Creating rural allied health leadership structures using district advisors

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Allied health leadership

- Allied health leadership structures have developed ad hoc over the years
- The district advisor model is a common feature of allied health leadership across the state
- There is limited research on allied health leadership models
- To date the advisor model has not been examined
Advisors in Southern NSW LHD

- Southern NSW LHD commenced in 2011
- Allied health worked as single facilities, single departments or single therapists
- Advisor model of leadership commenced with appointment of 0.21 FTE advisors in
  - Dietetics
  - Occupational Therapy
  - Physiotherapy
  - Social Work
  - Speech Pathology
- Advisors commenced in 2013
The research

- Action research methodology
- Focus group with advisors to create list of:
  - Activities & outputs
  - Outcomes (past & future)
  - Barriers
- Survey of clinicians and managers
- Program logic model to describe model of leadership
Respondents

- Four advisors participated
- Questionnaire responses from 28 clinicians and 1 manager, (overall response rate of 22%)
- Profession response rates 7 - 31%
- Senior clinicians (Level 3-5) more represented than Level 1-2 staff
# Advisor activities

<table>
<thead>
<tr>
<th>Priority</th>
<th>Activity</th>
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</table>
| **High** | Representation and liaison of the profession outside the LHD  
Input into and development of policies, procedures, standards and legislative reviews  
Connecting clinicians to other clinicians  
Support for department heads  
Communicating and facilitating communication within the LHD |
| **Medium** | Support of clinicians, sole therapists and new staff  
Strategic planning such as workforce planning and inter-district agreements  
Input into Human Resources issues (e.g. recruitment, regradings, performance management) |
| **Lower** | Advising on and developing models of care  
Education, professional development and clinical supervision  
Using, accessing and conducting research and evaluation |
## Advisor outputs

<table>
<thead>
<tr>
<th>Output</th>
<th>Total (%)</th>
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<tbody>
<tr>
<td>Contact lists for clinicians</td>
<td>21 (72)</td>
</tr>
<tr>
<td>Discipline intranet site</td>
<td>21 (72)</td>
</tr>
<tr>
<td>Internal reports</td>
<td>21 (72)</td>
</tr>
<tr>
<td>Policy documents</td>
<td>19 (66)</td>
</tr>
<tr>
<td>Practice guidelines and models of care</td>
<td>10 (34)</td>
</tr>
<tr>
<td>Advisor work plans</td>
<td>9 (31)</td>
</tr>
<tr>
<td>Information and summary sheets</td>
<td>7 (24)</td>
</tr>
<tr>
<td>Research reports, presentations or publications</td>
<td>6 (21)</td>
</tr>
<tr>
<td>Responses to ministerial requests</td>
<td>6 (21)</td>
</tr>
<tr>
<td>Workforce planning and modelling documents</td>
<td>2 (7)</td>
</tr>
</tbody>
</table>
Rural Allied Health District Advisor Leadership Model

Situation: Leadership structures in rural allied health have traditionally developed ad hoc in response to historical precedent, perceived need and budgetary considerations. Prior to the appointment of Allied Health District Advisors commencing in 2013 in Southern NSW LHD rural allied health clinicians worked in single roles or within single departments with little scope for coordination, development or strategic alignment of allied health services. Communication including knowledge and resource sharing between clinicians was limited to inform networks. Development of initiatives such as policy and procedure was reactive. It was in this context that the Allied Health District Advisor model of leadership was established.

Inputs

- Staff: District Advisors 1.05 FTE comprising 0.21 FTE in:
  - Dietetics
  - Occupational Therapy
  - Physiotherapy
  - Social Work
  - Speech Pathology
- Funding: Nil specific funding beyond staffing
- Partners: SNSW LHD Allied Health Education
- Evidence: There is evidence that Allied Health District Advisor leadership structures are both necessary and complex. Little evidence exists of a coordinated approach to allied health leadership in rural areas.

State alignments: District advisors are part of a network of similar positions across the state.

Activities

- Activities (presented in order of perceived importance)
  1. Representation and liaison of the profession outside the LHD (e.g. state-wide advisor meetings, meeting with strategic partners such as Enab, liaison with universities)
  2. Input into and development of policies, procedures, standards and legislative reviews
  3. Connecting clinicians to other clinicians (e.g. district meetings, interest groups, linking specialists)
  4. Support for department heads
  5. Communicating and facilitating communication within the LHD (e.g. linking clinicians to managers and executive, information sharing, regular reporting, intranet sites)
  6. Support of clinicians, sole therapists and new staff
  7. Strategic planning such as workforce planning and inter-district agreements
  8. Input into Human Resources issues (e.g. recruitment, regradings, performance management)
  9. Advising on and developing models of care
  10. Education, professional development and clinical supervision
  11. Using, accessing and conducting research and evaluation

Products/services produced (presented in order of reported awareness)

- Contact lists for clinicians
- Discipline intranet site
- Internal reports (e.g. advisor monthly reports, minutes of district meetings, site visit reports)
- Policy documents either complete (e.g. Allied Health Credentialing) or in draft (e.g. Equipment pool policy, dry needling policy and procedure)
- Practice guidelines and models of care (e.g. practice manual, orthopaedic model of care)
- Advisor work plans
- Information and summary sheets (e.g. changes to home mode, info sheet on GP management plans)
- Research reports, presentations or publications (e.g. physiotherapy public-private partnership)
- Responses to ministerial requests
- Workforce planning and modelling documents (e.g. decision memos, staff ratio project reports)

Outputs

- Health Care Consumers
  - Consistency in care (e.g. paediatric services)
  - Better supported staff who are focused on client care
  - A voice for clinicians to raise issues of concern for clients within the LHD
  - Clarification of organisational direction which allows clinicians to provide better information to consumers
  - Advisor involvement to ensure services matched to client and community needs

- Health Care Consumers
  - Creation, finalisation and implementation of Allied Health policy and procedure
  - Equitable access and standard of care across sites
  - Clarification of organisational direction which allows clinicians to provide better information to consumers
  - Advisor involvement to ensure services matched to client and community needs

Outcomes

- Short term (last 1-2 years)
- Medium term (next 1-2 years)
- Long term (next 3+ years)

Organisation

- Increased profile of Allied Health as a whole and individual professions within the LHD
- One point of contact for the profession within the LHD who responds to district-wide issues
- Development of necessary policies and models of care
- Improved cohesiveness and information sharing leading to greater consistency of approach
- Linking with strategic partners outside the LHD
- Representation of the LHD and rural health more broadly at state level

Organisation

- Workforce planning to ensure an equitable strategic approach to Allied Health services
- Development and support of departmental structures and leaders within AH disciplines
- Coordination of service planning and community capacity building
- Linkage with key partners for multidisciplinary care
- Improved profile of Allied Health within the organisation and at executive level
- Enhanced interdisciplinary coordination
- Improved collaboration across LHD boundaries
- A greater voice for rural services at the state level
- Quality improvement coordinated and driven from district level
- Succession planning for the next generation of Allied Health leaders

Assumptions

- There is organisational value in a strategic leadership role for Allied Health disciplines within Southern NSW LHD
- Clinicians and managers want to have an individual within a strategic leadership role for the allied health profession
- An advisor within an advisory position will represent their discipline within and outside of the organisation
- Advisor activities will have an indirect effect on services provided to clients of the organisation
- Advisors will not represent their own profession but will work together as an advisory team to allow for multi-, trans- and interdisciplinary collaboration

Barriers

- Limited time for Advisors to undertake a complex and diverse workload
- Multiple sites to support with a large geographical distance between sites
- Lack of clarity about Advisor roles, duties, boundaries and procedures for Advisor involvement
- Limited resourcing of Advisor roles (reliable work space, consistent contact details, Advisor induction and mentoring)
- Expectations on Advisors to be knowledgeable on every issue related to their profession
- Lack of policy and procedures leading to a reliance on historical precedent for ways of working across sites
- Limited profile and promotion of Advisor roles
Outcomes achieved since advisors appointed

- Clinicians
  Connection. Coordination. Advocacy. Communication

- Clients

- Organisation
  Increased profile. One point of contact. Consistency of approach. Linking with strategic partners. Representation.
Desired outcomes: medium term

- Consumer engagement in service planning
- Workforce planning and strategic service planning
- Service coordination
- Assist with change management
- Increased profile of allied health
Desired outcomes: long term

- Strategically planned workforce with evidence based staff-client ratios
- Increased collaboration across LHD boundaries
- Quality improvement coordinated and driven from district level
- Succession planning for the next generation of Allied Health leaders
- Well functioning and well-resourced Allied Health teams across the LHD
Barriers

- Limited time for a complex and diverse workload
- Multiple sites over a large geographical distance
- Lack of clarity around advisor roles, duties, boundaries and procedures for advisor involvement
- Limited resourcing of advisor roles
- Expectations to be across every issue related to their profession
- Lack of policy and procedures
- Limited profile and promotion of Advisor roles
In a nutshell…

“The advisor roles have been an excellent support for our department and have allowed the advisors to deal with the bigger issues rather than each department individually”.
Conclusions

- Instituting a strategic leadership model has improved communication, cohesion and coordination across the district
- There is a vision for increased high level workforce planning and coordination
- The major barriers to future success of the model are the existing low levels of staffing for advisors and competing workloads
Recommendations

- Advisors use information from this study for workload planning
- Program logic model to be reviewed annually
- LHDs review existing staff profile and consider FTE increases
- LHD consider a structured review of leadership roles in other professions
- Findings of this study shared with other LHDs
Acknowledgments

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