to be treated by the ophthalmologist in some other way come to the ophthalmologist.

5.6 Case study description: Task shifting between GPs and Family nurses in primary care sector in Lombardy

Abstract

PoliS-Lombardia is in charge of both general practitioner (GP) and Family Nurse Practitioner (FNP) training for the Lombardy Region. Since the first edition of the FNP course in 2021, PoliS-Lombardia was aware of the importance of collaboration between these two professions and, consequently, encouraged GPs and FNPs by offering shared training modules and shared internships. In the TaSHI project, PoliS-Lombardia wants to take a step further promoting task shifting (TS), and not only good cooperation. Accordingly, we developed and administered a questionnaire to assess maturity level and readiness/willingness of GPs and FNPs trainees and related tutors regarding TS introduction and implementation in their practices. Alongside, PoliS-Lombardia is collecting qualitative data from stakeholders interviews and meetings.

Background and context

Lombardy is a region located in the north of Italy and it counts more than 10 million inhabitants. Italy has a National Healthcare System (NHS), which provides universal coverage for all citizens and residents. More concretely, healthcare services are provided to the citizens at regional level by the 20 Regions through Regional Healthcare Systems. Each person is assigned to a local GP, who is the gatekeeper to all public primary and secondary care services. In Italy, GPs are self-employed but paid by the NHS under a specific individual contract regulated by regional and national agreements. GPs used to work alone; however, in recent years, the Government has established incentives to encourage collaboration among GPs (GP groups, GP associations, and GP cooperatives).

In 2020, the Government has created a new nurse role, the Family Nurse Practitioner, which should cooperate with several actors: GPs, social workers, volunteering associations members, psychologists, physiotherapists, etc. The FNP is employed by local health facilities and he/she is not the GP's employee. FNPs provide services at primary care structures (e.g. GP's office, Community Health Center, Local Health facilities, etc.) or directly at the patient's house. In Lombardy Region, 1,600 FNPs will be trained and employed in the next few years (8 nurses every 50,000 inhabitants). Currently, the FNP training course is divided into eight learning units (4 organised by PoliS-Lombardia and 4 organised by local health facilities) and

200 hours of internship in facilities of the territory. The joint training of GPs and FNPs presents a high potential for sharing of knowledge, competences and tasks.

Despite FNPs' specific tasks have not been well defined yet, there are several reasons to focus our attention on the FNPs. Firstly, there is an increase of health demand and a transformation of health demand due to ageing of the population (and consequently an increased number of patients with chronic diseases). Secondly, there is an uncertainty of GPs supply due to ageing of current GPs (70% of them are expected to retire in the next 4-5 years), low attractiveness of the GP profession and the opening of new Community Health Centers[5]. Thirdly, public health expenditure is continuously increasing, with more than 19 billion euros only in the Lombardy Region in 2018, and cost containment is always an issue.[6] Fourthly, the Covid-19 pandemic impacted not only population health (in the medium and long-term run too) but also forced health care providers to shift some tasks in different sectors (Marcotrigiano et al., 2022). A paradigmatic example is the possibility for pharmacists to administer Covid-19 vaccination at the local pharmacy, a decision that has aroused quite a few controversies.

For all these reasons, TS and task sharing are surely needed to improve quality of care of chronic patients, particularly where several (or continuous) home visits are required. Therefore, we expect that new tasks will be assigned to FNP (job enlargement) and some tasks will be shared/shifted in the future from GP to FNP. However, we have to take into account some barriers such as the fact that the regulatory framework for nursing has not been revised to allow new roles and TS, as is the case in several other EU countries (OECD, European Observatory on Health Systems and Policies, 2020), and the scarce attention to TS between professional groups and inconsistent collaboration between professionals that features our system (Cicchetti et al. 2021).

Scope of the pilot project

The aim of the pilot project is to investigate the possibility of introducing TS practices in primary care between GPs and FNPs in Lombardy. The main objectives are:

1. to assess the maturity level and readiness of the Lombardy context;
2. to identify the tasks which may be shifted and/or shared between GPs and FNPs;

[5] Community Health Centers are funded by the National Recovery and Resilience Plan (PNRR) which is part of the European Next Generation EU (NGEU) programme. This program allocates EUR 15.63 billion for health.
[6] ISTAT-HFA: https://www.ISTAT.it/it/archivio/14562

3. to identify facilitators and barriers,
4. to identify learning needs among GPs and FNPs;
5. to test a learning module developed in TaSHI project; and
6. to assess the training through a second survey.

Task analysis

In Italy, there is a shortage of nurses (OECD, European Observatory on Health Systems and Policies, 2022) and the introduction of FNPs aims to empower the primary care sector. The number of chronic patients (which often display comorbidities) is continuously increasing and their needs are not always met in a reasonable time. The idea that GPs alone could take care of these patients is not only unfeasible but also unjustifiable (at least in terms of resource allocation). The possibility to share and/or transfer some competencies between GPs and nurses may reduce patient waiting time and also increase the overall quality of care.

In the project design and implementation, we have involved several stakeholders: the Technical Scientific Committee of Academy, the Family Nurses Course Advisory Board, the GPs Didactic Committee and the TaSHI Advisory Board for PoliS-Lombardia. Noteworthy, several policy makers are members of these committees.

We started our work by assessing the maturity level and readiness of our pilot site through a survey (Figure). We reached an overall audience of 1393 physicians (970 GPs trainees and 423 GPs seniors) and 348 nurses (337 FNPs trainees and 11 tutors), with a response rate of 96.6% for FNPs (336) and 35% for GPs (489).

Only 28% of FNPs and GPs (93 and 138 respectively) have heard of TS; although, 86% (289) of FNPs and 59% (290) of GPs are interested to be involved in a TS initiative. Only 47 (10%) of GPs have been directly involved in TS; 80 (16%) have attended a TS initiative, 64 (13%) have heard of TS at work, and 217 (44%) have heard of it elsewhere. 31 (9%) nurses have been directly involved in TS, 25 (7%) have attended, 48 (14%) have heard of it at work, and 46 (14%) have heard of it elsewhere.

Interestingly, 287 (59%) GPs believe that some tasks, currently carried out by GPs alone, could also suit nurses. These tasks are mainly related to clinical activities, but also to administrative and educational activities were mentioned as an example (Andrade at al. 2017).

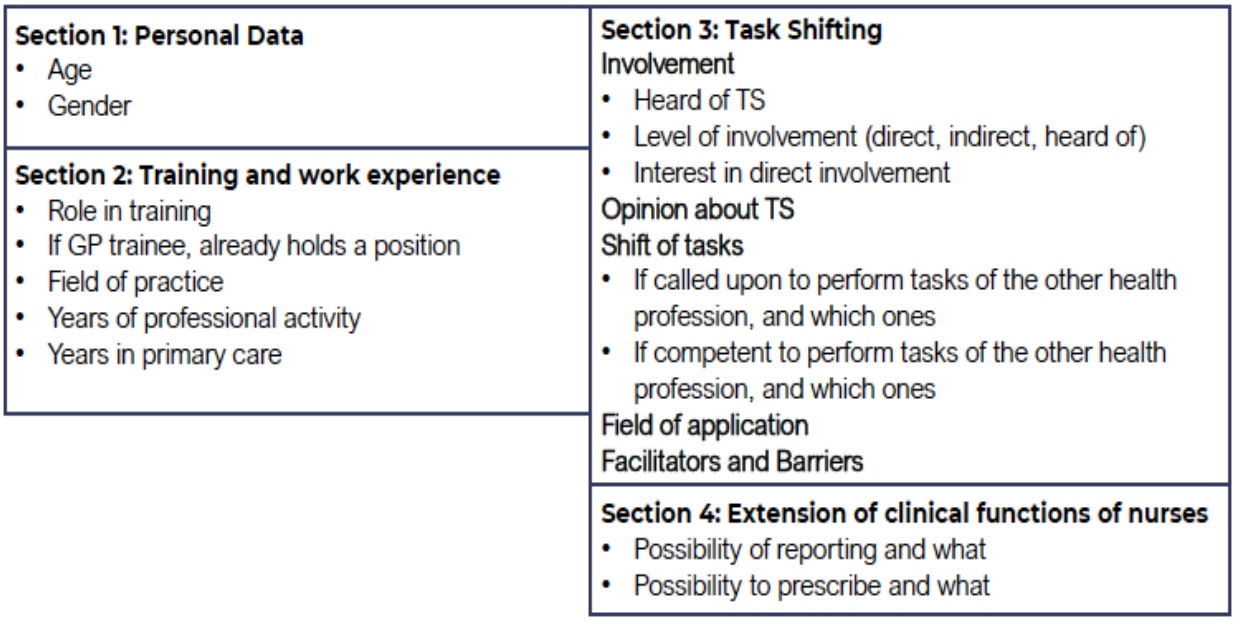

Figure 2 – Structure of the survey in Lombardy Region

Interestingly, GPs and FNPs agree regarding facilitators and barriers; however, FNPs gave higher scores than GPs in all domains. The facilitators, in descending order of importance, are the following: healthcare demand transformation, increasing healthcare demand, health emergency (Covid-19 related), generational change of healthcare professionals, Recovery and Resilience National Plan (PNRR), normative institution of FNP, and changing gender composition of healthcare professionals. Both GPs and FNPs agree that barriers to TS are regulatory constraints, managerial constraints, contractual aspects, and medical responsibility. However, FNPs believe that Professional Orders and cultural elements are particularly relevant barriers. Neither GPs nor FNPs see technology as a barrier.

FNPs believe that TS could be successfully applied in managerial, clinical, and administrative fields. On the other hand, GPs think TS may be applied mostly in the administrative field.

Noteworthy, 114 (23%) GPs and 223 (66%) FNPs believe that a nurse could prescribe. As an example, GPs mainly referred to the repetition of chronic therapies, medical aids, and some analgesics. Similarly, FNPs indicate over-the-counter medications (such as anti-inflammatory and analgesic therapies), medical aids, and chronic therapies.

Regarding reporting, 91 (19%) GPs and 109 (32%) FNPs think that a nurse could report. Specifically, GPs referred to ECG, vital parameters, spirometry, and pads; whereas, FNs gave as an example ECG, echography, and laboratory tests.

Based on our survey results, several meetings with stakeholders, and some interviews with physicians and nurses, we believe that the role of nurses and their skills are not so well-known by physicians and, sometimes, by nurses too. This fact is relevant and it would be interesting to understand if there is a correlation between nurses' education and their awareness of their skills (and consequently with their answer concerning prescription and reporting). Although a reorganisation of HWF is already perceived as a necessity to all healthcare professionals we have met, there is great resistance to talk about TS in Italy. In our experience we found that physicians are easily more available to talk of task sharing. However, all stakeholders we have met agree on two points: every reflection (and changing) should be based on patients' needs and the necessity to have a legal basis to support TS and protect healthcare professionals.

TASK SHIFTING IS ALREADY HAPPENING

We addressed the TaSHI advisory board for Polis-Lombardia asking whether they are involved in (or are aware of) task shifting practices that might be already happening in the primary care sector. In fact, a recently graduated GP stepped forward and proposed his experience regarding medical aids prescription after home visits performed by the nurse of his medical office.

The GP works in a medical office located in the outskirts of Milan along with three other GPs ("medicina di gruppo", GPs working in teams) and, dealing as a collective, these four GPs hired three secretaries and a nurse[7]. The nurse is in charge of advanced medications at the medical office, and the evaluation of patients at home for three main areas: hygiene, bedsores, and fall risk. As a general rule, the nurse visits patients at home in three cases: (i) if they are new patients, (ii) when recently discharged by a hospital, or (iii) when their health condition is deteriorating. During a home visit, the nurse must assess the patient's needs, risks, and management by caregivers; afterwards, the nurse will produce a detailed evaluation. Regarding medical aids, the nurse' activity is not only limited to general suggestions, but the nurse chooses the specific medical aid, which is deemed appropriate (for example: a specific type of: bed, mattress, bed sides, diapers, shoes, etc.). Later, the GP prescribes the medical aids in accordance with the nurse's evaluation. In this way, more home visits can be carried out, waiting time is reduced and

[7] Lombardy Region promotes the presence of nurses in GPs' offices with an incentive of 4 euro per patient per year (currently a GP may have up to 1800 patients). The remaining part is paid by the GP(s). The hourly rate of a nurse is between 30-35 euro.

less patients have to travel to the GP's office. Moreover, GPs can use their time for patients who need more advanced care.

In Italy, nurses cannot prescribe; therefore, even if the visit and the assessment is made by the nurse, the prescription is performed by the GP.

Learning needs

Data collected by survey, meetings and interviews suggest that the majority of nurses are interested in TS and feel ready to expand their knowledge, skills and competencies.

The training course for GPs and FNPs is an incredible opportunity to propose learning module(s) regarding TS. Trainees could acquire new knowledge, skills and competencies, which can be useful for TS in primary care. The idea is to submit a survey to test general knowledge regarding TS and then propose video lecture(s) and a digital simulation. Italy, Lithuania, and Estonia will test the generic module (fundamentals of TS) developed in TaSHI training materials. In this module, it will also be taught the legislation regarding TS. Finally, a joint training and internship of GPs and FNPs could increase awareness of nursing roles and skills.

Opportunities and limitations

OPPORTUNITIES	CHANGE MECHANISMS		RISKS AND MITIGATIONS
	ENABLERS	BARRIERS	
Increased competence and skill transfer	1. Understanding of the patient's daily living	1.Lack of normative framework 2. Lack of shared protocols 3. Lack of resources for training 4. Lack of allocated time for learning 5. Communication with and involvement of the patient	1.Revision of normative framework for nurses 2. Ambiguous leadership 3. Funding for developing learning resources 4. Sustained motivation in the workforce
Professional cooperation between GPs and FNPs	1. Understanding each other's skills and competences. 2. No hierarchy (since FNPs are not GPs' employes)	1. Lack of mutual acknowledgement and trust 2. No tight collaboration as in hospitals or at GP's office. 3. Limited opportunity for collegial discussion and feedback	1. Misunderstanding of roles and responsibilities
Freeing up resources and reducing waiting time	1. Successful use of the service in the management of suitable patients 2. No need for patient to travel	1. Lack of trust by patients who prefer to be visited by a physician	1.Communication with patients 2. Communication between GPs and FNPs.

Table 3 - Opportunities and limitations in Lombardy Region

5.7 Case study description: Task shifting in mental health in Estonia

Background and context

Primary care in Estonia is based on family doctors who work in teams with family nurses and serve patients who are in their patient lists. The doctors can work in a solo practice or can join and form bigger centres. According to the Estonian Health Insurance Fund as of 01.12.2022 there are 783 patient lists served by over 500 companies[8]. During recent years, it has been promoted to bring family doctors together into primary care health centres (PCC), where, in addition to a doctor and family nurses there are midwives, physiotherapists and home nurses. The team can include more specialists; e.g hiring a clinical psychologist or a mental health nurse are also financed by the Estonian Health Insurance Fund. Building structures for PCC facilities has been supported by the European Regional Development Fund. In Estonia, there are now 59 PCCs with almost half of the patient lists serviced there.

Nursing degree takes 3.5 years to attain in Estonia and one can complete it with master studies of 1.5 years. The master's curricula distinguishes specialisations in clinical nursing, health nursing (family nurses, occupational nurses, and school nurses), intensive care nursing and mental health nursing. Currently the funding for specialised nurses is not differentiated by Health Insurance Fund, but there is an initiative for doing so. What complicates the issue is that specialisation is not yet a requirement for working and nurses with different levels of training can take on similar roles and responsibilities in a team.

Mental health nursing curriculum was opened for studies in 2018. According to the Estonian Healthworkers Register as of 01.02.2023, there are 166 nurses who have completed it[9]. Most of the mental health nurses (MHN) are working in either hospitals or private practices with psychiatrists. They are part of a treatment team or work independently, often being the first contact and need an assessor in psychiatric care prior to psychiatrist appointment. Vast clinical knowledge in the field is needed for work with psychiatric patients and the hospitals might invest a lot of time supporting new MHNs to gain experience and fully take on the role. However, specialised nurses have more rights and independence, for example prescribing certain medicines.

[8] See https://www.haigekassa.ee/inimesele/arsti-ja-oendusabi/perearstiabi/tervisekeskused

[9] Source: Terviseameti Registrid (2023). Tervishoiutöötajad. https://medre.tehik.ee/search/employees

Some PCCs have used the opportunity to hire MHNs to their practice. Sometimes they are nurses who worked in the centre before as a family nurse and complemented their profession with MHN master's degree. It is not a common practice yet, as there are not many MHNs altogether and there is a competition between care providers for hiring them. The role and tasks of a MHN in a PCC are not agreed on and can vary between PCCs.

The rise in mental health problems has been further accelerated during the COVID-19 pandemics and public awareness of the topic additionally increases the demand for mental health services. Shifting some tasks from psychiatrists to other specialists is one way to reasonably allocate the resources. Some tasks are given to family doctors, but as many family doctors do not feel very confident in the field of mental health illnesses and therefore need training. It would be reasonable to take a step further and put the effort in shifting some of the tasks to mental health nurses instead.

The timing is good for making MHN a member of a standard primary care team. A new primary care master plan is being developed and part of the process is to evaluate the needs of a PCC to serve its patients in the best possible way. As primary care takes on more and more roles and providing accessible and good quality care near home is expected to go on, it can be concluded that the team needs to widen. The mental health topic is also well recognised on a national level. In 2022 a Mental Health Department was created in the Ministry of Social Affairs to address the problems and find solutions on every step and level of care[10].

Scope of the pilot project

The pilot project's objective is to describe the role of a MHN in primary care setting and find the prerequisites for having them work in PCCs. It includes assessing the master's curriculum in terms of its adequacy for preparing the nurses for work as MHNs without extra practice in specialised psychiatric care units for gaining clinical experience.

Analysing the team roles and tasks in the PCCs where a mental health nurse is already part of the team

[10] See https://www.sm.ee/sotsiaalministeeriumis-alustas-vaimse-tervise-osakond

Currently there are 15 mental health nurses working in PCCs. Part of the pilot project is to analyse their work and tasks shared and shifted in the centre and take their compound experience as a basis for describing the role on a national level. Kerli Kaskla, one of the MHNs, did her masters project on the topic and this paper can be used as a draft or starting point for the description. She has also been interviewed along with the family doctor from the same practice to provide a task shifting true story by the pilot site. Task analysis and reflection on awareness of the task shifting in process will be done using a qualitative method combining questionnaire, interviews, and group work.

Including experience from a project Klaabu

Estonian Health Insurance Fund is financing a project Klaabu. It was initiated by Estonian Society of Psychiatrists in 2021 with the aim of bringing mental health competence to primary care level and helping family doctors to have more confidence in helping patients with depression and other mental health conditions. Primary care providers take part in the project as well as providers of psychiatric care. The MHNs working in specialised care participate in the work of PCCs but remain in their main jobs in hospitals and with specialised care providers. Apart from this, they spend a few days at family doctors' offices and make appointments for the patients there. The family doctors can refer their patients to MHNs in their own centre instead of referring to psychiatric care. This kind of collaboration empowers the family doctors to take a bigger role in helping people with mental health problems. The project also provides training for primary care providers to gain more knowledge on the topic. There are modules on psychotic and sleeping disorders, addictions, eating disorders, anxiety, mood disorders and preventing suicide, child- and adolescents psychiatry, acute stress reaction and post-traumatic stress disorder.

Currently the Klaabu project takes place in 5 counties of 15, although not all care providers in the area are included. It is planned to widen the project to other counties over Estonia.

Assessing MHNs willingness to work in primary care

An online questionnaire will be circulated among the nurses to gain information and find out their expectations and hesitations regarding the option.

Assessing nurses' and nursing students' willingness and motivation to work as mental health nurses in primary care

An online questionnaire among the nurses and students will be held to gain information and find out their expectations and hesitations regarding the option. The results from 4.1 will be used in preparing the questions.

Analysing the needs for extra training

After the aforementioned steps, current curricula and training opportunities will be assessed for compatibility with the needs and expectations.

Task analysis

A preliminary task description for MHN in PCC was given by the Estonian Health Insurance Fund when they started covering the costs of such a role. The tasks of a MHN were described as following.

The role of a mental health nurse in primary care is to be a regular contact person for patients with mental health problems, to assess and follow their status, to provide simple interventions and consult other professionals in the team on mental health topics. The MHN works in collaboration with both their PCC team and mental health professionals from outside the centre.

Situations when a family doctor will involve a MHN:

- Screening and assessing a patient with suspected mental health concern
- Counselling when starting mental health related treatment
- Teamwork in management of moderate mood and conduct disorders
- Treatment of physical illness for which the role of mental health support is important
- Communicating the diagnosis of a serious illness
- Patients with anxiety, chronic stress
- Trauma or grief support

Mental health nurse tasks in primary care:

- Status or risk assessment
- Informing patients of mental health problems: aetiology, risk factors, treatment and support

- Teaching the patients in self-monitoring and for healthy and mental health friendly lifestyle
- Prolonging prescriptions

Kerli Kaskla described in her master's project a code of practice for a MHN in primary care. Her aim was to focus on the MHN tasks based on nurses core competencies handling patients with mental health problems. The overall objective of the tasks is to establish a trusting relationship with the patient, based on patient needs and to involve them in decision-making that ensures the promotion and maintenance of mental health and the prevention of mental health problems. MHN task are following:

- General assessment of the patient's health condition based on the patient's mental health
- Collecting patient history: clarifying the problem, family history of the mental health disorders, usage of alcohol, tobacco and drugs, risk factors, somatic diseases
- Counselling: on mental health diseases (individual and family counselling), on work and living arrangement based on patient's mental health, on restoring and maintaining health, teaching primary self-help techniques (anxiety, panic attacks, sleep disorder), group counselling - simultaneous counselling of several patients in a group with same mental health problems)
- Planning nursing activities: preparing and monitoring a treatment plan, referral to a physician, agreeing on repeated visits during therapy for treatment monitoring
- Prescribing and performing procedures: prescribing and taking blood tests, prescribing and making an electrocardiogram, blood pressure measurement, heart rate measurement, various questionnaires filling assessment (EEK-2, AUDIT, MOCA), interpretation of results, documentation
- Ability to case analysis in team

The code suggested in Kerli Kaskla's master thesis and the one proposed by the Estonian Health Insurance Fund are similar regarding the content of the tasks although different in structure and detail.

The mental health nurses taking part in the Klaabu project describe working in primary care as a versatile experience. There are first and repeated appointments, both for people already diagnosed and receiving continuous treatment and for people who need counselling and recommendations to prevent developing clinically significant mental health conditions. The patients might benefit from coaching and lifestyle counselling, but there are also cases of referring the patients to inpatient care. These MHNs have experience in specialist care and working alongside psychiatrists.

The situation analysis thus shows that a mental health nurse in primary care is currently rather described by the title of the job rather than a set of tasks they perform.

TASK SHIFTING IS ALREADY HAPPENING

In autumn 2022, a mental health nurse from a family practice and a family doctor she works with were interviewed. The nurse has been working in this centre for years and recently decided to complete the studies with a master's degree. She was recommended to choose mental health nursing for the master's program. Seeing many people struggling with mental health problems made the choice easier. While she also continues her work as a family nurse in the same family practice, she started to have specially dedicated appointment times for mental health nursing and this workflow is kept separate. She mentioned that there is a need to increase the weekly time spent on specialised nursing, both for the high demand, but also because she recognized the need to educate herself daily in mental health care.

Both the doctor and the nurse found offering mental health nurse appointments useful to patients and well accepted. They both explained how it is crucial to have enough time for people with mental health problems and making 60 min appointments gives the nurse an opportunity to have a good personal contact with the patient. This time can often be used for counselling people about overall lifestyle that also affects their mental health, e.g. having enough sleep and exercising regularly. This indicates that there are probably some parts of the mental health nurses tasks that could be and are already also performed by family nurses, as recommendations on healthy habits work for both mental and physical health. Furthermore, providing information and support for people to form and keep healthy habits can be also supplemented by using digital tools. It requires

more than lifestyle coaching and specialised knowledge is needed for work with people with mental health problems. While saying that knowing about specific clinical conditions and treatments is important to work as a team with both family doctors and psychiatrists, the nurse also mentioned that specialising in mental health made her approach to other patients different as well. For example, she notices signs of depression or how she understands and can help people with fear of blood sampling.

The interviews showed that having a mental health nurse in the primary care team is appreciated by both patients and professionals working in the centre. The gain originates both from having extra time for care and from the specialised knowledge. While in the centre they do have work instructions and mutually agreed on workflow, it was also recognized that for functional and meaningful task shifting there should be nationwide recommendations for the role of mental health nurses in primary care.

Learning needs

Competences may vary a lot among the nurses who already work as MHNs in primary care or could take on that role. Among the MHNs with a main job in primary care there are both nurses with primary care background as well as MHNs who used to work in specialised care and shifted to primary care. While their experience and clinical knowledge may be very different, nurses are very well educated and prepared and ready to take on even more responsibility than before. One of their most important values is the patient's well-being, which makes them a strong and important partner in patient-centred healthcare. Nurses' strong identity allows them to work independently and be great team members.

While the teams of PCCs are also very different, it is also important to assess the competencies that are needed for collaboration with a MHN in the team. Current pilot sites may offer a biased perception as the centres that already searched for and hired a mental health nurse are probably more prone to innovation and task shifting. They are more likely to acknowledge the importance of mental health and have more competence in the field. The risk of a MHN being left without support could be mitigated if the nurse's education also prepares her for independent work and the work organisation enables direct cooperation with specialists outside the team. Additional training should also be offered to health centres' teams.

Opportunities and limitations

The situation analysis shows that a mental health nurse in primary care is currently rather described by the title of the job rather than a set of tasks they perform.

In autumn 2022 there were discussions held for preparing an Estonian Primary Care Development Plan as well as a Work Plan for the Mental Health Department of the Ministry of Social Affairs. In the discussions with stakeholders there was a consensus on having mental health nurses in a standard primary care team in the future. What could facilitate this kind of agreeability and on the other hand could make the process more complicated in the future is that this potential role has not been formalised and any stakeholder can imagine it according to their needs and expectations.

Further discussions including all primary care team members and psychiatry specialists are needed to identify the proper set of roles for a MHN in PCC. This set needs to be flexible enough to fit MHNs with different possible backgrounds so their role in the team would be commensurate with education and experience, also taking into consideration the other team members competences in mental health.

OPPORTUNITY	BARRIER	MEASURES TO BE TAKEN / ENABLER
Widening the primary health care team to have more resources and flexibility in helping the patients	Lack of specialised nurses and sharing the workforce with specialised care	Describe the role and its need to increase the numbers of training. Give an opportunity for the teams to widen flexibly according to needs, e.g. alternatively offer extra mental health training for family nurses without going through an extra MA program.
	Different levels of competency and readiness among doctors and PCCs to help people with mental health problems.	Training in collaboration with the whole team

	No legal regulation on the role.	Reach an agreement on a national level on the primary care specific role of a MHN, their tasks and responsibilities.
	Many patients do not expect to get mental health help from primary care	Start out with the ones who do.
Offering good quality mental health care on primary care level	Patients may be hesitant to get help from a nurse instead of a doctor	Emphasize the MHNs professional training and specified knowledge on the field as well as the importance of being able to concentrate on the patient individually as the appointment times can be longer.
	Training of MHNs in the master's program does not provide enough clinical competence	Offering extra training on different subject areas, depending on the nurses background and needs.
	Documentation and sharing information	Agree internally on the workflow and at what moment what information is collected and how it is shared
	Lack of trust between the professions, especially towards a novel role	Trust within the team
	Uncertainty when taking on a new, novel role in traditional team	Building professional identity combining the characteristics of nursing, family medicine and mental health care
		High need for mental health services

Table 4 - Opportunities and limitations in Estonia

6. Conclusions and next steps

The case studies described in the previous chapters come from five implementation sites in five different European countries and illustrate the specific national and local context in which task shifting is being attempted. The case studies showed differences in the level of maturity and readiness and in the type of 'shifting'. The sector of implementation and, consequently, the health professionals involved also vary, although a focus on primary care has emerged, demonstrating a common need to change the way primary care is delivered.

Despite these differences, the adoption of a common implementation framework will allow the TaSHI project, at the end of the implementation period, to analyse results and provide useful information that can be extended to other professions, levels and countries by different stakeholders.

At this stage, the following early conclusions can be drawn:

- task shifting is already taking place, but the ongoing experiences are often far from consolidated and formally regulated practices that can be scaled up and transferred to other contexts;
- there is a clear need to regulate and guide the implementation of task shifting in order to respond to the increasing and changing demand for health care, taking into account the different types of task shifting and the different roles that can benefit from it, not only health professionals and not only in the health sector;
- there are several barriers and obstacles that threaten the formal adoption and regulation of task shifting solutions.

Based on these conclusions, some next steps and future practical implications can be highlighted:

- Analyse and agree on the training needs of the staff involved in the task shifting processes and to plan their future implementation (knowledge development at individual level);
- Present and discuss with stakeholders the results of the pilot projects as they progress (managing organisational culture for advanced openness and readiness).

- Promoting dialogue and inter-professional training, discussing national standards, professional guidelines and their sustainable application (influencing and building appropriate governance).

At the end of these pilot experiences, the TaSHI project will summarise the lessons learned from the case studies, identify guidelines on common minimum characteristics and conditions for effective task shifting that are valuable for both patients and health professionals, and highlight a set of evidence-based recommendations at the policy and organisational levels to increase the responsiveness and resilience of the health systems.

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Lombardy (Italy):

- "Accordo Collettivo Nazionale MMG" (General Agreement of GPs) which is renewed periodically and was created many years ago and laws regulating Family Nurses which instead are really recent If possible, please provide the relevant documents or the link to them here: https://www.quotidianosanita.it/lavoro-e-professioni/articolo.php?articolo_id=101611
- Other useful norms:
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