D5.2 GUIDEBOOK ON TASK SHIFTING

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1. Introduction

Health services in the European Union (EU) face significant challenges due to the ageing of the population and the ageing of the health workforce (HWF), leading to shortages and unequal distribution of HWF and resources, the growing demands for better integrated and person-centred care, driven by the rise of multi-morbidity and non-communicable diseases (Maier et al, 2022; Nguyen et al, 2019; van Tuyl et al, 2021; Orkin et al, 2021; De Maeseneer et al, 2019). A possible solution that can help professionals in tackling the various challenges in healthcare is represented by task shifting.

Even if the task shifting definition is an open question, we use the EU definition that defines task shifting in this way:

"Tasks can be shifted from health workers to patients and their carers, to machines, and to other health workers". (EU, 2019).

Possible benefits of task shifting

According to previous literature, task shifting could support and contribute:

- To face staff shortage: task shifting can contribute to the sustainability of the health workforce.
- To increase the skills of the staff: task shifting can be a means to improve the quality of care, where evidence shows that activities are performed better, or as well by one group than another.
- To increase collaboration between healthcare workers: task shifting can enhance the resilience of the health system, especially where different professional groups can substitute for one another in emergencies.
- To face the costs: task shifting can contribute to the financial sustainability of a health system. Many health professionals spend a considerable amount of their time undertaking activities for which they are overqualified.
- To facilitate innovation: task shifting might create new jobs by introducing new types of workers or technology (EU, 2019; Maier et al, 2022; Nguyen et al, 2019; van Tuyl et al, 2021; Orkin et al, 2021; De Maeseneer et al, 2019; WHO, 2008).

Task shifting can be put into practice and challenges are possible to overcome. Doubtless, task shifting has an impact on the HWF management and planning systems that show various levels of maturity in the EU (EC, 2021). Member States tend to focus on diverse aspects of managing their HWF (e.g. addressing shortages, more even territorial distribution, filling posts in remote areas or increasing wages and improving working conditions), and health policy focuses on optimising the operation of health systems by various measures. Task shifting initiatives can contribute to a more effective organisation of care and make health systems more efficient and sustainable in innovative ways. By involving new professionals, patients and carers, task shifting can increase the efforts of moving towards more integrated and person-centred health care. Task shifting has a key role in achieving a well-functioning health system, but it is also posing challenges related to the consequent change in current practices and organisation of care.

Table 1 presents different types of task shifting based on the previously identified literature:

Changing roles	
Enhancement	Increasing the depth of the job by extending the role or skills of a particular group of workers. Changing teamwork, that is, changes to the (way) of collaboration between at least two professions or more.
Substitution/ Delegation	Exchanging one type of work from one profession to another profession, breaking traditional professional divides. Re-allocation of tasks between physicians, nurses, pharmacists and other providers.
Innovation	Creating new jobs by introducing a new type of worker (or technology). Adding new tasks/roles. Supplementation of tasks or add-on of new roles that did not previously exist or were not routinely provided.

Table 1 - Types of task shifting (Sources: Maier et al., 2022, EU, 2019, Sibbald et al, 2004)

The term task sharing has also been used, but it does not imply substitution or delegation as in task shifting. Substitution refers to tasks being entirely shifted to a new profession, whereas delegation is the transfer of tasks to nonmedical professions such as nurses or pharmacists,

but with physicians maintaining ultimate responsibility (Laurant et al., 2005; Sibbald, Shen & McBride, 2004). The two terms “shifting” and “sharing” are sometimes also used simultaneously or interchangeably.

As to innovation, it refers to organisational change, such as new care delivery models. These can result from digitalisation and the exponential growth of accessible information and evidence, which have the potential to bring significant benefits and offer solutions to address HWF related challenges. Innovation might mean the involvement of digital health solutions, e.g. software applications, smart devices or Artificial Intelligence. Their introduction can result in digital-driven task shifting, where automation supports the workflows. It also modifies the job contents, contributing to the redistribution of tasks between the health workers themselves. Digital task shifting might result in decreased workload for professionals and processes that are more effective, but digital tools will never replace human relations and human resources (WHO, 2023).

When considering enhancement and delegation, we often face a lack of the right skills or lack of the right number of professionals in the health labour market (OECD, 2018). The recent pandemic has highlighted the shortage of healthcare workers, the vulnerability of the health workforce, and ensuing difficulty in providing safe and adequate levels of care. Shortages or maldistribution are not a new phenomenon; in fact, it is a global problem that will increase as the population ages and the demand for health care grows and more complex diseases and comorbidities require innovative long-term strategies. Task shifting represents an opportunity for system innovation in the direction of more efficient use of available human resources. During the COVID-19 pandemic, the need for task shifting was further emphasised and accelerated in order to face complexity. Some types of task shifting reported:

- Temperature measured by electronic devices or by non-healthcare workers,
- Swabs carried out by pharmacists instead of nurses,
- Innovative technologies introduced for contact tracing, remote care and monitoring (Groenewegen et al. 2022).

Task shifting can make more efficient use of existing human resources and ease bottlenecks in service delivery. Where additional human resources are needed, task shifting may also involve the delegation of some clearly delineated tasks to new health professions (Dankers-de Mari et al, 2023; de Bont et al, 2016; Maier CB, 2018) who receive specific, competency-

based training - such as physician assistants or advanced practices nurses. From the point of view of task shifting, there are no hierarchies among professionals, but a cultural and mindset change is necessary, for example, from the doctor to pharmacists or nurses, or for example from nurses to the pharmacists (MUNROS Project, 2017; Sundling et al, 2022).

Some health professions, such as nursing, around the world have seen years of scientific progress and social recognition. Since 2010, 8 countries (Finland, the Netherlands, Cyprus, Poland, Spain, Estonia, France and the Swiss Canton of Vaud) have gradually begun to authorise specific groups of nurses including advanced practice nurses to prescribe certain drugs. Countries adapted their legislation in this regard, and enormous steps have been made for midwives (De Palma, 2022). Healthcare professionals in many countries have now achieved professional autonomy and are recognized as responsible for the management of patients, in the fields of prevention, treatment, rehabilitation and palliation. Today all health professionals are required to act with competence and professionalism, which can only be achieved with well-designed study paths, with continuous updates, where training is not to be understood only as a regulatory obligation to be met, but necessary in order to provide patients with quality, effective and safe assistance (Kroezen et al, 2011).

1.1 From informal to formal activities - some examples of regulations of task shifting

Task shifting often represents the regularisation of informal practices (EU, 2019). In past experiences of the application of task shifting in the EU, Belgium with a law from 2016 takes a different approach. The health professions are described in terms of competences rather than the previous list of interventions they are allowed to undertake. In Ireland, a move to manage the care of patients with epilepsy in the community stimulated the development of a new professional group, that is, the epilepsy specialist nurses. They work in a multidisciplinary team, but with substantially enhanced roles. A law in The Netherlands (2011) made nurses lawful for them to conduct a range of procedures that had previously been reserved for physicians, such as cardioversion/defibrillation, catheterization, endoscopy, injections, some prescribing, and minor surgical procedures, although in practice, they had long been undertaking some of them informally. Progress in task shifting in England and Scotland, all of which introduced legislative or regulatory change between 2010 and 2015, found that

progress in shifting tasks from doctors to nurses was more likely than in other countries. Finally, the recognition of the specialist family or community nurse in Italy, with law n. 77/2020, represents the regularisation of previous practice, to face the enhanced needs of the population during COVID-19 (AGENAS, 2023).

These examples show that there are certain tasks already shifted in some countries and have been formalised by legislation. Analysing what is already happening is useful in order to better understand the feasibility of the transfer of tasks and skills, as well as revealing the main legal, economic and political constraints that can help realising and implementing task shifting. For instance, workers with additional training, new skills and therefore having new responsibilities will expect higher remuneration. Regarding policies, however, task shifting initiatives often result in isolated working groups and not a global and shared vision at the national level or beyond. New skills acquired in a specific context are not always recognized in other healthcare facilities in the same country or in other countries. This might generate problems by creating potential differences in skills between professionals who carry out the same job but in different places, or when professionals decide to provide care in a new place – e.g. intra- or international mobility.

1.2 Who is this guide for

The guide is a useful tool for professionals working in health management and education, policy makers and other stakeholders interested in the planning and organisation of services, and researchers. This guide is for practising healthcare professionals delivering direct care, such as doctors, nurses, and allied care personnel, as it has been developed for all who want to deepen their knowledge on task shifting.

1.3 Why is it important to read this guide?

The purpose of this guide is to summarise the findings of the practical implementation process and provide a general guide in the form of guidelines and lessons learned on task shifting, based on the pilot exercises carried out in five European countries as part of the TaSHI project “Empowering EU policies on Task Shifting”. Pilots took place in diverse healthcare facilities, with various health professions and different task shifting types were tested (see more detailed in Michelutti et al, 2022).

This guide provides evidence-informed recommendations for professional organisations, policy makers and practitioners, who plan task shifting projects, or formalise situations where some tasks and activities are already shifted between professionals, but without formal recognition. It intends to enhance knowledge related to task shifting in a comprehensive but practical way. It includes a survey tool to assess the readiness and openness toward task shifting (Annex 1), as well as an overview and examples of how task shifting pilot projects were structured in the five countries participating in the TaSHI project. This practical guide summarises lessons learned on activities to mitigate the risks and the difficulties of a task shifting initiative. This will allow stakeholder organisations and professionals to evaluate the potential impact of task shifting in their own practice, as well as to find recommendations based on the evidence generated from the experience gained in this project.

Implementing the "Task Shifting Practical Guide" enables widening task shifting knowledge and understanding, while helping to design task shifting projects in practice. The guide will support planning and preparation protocols and procedures for task shifting, even between various professionals and in different healthcare settings.

1.4 The TaSHI Project

In March 2020, the European Commission within its third Health Programme (HP3) published a call for project proposals to support reforms in the health workforce field, targeting actions focusing on retention policies, medical deserts and task shifting. The Commission approved five projects, which started in early 2021. One is "Empowering EU health policies on Task SHIfting" – TaSHI, with a duration of three years, starting in April 2021. The project involves seven partners in Italy, Hungary, the Netherlands, Estonia, Norway, and Lithuania. The main objectives of the TaSHI project are to provide a novel understanding and up-to-date knowledge on task shifting and on transferability and uptake of good practices in its implementation – see more details at https://tashiproject.eu/.

2. Overview of the case studies in the implementation sites

In the TaSHI project, pilots have been launched in five European countries in primary care, mental health care, wound care and ophthalmology, including the role of telemedicine and digital health:

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 in 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 and task shifting in eye care in the region of Twente, in the Netherlands, where task shifting between ophthalmologists and optometrists have been taken place to organise 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 in detail in D5.1 Case study of implementation sites (https://tashiproject.eu/tashi-outcomes/).

The pilots address job crafting[1], job carving[2], enrichment and creating new professions and roles. In the analysis of reconsidering services, tasks and competences, the pilots also focused on various professional and non-professional groups involved in task shifting:

a) between different types of health workers,

b) from health professionals to patients,

c) from health professionals to informal caregivers;

[1] 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.

[2] 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.

d) from health professionals to volunteers and informal caregivers;

e) from health professionals to community workers;

f) from health professionals to administrative/managerial staff;

g) from health workers to technology.

Innovation type of task shifting: in Estonia and Lombardy, a new health profession's role is the key subject, mental health nursing in Estonia, and family or community nurse in Lombardy; and their relationship with the other health professionals' tasks and responsibilities. In Norway, the project analysed how the task shift between health professionals is facilitated by the use of technology.

Enhancement and delegation type of task shifting: in the Netherlands and Lithuania, tasks were shifted between various professions, namely, ophthalmologists and optometrists and GPs and nurses working with psychiatrists, respectively. We could detect some changes to the ways of collaboration between the professions, and re-allocation of tasks.

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

- In the Dutch and Norwegian sites, the TaSHI pilots analysed:
  - the effects, the learning needs, and the potential scalability/sustainability of task shifting practices currently taking place in eye care at the regional level (the Dutch pilot sites);
  - the learning needs and 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 to task shifting to health professionals working in the primary care sector;
  - to survey their readiness and openness to task shifting (see Annex 1.);
  - and consequently to engage them in learning activities with the final aim of providing evidence and creating task shifting opportunities among health professionals.

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 was part of their objectives.

A. In Lombardy, the tasks potentially to be shifted are related to new functions in primary care;

B. In Estonia, the tasks to be shifted were analysed during the project that 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 were identified through discussions with stakeholders during the project. (See Annex 2 for the detailed list of tasks shifted in Lithuania.)

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.

2.1 The experience in Norway: Task shifting in wound care using videoconferencing

The Norwegian pilot focused on "Task shifting in wound care using videoconferencing: Connecting outpatient physicians and nurses with municipal home care personnel".

The pilot project aimed to 1) describe the digital wound care service (telemedicine) in terms of task shifting potential between wound care specialists and municipality health workers, 2) assess learning needs among stakeholders and 3) test a learning module based on generic and specific task sifting curriculum and learning materials developed in TaSHI project.

2.1.1 Key findings from Norway

Box 1 presents the key facts and messages as well as the results of the Norwegian pilot project:

Key findings from Norway:

- Professionals determined learning needs in interviews/workshops.
- The learning needs are linked to context-specific knowledge and skills (advanced wound care), interprofessional teamwork, cultural sensitivity and communication.

- Task-shifting potential is confirmed, as it is already happening. Municipal nurses now perform wound treatment under the supervision of more specialist outpatient staff – treatments that patients otherwise need to receive at the hospital.
- Full task-shifting, that is, performing more advanced wound care independently will be facilitated by the peer-learning processes happening through collaboration between professionals.
- The cultural change requires time.

Box 1 - Key findings from Norway

2.2 The experience in the Netherlands: Task shifting in eye care at Rotterdam Eye Hospital Task shifting in eye care at Twente region

Box 2 presents the key facts and messages as well as the results of the Netherlands pilot projects:

Key findings from the Netherlands:

- Both optometrists and ophthalmologists have been working on a multi-disciplinary agreement to regulate task shifting initiatives.
- This agreement endorses a 'Code of Conduct' for optometrists, including protocols on tasks optometrists are authorised and qualified to take over from ophthalmologists, and to independently make decisions and execute these.
- Protocols have been developed for referral at the established optometrist centre within the Rotterdam Eye Hospital. These protocols describe a clear division of tasks and responsibilities at and after handover tasks from ophthalmologists to the optometrist.
- The protocol for monitoring at the optometrist centre is aimed at the activities described as well as the skills and responsibilities of the optometrist to ensure that tasks are executed within their own area of expertise. This includes the working method on consultations and prescriptions, including what to be reported by the optometrist in the patient record file.
- Careful information and communication ensured that patients and citizens got aware of the changes of responsibilities.

Box 2 - Key findings from the Netherlands

Based on the interviews conducted with employees and patients of the Rotterdam eye hospital and in the region of Twente, a national survey has been conducted among optometrists, between July and September 2023 in collaboration with the Optometrist Association. The survey was based on the questions developed for the TaSHI pilots in Lithuania and Italy, to enable comparison across the TaSHI pilots. After the closing of the survey, a total of 112 responses were collected representing about 11% of all optometrists working in the Netherlands. Upcoming steps will discuss the upscaling and extension of task shifting between optometrists and ophthalmologists, as well as how to overcome the main barriers and leverage the main drivers.

Results from the Netherlands' national survey:

- 69% of the optometrists have experience with task shifting between ophthalmologists and optometrists.
- 94% are positive about task shifting between ophthalmologists and optometrists in their practice.
- 41% state that task shifting has decreased waiting lists for patients.
- 70% state that task shifting will decrease the shortage of ophthalmologists in the Netherlands.
- 52% state that task shifting has increased their workload.
- 56% state that task shifting has increased their quality of care.

Box 3 - Results from the Netherlands' national survey

2.3 The experience in Italy: Task shifting between GPs and Family nurses in primary care sector

The Italian pilot focused on the possibility to introduce task shifting practices in primary care between GPs and family nurses in Lombardy. A mixed methodology was used, survey and interviews were carried out, and trainings were organised.

The main objectives were:

1. to assess the maturity level and readiness of the Lombardy context and possible barriers and facilitators. This was explored by a questionnaire survey methodology.

2. to identify the tasks which may be shifted and/or shared between GPs and family nurses. The survey was completed with additional interviews.
3. to develop specific training modules for GPs and family nurses in order to implement task shifting good practices in primary care.

2.3.1 Facts, key results in the Lombardy pilot

In Box 4, we report some facts and results from the Italian project on task shifting between GPs and family nurses.

Key findings from Lombardy:

- Task shifting is already present in an informal way.
- Majority of professionals have not heard of task shifting, but they declared to be interested in being involved in a task shifting initiative.
- More than half of the GP respondents believe that various activities, which are carried out exclusively by doctors today, could also be carried out in the future without problems by nursing professionals. They also believe that task shifting can be applied especially in administrative settings. Meanwhile nurses believe that task shifting can be successfully applied in managerial, clinical and administrative settings as well.
- Nursing prescription of drugs and aids was less likely supported by GPs, while nurses believe that a nurse can prescribe, referring to the repetition of chronic therapies, medical aids and some analgesics.
- As regards reporting, GPs are less likely to support the idea that tests such as electrocardiograms, spirometry and vital parameters can be prescribed and sometimes reported by nurses, while nurses feel capable of also reporting tests such as ultrasounds and laboratory tests.
- Interprofessional education and training was introduced for GPs and Family Nurses during their mandatory education.
- Both GPs and nurses were satisfied by the proposed joint training.

Box 4 - Key findings from Lombardy

2.4 The experience in Estonia: Task shifting in mental health

In Estonia, primary care is guaranteed by family doctors, working in teams in Primary Care Health Centers (PCC), which also include the presence of family nurses, rehabilitation specialists (physiotherapists), home care (specialised nurses) and maternal and child care specialists, also midwives. Within these centres, mental health can also be guaranteed, providing for the inclusion of additional professionals, such as the psychologist and the mental health nurse (MHN).

With this pilot project, we intended to achieve the following objectives:

- to support task shifting for mental health nurses working in primary care;
- to attract more mental health nurses to primary care centres;
- to review and update the current curriculum for mental health nurses across Estonia.

2.4.1 Facts, key results in Estonia

Box 5 presents the key facts and messages as well as the results of the Estonian pilot project:

Key points and findings from Estonia:

- Mental health nursing curriculum was opened for study in 2018.
- The Estonian register of healthcare workers reports 166 nurses specialised in this area at the beginning of 2023. Most mental health nurses work in hospitals or private practices with psychiatrists, and a few work in primary care settings.
- Given the shortage of nurses specialised in mental health, not all PCC centres have managed to guarantee the presence of these professionals within their facilities.
- Task shifting actions have been (partly) implemented by different professionals already prior to the pilot project, mostly informally. The major issues have been the discrepancies in the way these tasks have been shifted by different organisations and health care professionals.
- Employing mental health nurses showed that more time and appointment times were specifically dedicated to mental health nursing.
- Both doctors and nurses believe this new approach and model of care is useful and well-received by patients.
- Further integration is needed with interventions of telenursing using digital tools.

Box 5 - Key findings from Estonia

2.5 The experience in Lithuania: Tasks Delegation from Family Physicians and Psychiatrists to Nurses, Psychologists and Nursing Assistants

The Ministry of Health of the Republic of Lithuania (MoH) is directly involved in this project, called "Tasks delegation from family medicine doctors and psychiatrists to nurses, psychologists, nurse's assistants' impact on accessibility and quality of primary health care services in Lithuania". The project involved collaboration, in the field of primary care, with the two largest providers in the country, which are identified as the "Centro poliklinika" and the "Kauno miesto poliklinika" centre and is being worked on at a regional level, in the districts of Vilnius and Kaunas.

The objectives of the project were the identification

1) of the tasks that could be delegated to other primary health care professionals (or IT),

2) of the most effective ways of delegating tasks, and

3) of the competencies that should be additionally provided to nurses and nurse's assistants.

2.5.1 Facts, key results in Lithuania

Box 6 presents key facts and messages, as well as the results of Lithuanian pilot project:

Key findings from Lithuania:

- Both doctors and nurses are in favour of rethinking their skills and a possible expansion or deepening of skills. Therefore a number of tasks were identified agreed with professionals that could be transferred from doctors to nurses working in primary care.
- The tasks were grouped: in the first group they perform the task by moving around independently, the second group was the one where they were able to perform the task with some consultation or assistance from doctors. The third group was one in which nurses were not capable or capable, due to lack of skills or knowledge, to perform one of the identified tasks.
- Regarding the satisfaction of the groups affected by the project: the patients were the most sceptical. In any case they wanted to see a doctor, so further awareness raising is necessary.

- Doctors are the happiest. They have more time with patients.
- Nurses appeared satisfied. They were happy to have been given new tasks and responsibilities and to be able to carry them out, but they were dissatisfied with the payment. They need more time to carry out the new tasks, so some tasks need to be identified to be further transferred to nursing assistants.

Box 6 - Key findings from Lithuania

3. Lessons learned and recommendations from the TaSHI project

In this section, we summarise what we learned about task shifting during the pilot exercises in five European countries and then we define key elements for implementing task shifting, and a list of recommendations that might be useful in planning task shifting initiatives in various countries or healthcare settings.

Lesson learned 1: Changes at all levels of the health system are needed to make task shifting successful

Health care providers need flexibility in delivering appropriate services to population needs, therefore it is reasonable to enable and manage organisational changes for more efficient care provision. As the literature and experience from TaSHI pilots reported, concrete steps must be taken to provide the certainty and motivation for care providers to shift their tasks, as the tasks move together with responsibility and financing. At organisational and system levels, we need a paradigm shift towards new innovative ways of working, a mindset change for more effective utilisation of health workforce supply, because the shortage of professionals in primary care and mental care is already overwhelming. Not only at the individual and organisational level, but also the macro level environment can influence the success of task shifting. Policy support and explicit laws and regulations are necessary on the macro level to encourage flexibility, to amend scopes of practice and responsibility for diverse activities.

Lesson learned 2: Acceptance of task shifting shows a variety by professionals

At the individual level, health professionals' knowledge, openness, readiness and preparedness for task shifting is necessary. There may be some resistance to change, both from the professionals involved, who may feel threatened by the advancement of professional

skills of other professions; and from those who see their skills expanding without social and economic recognition or legal protection in case of risks.

The TaSHI pilot projects showed that good governance and continuous communication about task shifting can contribute to changing the culture, the mindset and initiate closer collaboration between professional groups. In fact, during one of the pilots, the majority of medical doctors reported having a distorted perception of task shifting and consequently did not wish to engage with it. When task shifting was further explained and illustrated by concrete examples, they became less resistant and willing to accept task shifting. In order to gain more knowledge and acceptance on the redistribution of healthcare tasks within the workforce and reveal potential challenges and opportunities related to implementation, the involvement of several stakeholders is crucial. An essential point in task shifting is the readiness and motivation of health professionals to hand over or receive new tasks. Since tasks go along with responsibilities, compensation is a crucial issue. Healthcare teams and managers should see clearly the competences and tasks to be shifted or shared, so the compensation mechanisms could be built up at organisational level.

Lesson learned 3: Patient education and awareness raising are critical to implement task shifting

Patients accustomed to receiving care from doctors may show a lack of trust in receiving care from other health professionals. Task shifting is often a need-driven and person-centred approach, so the inclusion of patients, informal carers and communities is relevant. Overcoming patients' mistrust towards task shifting, awareness campaigns on the extended or new skills of certain professional groups, or open days where various professionals meet patients to discuss and educate them could be highly beneficial.

Lesson learned 4: Basic and continuous interprofessional education supports the collaboration of professions and helps make task shifting possible

Continuous Professional Development (CPD) is either voluntary or mandatory in different countries for different health professions. Based on the pilot experiences and the piloting of

the task shifting curriculum[3], we learned the importance of continuous learning development carried out involving different types of professionals (e.g. GPs, family nurses, and primary care teams). Interprofessional trainings provide opportunities for different professional groups to meet each other and understand better the competencies and scope of daily practice, and to break the silos, increasing the sense of trust. Not only the way of learning but also the content of learning must be updated. Learning about transversal skills, the knowledge on task shifting as well as on the supportive role of digital health solutions are needed for staying fit to practise in the evolving development of the healthcare sector. The education sector indeed has a critical role. We need to train professionals based on the latest emerging skill needs, fill the skill mismatches and gaps due to the latest trends and developments in healthcare, and know about the new skill needs. Education has an important influence in changing culture and mindset, and to make the health workforce more resilient to sudden and disruptive changes.

Lesson learned 5: Barriers to implementing task shifting must be identified and addressed

Our results support previous literature on the factors enabling or impeding task shifting, regardless the type of task shifting, the professions involved and the level of care (EU, 2019; Karimi-Shahanjarini et al, 2019).

All pilot projects faced some of the following barriers:

- Regulatory, legal constraints;
- Salaries not meeting expectations of professionals receiving new tasks;
- Patients' expectations and preference to consult with a GP/doctor;
- Lack of skills and competencies;
- Lack of training and education;
- Lack of funding for training;
- Lack of communication between the professionals involved.

[3] In the TaSHI project, we designed task shifting curricula that were piloted in the implementation sites of five European countries. See forthcoming TaSHI Project Report on task shifting curriculum (https://tashiproject.eu/tashi-outcomes/).

These barriers must be addressed and managed, thus this guide concludes a series of recommendations on task shifting prerequisites, suitable/appropriate conditions, useful tools and methods for implementation phases.

3.1 Understanding task shifting from a practical point of view

In this section, recommendations on planning and managing task shifting initiatives are discussed and summarised. The section considers prerequisites, preconditions, methods and tools for stakeholders.

3.1.1 Preconditions for task shifting projects

Prerequisites for task shifting

The TaSHI project produces various outcomes that support implementing task shifting initiatives. We create tangible training materials and realise a curriculum for human resource for health management and health workforce development (Sundling et al, forthcoming). Sundling et al. (2021) has already identified several useful tools and methods for task shifting (Collection of useful tools and practices in task shifting) and formulated the so-called prerequisites for task shifting. The explorative desk research study identified a set of prerequisites: suitable leadership, necessary resources, appropriate patient referral system, documentation, evidence-based guidelines, communication skills and record keeping.

Figure 1 - Prerequisites for task shifting by Sundling et al. (2021)

3.1.2 Recommended tools and methods

After considering all preconditions and setting up our task shifting project, some methods and tools can support the implementation. The TaSHI pilot implementation sites tested and verified methods and tools that are useful and fitting to achieve more general task shifting objectives.

- **In order to understand task shifting better, to gain more in-depth knowledge on real-life task shifting, seminars, workshops, and general meetings can be useful tools.** Raising awareness about the effectiveness of task shifting can lead to broader acceptance of task shifting and even mindset change. In the Italian pilot study, the seed was put to facilitate task shifting between GPs and family nurses. Communication started between health professions to break the silos. In Estonia, a workshop brought together practising professionals in mental health care. Mental health nurses received new knowledge of the fundamentals of task shifting, discussed experiences on task shifting already happening in mental healthcare and identified learning needs to implement task shifting.
- **For collecting evidence, evaluation of previous studies, existing documentation (e.g. job descriptions) or evidence (e.g. task lists), conducting new qualitative and quantitative data collections (e.g. interview, focus group or survey) can support the analysis of maturity, the attitudes of openness and readiness of stakeholders.**

  These tools enable to reveal and analyse the current situation and formulate task shifting projects. These tools are essential, in fact, they were used in all the pilot studies in the TaSHI project. The task shifting survey was initially designed in Italy, Lithuania and later it was adapted also for the other pilot sites, carried out in the Netherlands and Estonia as well, in order to enable comparison across the TaSHI pilots (see Annex 1.).
- **To develop transversal skills to be more resilient, to organise adequate training programmes, the tools of seminars, workshops, interprofessional focus groups can be useful.**

  A workshop on videoconferencing in wound care in Norway discussed education needs. Stakeholders provided important feedback on priorities of learning outcomes

for a curriculum in task shifting, as well as important content for learning materials for task shifting in wound care using videoconferencing.

- **To enable fair workload and codify/regulate task shifting in the scope of practice of various health professionals, to ensure the sustainability of task shifting practices, namely, introducing clear regulatory framework and legislation in the matter can facilitate the formalisation and institutionalisation of task shifting.**

  It is highly important to manage appropriate documentation and record-keeping. As we reported from the Netherlands, legislation exists on nurse task enhancement, and health professionals in eye care endorse the "Code of Conduct". In Lithuania, the participants of the pilot project recommended changing the law so that nurses could lawfully do the delegated tasks. The successful pilot project has led to the Ministry of Health's plans to start improving the law that will go into force in 2024.

4. Programming and Implementing Task Shifting - The TaSHI Practical Guide

Based on the results of the TaSHI project, we developed a new practical guide for task shifting implementation. In the previous sections, some key preconditions for task shifting projects were described, some task shifting objectives were linked to useful tools and methods (see also Sundling et al, 2021 (Collection of useful tools and practices in task shifting), furthermore, detailed descriptions of real-life pilot implementations in five European countries can serve as good practices (see Michelutti et al., 2022 (Case studies of implementation sites).

This section describes and discusses the TaSHI Practical Guide, as an important result and outcome of the TaSHI project. It aims to support professionals to design, plan, manage and implement task shifting projects. Since task shifting projects are highly focusing on processes, phases must be foreseen that follow one after the other, paying attention to their schedule dependencies, the completion of the previous phase before being able to move on to a new phase, or carefully evaluate which phases can be carried out simultaneously. The eight phases of the TaSHI Practical Guide presented below demonstrate a method of thinking about task shifting, not only as a series of phases but starting from building a new culture and mindset on task shifting. It provides an expansion of the entire concept of task shifting, divided into several phases, starting from a broader concept. Beyond the eight phases, we would like to underline the importance of a transversal phase, related to continuing supporting and

monitoring, and strengthening the applicability of task shifting by highlighting the transversal elements (see Figure 3).

4.1 Eight implementation phases of task shifting

Stakeholders might have very different approaches, so they must be involved from the beginning to guarantee culture change. There is a need to create collaboration and common knowledge between the various professionals, starting from educators, such as universities with basic training through CPD and on-the-job training. In addition, taking into consideration the emerging and changing needs of the population, the changing health services such as new organisational models, the new care pathways towards more integrated care, as well as new technologies, and the new ways of working. Stakeholders with economic, legal and policy background should be invited and committed to task shifting initiatives in order to manage the system level enablers.

Figure 2 presents the implementation phases of task shifting. Based on the TaSHI pilots, we could identify eight phases that are needed to carry out to task shifting projects successfully. Phase 1. is the analysis of the current supply and demand to know the precise situation. After the situation analysis, Phase 2. focuses on planning task shifting projects with specific steps to be followed. Phase 3. aims to create and shape the task shifting culture, and Phase 4. discusses the importance of interprofessional and collaborative training. The next ones, Phase 5 and 6 address managing change and experiencing growth. The last phases conclude the lessons learnt after the introduction and run of task shifting projects (Phase 7), and the results of the institutionalisation process. With a successful implementation, we can reach the new normal with task shifting culture embedded into task shifting-supported environment and organisational climate.

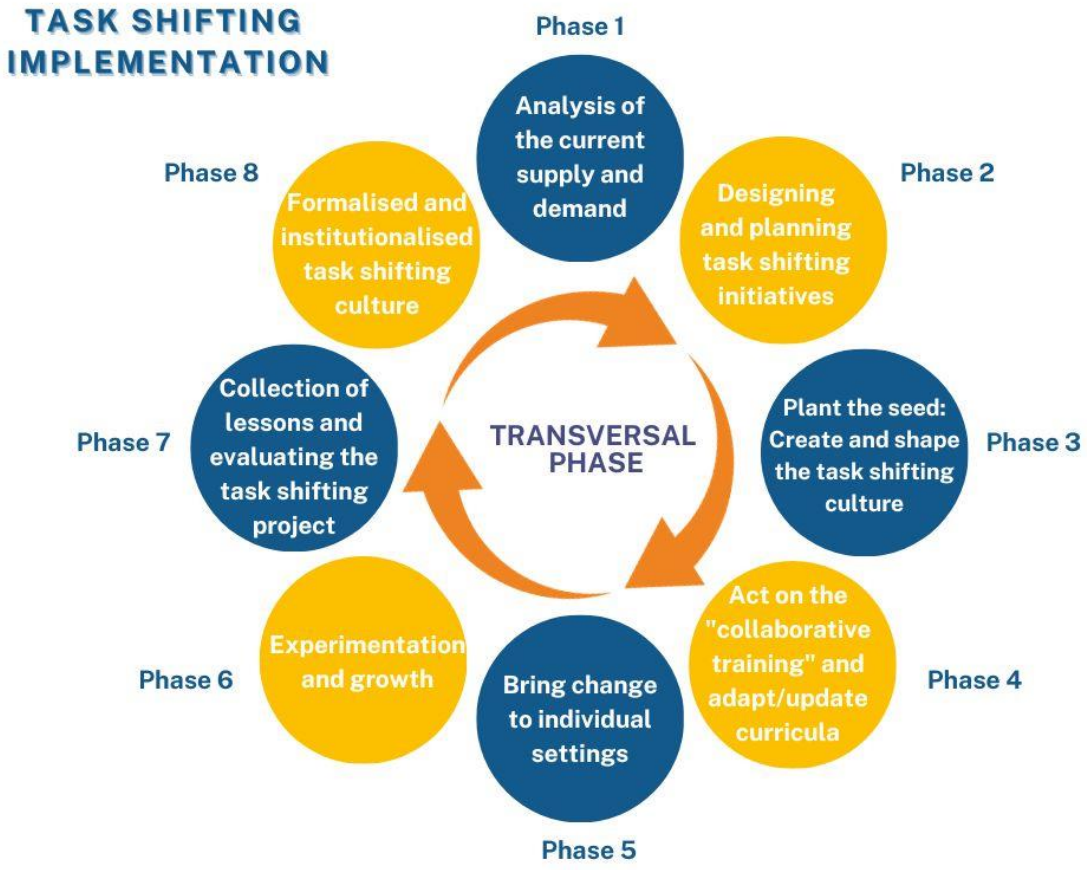

Figure 2 – Task shifting implementation phases

PHASE 1. Analysis of the current supply and demand

In this phase, we start with a health labour market analysis (WHO, 2023). It is important to investigate the health workforce coverage, the numbers and distribution of health professionals in the given setting. Not only the supply side, but also the population needs should be predicted for health consumption. The next step is to evaluate the professional profiles of health professions on-site, which tasks are most performed by professionals and what are the skills in use in the actual scope of practice on a daily basis. In this phase, it is therefore important to know the legislative constraints linked to the skills of professionals (see for example CPD and revalidation regulations). This analysis enables leaders seeing skills mismatches and gaps, skills applied for real, and over- or underskilling in jobs. Tasks that are transferred and shifted are connected to the new real needs of patients and not only to the needs of professionals (JA EUHWF 2016).

Stakeholder involvement: Stakeholder coverage must be considered from the beginning, therefore professional and patient associations must be involved in this phase.

Some methods and tools that could be used in this phase are: analysis of the literature and evidence collection, evaluation of previous studies, existing documentation (e.g. job descriptions) or evidence (e.g. task lists), conducting new qualitative and quantitative data collections (e.g. interview, focus group or survey). Scenario building exercise can support setting up estimates for the future.

Expected results: clear overview about the current situation and explicit needs.

PHASE 2. Designing and planning task shifting initiatives

When planning task shifting projects, some essential steps are recommended to be conducted.

1) Goal setting – at the start, define the intended scope of the task shifting project, define the needs for task shifting, develop and communicate clear objectives, formulate results to achieve in a given timeframe with success criteria and metrics.
2) Choose a suitable leader to coordinate the task shifting project and to create a task shifting-supportive environment and organisational climate.
3) Lay-down system level enablers (legislation, institutional background, training facilities, training materials).
4) Invite stakeholders – organise the stakeholder involvement, including engaging various types of stakeholders. For example, involve institutions in the legislative aspects (such as legal-medical responsibility) and organisational aspects; invite professional associations. Take into account different doubts and perspectives.
5) Calculating resources – when planning a task shifting project, list all key resources. Before the launch of the task shifting project, human, technical and financial resources should be identified and carefully planned.
6) Analyse, monitor and evaluate – Ensure smooth running of the project, work efficiently and productively. Evaluate barriers and facilitators, prepare a risk mitigation plan and documentation.

Stakeholder involvement: policy analysts and health economists can carry out cost-benefit calculations, financing mechanisms, as well as design financial sustainability of task shifting. Project managers play a crucial role in this phase.

Some methods and tools that could be used in this phase are: Gantt chart with activities and schedules or similar project management tools, SWOT and cost analysis, setting up success criteria, process/output/outcome indicators (see for example EC, 2021). These methods support the appropriate design of the task shifting project.

Expected result: well-defined project with well-defined parameters.

PHASE 3. Plant the seed: Create and shape the task shifting culture

In this phase, act on the society of health professionals, triggering a culture of task shifting, where the skills are not necessarily divided by professional profile in a rigid manner with the typical traditional organisation by professional 'silos'. Awareness raising on resilience and knowledge transfer on task shifting should be in place, as well as creating the task shifting-supportive environment and organisational climate. It is highly important to influence cultural sensitivity, as shaping and changing the mindset is a complex task. In this phase, it is necessary to carefully study the flexibility and create clarity, which tasks could be subject to task shifting at all. In this phase, professionals must be questioned to understand what their interpretations, attitudes and needs are regarding ask shifting and new responsibilities and skills. In this phase, it should be emphasised 1) how task shifting impacts individuals' scope of practice, 2) how task shifting can be embedded into care organisation at organisational level, and 3) how task shifting as an innovative tool and strategy can benefit the whole health system.

Stakeholder involvement: in this phase, professionals must necessarily be involved with the addition of policy makers (e.g. ministries of health). Professional and interprofessional associations could enable deeper understanding and impact on readiness, openness and willingness of health professionals towards task shifting.

Some methods and tools that could be used in this phase are: seminars, workshops, general meetings can be useful tools. Awareness raising campaigns can foster the knowledge and understanding of task shifting. Questionnaire survey may serve as an important tool to capture the current mindset of professionals as well as to influence cultural sensitivity on task shifting. See also the newly designed Task Shifting Survey in Annex 1.

Expected results: initiating change for task shifting mindset and culture.

PHASE 4. Act on the "collaborative training" and adapt/update curricula

In this phase, consider university training courses, CPD courses and on-the-job training that include continuous exchanges with current and future professionals. Introduce transversal upskilling to curricula, with a particular focus on task shifting (Sundling et al, forthcoming). “Transversal skills include interpersonal skills, such as person-centred communication, interprofessional teamwork, self-awareness and socio-cultural sensitivity, as well as analytical skills, such as adaptive problem solving to devise customised care for individual persons, system thinking, openness to continuous learning, and the ability to use digital technologies effectively” (OECD, 2021). In fact, we cannot expect steady collaboration and teamwork of professionals, who have been trained separately without ever coming into contact with other professionals. For utilising task shifting the best, we suggest holding interprofessional trainings in accredited/certified courses.

Stakeholder involvement: in this phase, universities, post-academics and educators must necessarily be involved.

Some methods and tools that could be used in this phase are: interprofessional training programmes, seminars, workshops, and inter- and intraprofessional focus group discussions can be useful.

Expected results: identified interprofessional study plans and curricula gaps.

PHASE 5. Bring change to individual settings

In this phase, "internal facilitators" should be selected to foster the impact of change management. At this stage, the objective of the task shifting project and the expected benefits for professionals, healthcare facilities and patients must be explicitly declared and discussed at the setting. The analysis of the stakeholders to be involved must be carried out precisely, so as not to jeopardise the success of the project. The local reality, the setting where the task shifting project is conducted will need to be carefully studied to evaluate and assess the feasibility of the transfer of skills. Rethinking the service provision, changing the way of procedures has a crucial role in this phase. Do not limit yourself to monocentric studies, rather create a network of structures that guarantee similar or homogeneous services. Try to activate multi-centric task shifting initiatives, in centres preferably located in different parts or regions of the country (e.g. North, South, central location, large city and rural context), to better broaden the concept.

Stakeholders involved: in this phase, healthcare providers, leaders and managers are the main target group for involvement.

Some methods and tools that could be used in this phase are: meetings and workshops can help to clarify the needs for reorganising the service provision and document analysis supported by flowcharts can map current procedures in place. Creating networks, horizon scanning and strengthening coordination mechanisms can upscale and exploit task shifting projects.

Expected results: enhanced change at more and more settings.

PHASE 6. Experimentation and growth

In this actual phase, individual professionals test and experiment with new tasks and skills. Evaluate tasks and activities that can already be carried out 1) independently, 2) with supervision, or 3) which cannot be carried out due to lack of training, non-appropriateness to the professional profile or due to legal constraints.

Stakeholders involved: health professionals and patients experiencing task shifting in this phase.

Some methods and tools that could be used in this phase are: qualitative and quantitative feedback techniques, e.g. data collection by questionnaires, interviews. Checklists and newly designed task repositories can be created at on-site training and workshops.

Expected results: task repository.

PHASE 7. Collection of lessons and evaluating task shifting project

From time to time, it is essential to evaluate the task shifting project development. At this stage, after experimentation we suggest a thorough evaluation phase. Collecting experiences and lessons learnt, monitoring metrics and success factors and facilitating dialogue again with all project stakeholders is necessary. In case of positive results, think about the subsequent normalisation of skills, maintaining the tangible factors and enablers for task shifting, and assessing long-term feasibility and sustainability.

Stakeholder involvement: all stakeholder types should be part of this evaluation dialogue.

Some methods and tools that could be used in this phase are: the collection of qualitative and quantitative data, revisiting cost analysis, success criteria, and process/output/outcome indicators can address positive, neutral and negative results. Development needs for the future can be discussed here. Questionnaires can focus on mapping satisfaction of various stakeholders, and focus groups or workshops can reveal how to stabilise task shifting-supported environment and organisational climate.

Expected results: project evaluation, explicit sustainability plan.

PHASE 8. Formalised and institutionalised task shifting culture

In this phase, we face the new normal, meaning health professionals working in interprofessional teams with new skills and tasks acquired, in the new task shifting culture.

The core curriculum and adjusted competences, the regulations and legislative background, the salary increment have to be reviewed. Communication about task shifting including the media can enhance the knowledge on task shifting and bring it closer to the whole health workforce and even non-professionals.

Stakeholder involvement: all stakeholder types should be part of the enhancement and dissemination.

Some methods and tools that could be used in this phase are: monitoring and collecting data can show steady growth of task shifting-related news and media communication. Dissemination methods such as short video content, press releases or posts can assist and enlarge the target audiences.

Expected results: increasing awareness and dialogues about task shifting.

TRANSVERSAL PHASE – Continuous support and monitoring

Support and monitoring are crucial during all phases of the project. The project leader, operative manager and decision maker in health policy must be a present and reference figure, to resolve doubts, barriers, obstacles and scepticism. Managing change in such a complex sector as healthcare is challenging. This is why we place this phase as a transversal phase above all others. The project needs good governance, must be supported and monitored continuously.

There are some transversal activities that are present and necessary in each phase of the implementation: a) clear vision, b) cultural sensitivity, c) stakeholder engagement, d) leadership, e) resources, f) ability for planning and monitoring.

Figure 3 - Transversal elements during task shifting implementation

5. Discussion and conclusion

Based on the experiences of the TaSHI pilot projects, we can conclude the management of task shifting initiatives, which helps us to create a task shifting-supportive environment and organisational climate. The core and unavoidable factor is the open culture towards task shifting. Changing culture – such as shaping the mindset, attitudes and cultural sensitivity - can be influenced and improved, however it requires time.

In task shifting management, the macro-level aspects should always be taken into account, e.g. how national legislation enables or regulates task shifting, how task shifting knowledge and related transversal skills are introduced into education and training programmes, how policy making supports task shifting, how can we enhance the capacity of health workforce policies, and how the outcomes of task shifting can be assessed and improved from time to time.

Task shifting can happen between health professional groups, as well as the increasing involvement of patients and technology is apparent. All of these actors should have a specific knowledge about task shifting in order to maximise its benefits, and additionally they should all be motivated and prepared for it. Application of task shifting must be well-communicated and coordinated, therefore the involvement of various stakeholders plays a decisive role. Task shifting initiatives might be accomplished, if accountability and ownership, that is, compensation and clarity in responsibilities are specified for health professionals receiving or handling over tasks.

In the management of task shifting initiatives, task shifting process itself has a significant function that should be planned, organised, led and controlled.

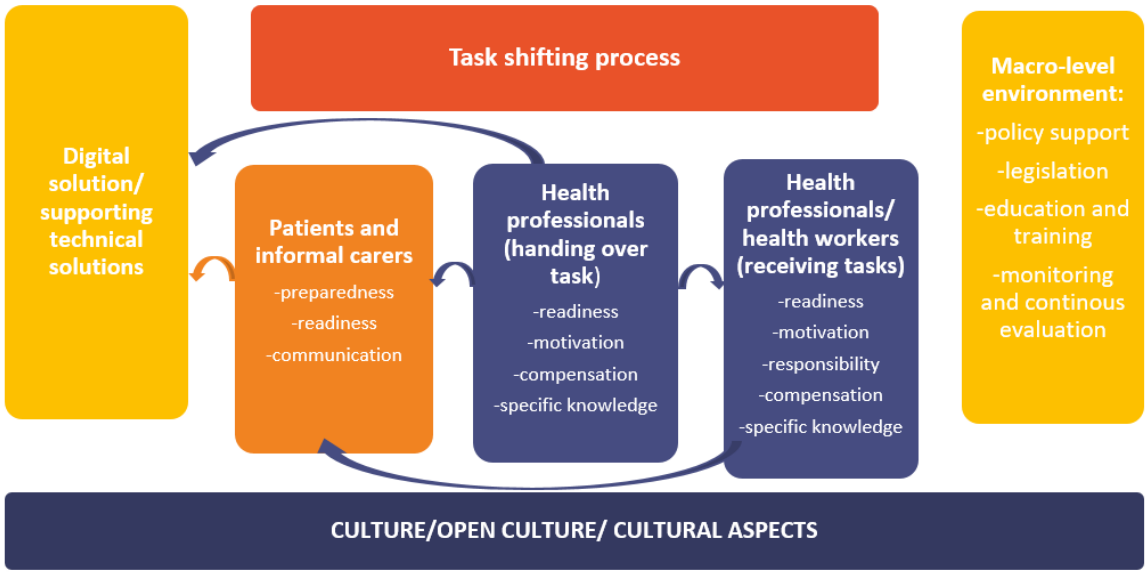

Figure 4 - Management of task shifting initiatives

6. General messages on task shifting in healthcare

The list of key results and messages aims to summarise the overview on task shifting experienced in the TaSHI pilot projects:

- Task shifting practices are often **informally** already present in professionals' daily practice.
- Task shifting offers opportunities not only for **patients** (e.g. increased quality of care) but also for the **professionals**.

- Task shifting can work effectively if the **professional and technological support** are ensured at the workplace and for the professions at macro level, including the ultimate responsibility.
- Suitable **leadership** for managing and controlling change should be set up.
- **Clear processes** (e.g., protocols and guidelines) and **appropriate communication** about task shifting initiatives are necessary.
- Task shifting requires an **attitude, mindset change**, as well as a paradigm shift towards the realisation and recognition of task shifting. Getting prepared and open to task shifting depends on the acceptance.
- In order to maximise the benefits of tsk shifting, a **task shifting-supportive environment and organisational climate** needs to be created. Task shifting should be embedded in the organisation of services.
- Shared understanding of **resource** availability, financial parameters are essential.
- Task shifting should be followed by **compensation mechanisms.** Financial sustainability for task shifting should be ensured.
- **Bottom-up initiatives** might work better than top-down approaches.
- Understanding the **legal aspects** might show the feasibility of task shifting. Legal environment could and should be adjusted accordingly.
- Through **transversal skill development**, professionals can acquire specific knowledge on task shifting. Upskilling is a continuous update of knowledge and skills – either voluntary or mandatory – serves the aims to stay fit to practice.
- Through **interprofessional education**, the various professions can understand more the competences of other professions. This is key in breaking professional silos.
- **Accredited courses** to guarantee a quality of training to harmonise knowledge among healthcare professionals
- Task shifting itself is an **innovative tool and strategy** for policy makers.
- **Stakeholders** should be invited and engaged from the beginning of any task shifting initiative. **Collaboration, co-creation** and developing task shifting together can establish creativity and long-term sustainability.

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8. Annexes

Annex 1 – The TaSHI Survey

TASK SHIFTING IN HEALTH CARE

The questionnaire on task shifting is anonymous and developed for the implementation of the pilot projects of the 3rd Health Programme of the European Union project No. 101018346 "Empowering EU health policies on Task SHIfting" (https://tashiproject.eu/).

The questionnaire aims to explore the knowledge, perception and attitudes of health professionals toward task shifting experiences and practices. Health profession categories can be tailored and further specified fitting the research purposes.

1. Age:
    a) >30
    b) 30-40
    c) 40-50
    d) 50-60
    e) 60<
2. Gender:
    a) female
    b) male
3. Education:
    a) Vocational training
    b) Bachelor's degree
    c) Master's degree
    d) PhD degree
    e) Other

4. City and region: ……..

5. Specialisation:

a) Medical doctor with specialisation (if any):

b) Nurse with specialisation (if any):

c) Pharmacist with specialisation (if any):

d) Dentist with specialisation (if any):

e) Midwife with specialisation (if any):

f) Other

6. Professional experience (the number of years):

a) <5

b) 6-10

c) 11-15

d) 16-20

e) 21-25

f) 26-30

g) >31

7. Professional experience in your current role and position (the number of years):

a) <5

b) 6-10

c) 11-15

d) 16-20

e) 21-25

f) 26-30

g) >31

8. What is your workload?

a) < 0,5 FTE

b) 0,5 - 1 FTE

c) >1 FTE

9. Have you ever heard about task shifting in healthcare?

a) Yes

b) No

10. In case you already knew task shifting, is it because (more than one option is possible):

a) You have been directly involved in a task shifting experience (in primary care institution or hospital)
b) You have not been directly involved, but you have witnessed a task shifting experience
c) You have read and/or heard about it during the academic years
d) You have read and/or heard about it at your workplace
e) The training sessions on the task shifting were organized by your workplace
f) You have read/or heard about it somewhere else
g) Other_____

11. In your opinion, is task shifting would be useful in your professional practice?

a) yes
b) no
c) I do not know.

12. On the basis of your knowledge and/or experience, what do you think about the task shifting between health professionals (more than one option is possible)?

a) It can improve the quality of patient's care
b) It can improve the efficiency of daily procedures, number of patients managed, workflow
c) It is a risky operation
d) It is an unclear operation
e) It is a premature operation in the current context
f) It is an operation which affects roles and professional identities
g) It is a chance to update roles, responsibilities and functions
h) It is an opportunity to explore personnel needs' analysis
i) It is an opportunity to encourage interprofessional collaboration
j) It is an opportunity to face costs
k) It is an opportunity to face understaffing
l) It is an opportunity to resolve unequal workloads or pressures
m) Other_____

13. Please mark the tasks for which you do not have enough time to perform?

a) Care Plan Preparation
b) Assessment of care needs
c) Physical examination
d) Administration
e) Care management
f) Other_____

14. In your opinion, could you perform certain functions assigned to another health profession?

a) Yes, please specify
b) No

15. In which processes of your work do you see a possible task shifting implementation (more than one option is possible)?

a) Clinical practice (diagnostic)
b) Clinical practice (treatment)
c) Clinical practice (rehabilitation)
d) Clinical practice (prevention)
e) Organisational sector (registering patients)
f) Administration sector (filling medical records, writing referrals, prescribing medication)
g) All options listed above
h) Other_____

16. Do you ever have to perform tasks belonging to the scope of practice of another health profession?

a) Yes
b) No

17. If yes, please describe (open question):

18. How often do you have to perform tasks belonging to the scope of practice of another health profession?

a) During each patient visit

b) Several times per shift
c) Once a week
d) Once a month or less
e) Never

19. Please indicate which tasks could be shifted in general to another profession (more than one option is possible):

a) Prescribing health-care supplies/medical equipment for home care
b) Patient consultation
c) Management of healthcare prevention programmes
d) Writing referrals for tests or scans/referring to specialists
e) Prescribing medication/prescription extension
f) Follow-up care/tests/surveillance
g) Health promotion
h) Maternity care
i) Parkinson's disease care
j) Wound care
k) Diabetic care management
l) Follow up patients, who previously were initiated on antiretroviral therapy by doctors
m) Rheumatic diseases care
n) Cardiovascular care
o) Hypertension care
p) Neurological care
q) Cardiovascular risk management
r) Cerebrovascular diseases care
s) Secondary prevention of heart disease
t) Home visits
u) Incontinence care
v) Pain management
w) Dyspepsia management
x) Education and promotion

y) Propose/prescribe hospitalization

z) Other

20. What areas and skills would you like to improve (more than one option is possible)?

a) Prescribing of medications/ prescription extension

b) Prescribing health-care supplies/medical equipment for home care

c) Digital skills (to perform administrative tasks)

d) Digital skills (to perform tasks related to the Electronic Health Services)

e) Wound Care

f) Reporting an ECG

g) Palliative care

h) Neurodegenerative diseases

i) Home care (coordination)

j) Other

21. In your opinion, what measures should be taken to improve competencies (more than one option is possible)?

a) Development of a dedicated education programs

b) Legislative changes

c) Competence development programs

d) Work environment changes

e) Strengthening teamwork activities

f) Other

22. In your opinion, which factors could encourage task shifting dissemination (more than one option is possible)?

a) Increased demand for healthcare

b) Increased number of health care services

c) Health emergencies (e.g. COVID-19)

d) Developments in legislation on nurses' competencies

e) Lack of human resources

f) Changes in the nature of healthcare services

g) Financial/material promotion

h) Non- material promotion

i) Gender balance in work

j) Other

23. In your opinion, which factors could hinder task shifting dissemination (more than one option is possible)?

a) Employees‘ attitudes, work practices, organizational culture, etc.

b) Legislation, regulating competencies of nurses

c) Lack of competencies

d) Lack of human resources

e) Organizational aspects (safety, working relationships with co-workers, psycho-emotional well-being of employees)

f) Patients' expectations/attitudes

g) Technical issues, organizational constraints (no suitable equipment and premises to perform additional tasks, etc.)

h) Other

24. How an institution you are working for (and/or other institutions) could contribute to the task shifting process? (open question):

25. In your opinion, would the task shifting affect your workload?

a) Yes, the workload would increase

b) No, the workload would remain the same

c) Yes, the workload would reduce

26. In your opinion, how would the task shifting affect the quality of services?

a) Yes, the quality of services would improve

b) No, the quality of services would not be affected

c) Yes, the quality of services would be reduced

27. In your opinion, would the task shifting have an impact on reducing patient queues?

a) Yes, patient queues would reduce

b) Patient queues would not decrease

c) Patient queues would increase

28. In your opinion, would the development of nursing competencies help to address the shortage of nurses in the country?

a) Yes
b) No

29. In your opinion, would the task shifting from nurses to nursing assistants help to address the shortage of nurses in the country?

a) Yes
b) No

30. In your opinion, what challenges specialists may face when taking over function? (open question):

31. What is important for effective task shifting (more than one option is possible)?

a) Having access to consult with colleagues / staff
b) Having access to equipment
c) Having access to supplies
d) Quality leadership
e) A sound referral system
f) Proper trainings
g) Doctor-nurse communication
h) Doctor-patient-nurse communication (about shifting and pros – attitude changing)
i) Other

32. What could be the barriers for the task shifting between health professionals? (more than one option is possible)

a) Patients generally feel nurses/nurse assistants are not able to deal with simple conditions
b) Patients prefer/want to consult with certain specialists
c) Lack of training
d) Lack of communication
e) Lack of management (project, culture etc.)
f) Other

33. Would you like to be personally involved in a task shifting initiative?

    a) Yes, please describe how:

    b) I would be more inclined to participate

    c) I would be reluctant to participate

    d) No

34. Please provide your further comments and suggestions below (open question):

Annex 2 - List of identified tasks in Lithuania

The results of the pilot project in Lithuania include the list of tasks, which were delegated from family physicians to nurses and were approved by participants:

- Writing referrals for prevention programmes (including selective mammography screening);
- Management of healthcare prevention programmes;
- Writing referrals for tests (including tests before surgery) or scans/referring to specialists;
- Prescribing medications;
- Prescription extension (if correction not needed);
- Patient consultation on tests results (in case of deviation, refer to the doctor);
- Education and health promotion: patient consultation on healthy lifestyle;
- Assessing memory disorders by taking psychiatric charts/tests (e. g. the mini–mental state examination (MMSE));
- Wound dressing replacement (including independent decision making of changing the applied medicine), wound care / assessment and management (more complicated wounds should be addressed to doctor);
- Stitches removal.

Identified tasks that could be delegated from nurses to nursing assistants:

- Management of healthcare prevention programmes (invitation, registration, ordering structured tests etc.);
- Prescribing health-care supplies/medical equipment for home care (wheelchairs etc.);
- Data collection, preparation, and submission for social care services (determination of disability; compensation for electricity; help providing if patient lives alone; insurance etc.);
- Management of various documentation;
- Helping/accompanying patients who register from smaller cities to institutions based in bigger cities for continuous healthcare services;
- Measuring blood pressure, height, weight;
- Surveys of drinking and smoking (prevention).

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