Health
South Eastern Sydney
Local Health District

T23/21359

Allied Health Services and Workforce Review

Report and Findings from Review

April 2023

The Sutherland Hospital &
Community Health Services

Contents

Version	Date	Revised by	Revision reason
0.1	13/7/22	Tayla Vella, SESLHD Graduate Management Trainee	Initial document
0.2	18/10/22	Brielle Gosch	Second draft
1.0	04/04/2023	Brielle Gosch	Further revisions

1 Executive Summary

The role of the Allied Health workforce in NSW Health is to provide services to patients/clients to enhance and maintain function. This workforce includes a diverse grouping of individual professions who work with a multidisciplinary team to support a person's health and wellbeing. At The Sutherland Hospital (TSH), these professions provide services to inpatients, outpatients and community clients. Community services at TSH are provided by the Aged Rehabilitation and Extended Care Team, known as Southcare. As services at TSH have grown and evolved over time, management of inpatient/outpatient and community allied health services has become siloed and aligned with differing workforce models.

This review was prompted by the SESLHD 2021-2022 Business Plan, which highlighted the need for Allied Health workforce structures to support career progression and professional supervision within Nursing and Medical structures. Additionally, TSH's 2021-2022 Business Plan highlights the need for strategies to support hospital access and demand pressure. In February 2022 a graduate management trainee was assigned to work with the Director of Shared Clinical Services to review the TSH AH workforce with the following aims:

- To map current services alongside the Allied Health workforce to evaluate workflow and accessibility while identifying gaps and improvement opportunities in line with the current TSH and SESLHD 2021-2022 Business Plans.
- To map the current Allied Health workforce to determine if processes and governance meet requirements, while exploring discipline advocacy and professional development opportunities, succession planning, clinical supervision and workforce flexibility within service groups.

Consultation occurred with a range of key stakeholders internally, and with an allied health manager at a peer hospital with an alternate workforce model. Findings are split in two main groupings per discipline as per current allied health workforce structures: inpatient/outpatient and Southcare.

In 2022, after consultation for this document was complete, draft versions of NSW Health 'Principles in Allied Health Governance' and SESLHD Allied Health 'Strengthening Allied Health: Guiding Principles' were made available for author review. Findings and recommendations in this document are reported in line with these governance guidelines.

This review found a number of opportunities for allied health services at TSH to align with best practice, with the following themes:

- <u>Workforce models and governance</u>

  Inpatient/outpatient services are organised in a division of allied health model, whereas community services operate in a unit dispersement model. Opportunities to improve strategic, operational, clinical and professional governance were identified.

- <u>Clinical Supervision</u>

  Clinical supervision across the majority of allied health services has been deprioritised as a result of the pandemic and requires a refreshed and coordinated approach.

- Professional Development

  Professional development opportunities available to allied health staff outside of departmental structures are often not allied health specific, and engagement with allied health programs such as BUILD is limited. Participation in quality improvement and research across allied health is varied.

- Workforce Utilisation

  Allied health workforce is in demand. TSH has an opportunity to be an employer of choice, enhancing attraction and retention of skilled staff through specialisation, working at top of scope, rotational skill development programs, and flexibility to achieve 7-day rostering. Recruitment, vacancy and leave management are challenges that effect staff satisfaction.

Recommendations to address these findings include:

- Alignment of all inpatient, outpatient and community allied health staff in a Division of Allied Health model

  Organisation of allied health staff in discipline specific departments within a division of allied health model would enable current gaps in governance to be addressed. This would require an internal matrix of allied health supporting clinical teams in the inpatient, outpatient and community settings.

- Documentation of small team governance processes

  In order to ensure transparency, consistency and safety the clinical, operational and professional governance of small allied health teams or sole practitioners working at TSH must be documented.

- Clinical supervision requirements are identified and monitored

  Compliance with clinical supervision standards should be monitored for each discipline within the TSH allied health workforce to support quality, safety and productivity consistent with SESLHD Allied Health Clinical Supervision Guidelines (SESLHDGL/016).

- Professional development programs are developed and evaluated

  HETI's Allied Health Education and Training Governance Guidelines and associated resources should be used to develop a robust professional development program.

If the above recommendations are endorsed detailed workforce planning and change management support is required.

2 Introduction

2.1 Scope

The aim of this project is to review current allied health services and workforce structures at TSH and identify opportunities for consolidating the contribution of this service, with the following objectives:

- To map current services alongside the Allied Health workforce to evaluate workflow and accessibility while identifying gaps and improvement opportunities in line with the current TSH and SESLHD 2021-2022 Business Plans.
- To map the current Allied Health workforce to determine if processes and governance meet requirements while exploring discipline advocacy and professional development opportunities, succession planning, clinical supervision and workforce flexibility within service groups.

This review included all inpatient, outpatient and community allied health services within the shared clinical services directorate and aged and community care services (Southcare). Allied Health employees working within Mental Health, PaCH and the Aboriginal Health Unit were not in the scope of this review, nor were Administration or Welfare Officers working within TSH services. Medical imaging and pharmacy were also not in scope as these services are managed by the Medical Services Directorate or District Director of Pharmacy. Podiatry was also not included as this service is managed across TSH and SGH.

This report does not aim to evaluate service KPIs and quantitative outcomes and was commissioned to explore the current state of the workforce that deliver TSH services to the Sutherland Shire community in a qualitative manner.

2.2 Background

This review was prompted by the SESLHD 2021-2022 Business Plan, which highlighted the need for Allied Health workforce structures to support career progression and professional supervision. Additionally, TSH's 2021-2022 Business Plan highlights the need for strategies to support hospital access and demand pressure.

Allied health services are widely recognised as providing a significant contribution to improving health outcomes, minimising risk and harm from illness and improving health system efficiency and capacity to meet increased demand cost effectively (Philip, 2015). Stronger Allied Health visibility and advocacy have been highlighted within the literature as a critical, yet underutilised element required to address the changing needs of Australian healthcare systems which are under pressure as a result of population growth, the ageing population and the increased demand for chronic disease management to enable healthy ageing in the community (Department of Health and Human Services, 2016; Gosling, 2019). In addition to this, it should be noted that the growth rate of Allied Health professionals in Australia significantly exceeds that of the medical and nursing profession which needs to be strategically considered when developing new models of care (Boyce, 2021).

TSH is a major metropolitan teaching hospital that sees approximately 50 000 people through the Emergency Department while admitting about 28 000 community members to its 375 beds every year. The hospital supports a range of specialties, with many inpatient and outpatient services available. In addition to this, TSH has community services managed by the Aged

Rehabilitation and Extended Care Team known as Southcare. This service consists of a diverse range of health professionals that support hospital avoidance models of care and health education services that encourage healthy ageing.

Although TSH already has several successful hospital avoidance models of care in place, the number of hospital presentations appears to be increasing. Australian Emergency Department presentations are predicted to continue to increase, with the Australian Bureau of Statistics population modelling demonstrates a marked acceleration after 2030 (Burkett et al., 2017).

TSH Allied Health Services support Inpatient, Outpatient, and Community services working independently and as part of MDTs that provide critical patient care. Although all services are provided as part of TSH, they are separately managed and staffed, with their workforce structures aligning with different models. The two models that TSH Allied Health Services workforce structures align with are the Division of Allied Health Model and the Unit Dispersement Model (Boyce, 2021).

The Division of Allied Health Model (integrated model) includes a Director of Allied Health, who is required to have an Allied Health background and reports directly to an organisation's Executive team, advocating for all other Allied Health disciplines (Boyce, 2021). Each discipline is supported by management pathways that branch from the Director of Allied Health, bolstering discipline advocacy within an integrated Allied Health domain. This model has been described as a "powerful catalyst" enhancing the status of Allied Health within traditional medical models of care (Boyce, 2021).

The Unit Dispersement Model allows the management of Allied Health professionals to be dispersed through an organisation's services, resulting in the non-discipline-specific management of Allied Health employees (Boyce, 2021). Although this model allows for service promotion, it has been suggested to limit discipline advocacy within health organisations (Boyce, 2021).

In July 2022 NSW Health released a draft version of 'Principles of Allied Health Governance'. This document outlines four domains with a number of specific principles to support best practice and effective allied health governance across all NSW Health LHD/SHNs. In August 2022 the SESLHD Allied Health Directorate released a draft version of 'Strengthening Allied Health: Guiding Principles'. These documents are intended to inform and guide allied health service design and development, and act as a blueprint for allied health organisational structures. This review has been analysed against these documents, with recommendations provided in line with the domains and guiding principles.

3 Review Methodology

In February 2022 a graduate management trainee was assigned to work with the Director of Shared Clinical Services on this review by the General Manger of TSH. The review was conducted over seven months and considered the workforce structure of the inpatient, outpatient and community allied health services. Before data collection and mapping process commenced executive stakeholders were consulted to identify and provide details about the review intentions, outcomes and possible recommendations. These stakeholders included the SESLHD Director of Allied Health, and Program 2 Nursing Co-Director and Nurse Manager (Aged, Rehab, Extended Care and Southcare).

Semi-structured interviews were conducted with the Department and Unit Heads within TSH inpatient, outpatient and Southcare services. SESLHD Allied Health Advisors and Discipline Leads were included in the consultation process for support and guidance. Further consultation was undertaken with allied health clinicians working within each service stream. In addition, consultation with Nurse Managers who operationally manage allied health clinicians were conducted. Additional semi-structured interviews were conducted with a sample of TSH Level 3, Level 1/2, and Allied Health Assistant (AHA's) employees. Follow-up meetings to address gaps and questions were coordinated as necessary. The same questions were used throughout the review and can be found in Appendix A.

Consultation with the Director of Allied Health at Hornsby Ku-ring-gai Hospital was undertaken to get an overview of an alternate workforce model in a peer facility.

During the later stages of this report, post consultation with the Allied Health Workforce, the SESLHD Allied Health Guiding Governance Principles (Draft) and Ministry of Health Principles in Allied Health Governance were released and will subsequently be referred to within the recommendations of this report.

The report includes the following sections: key findings, recommendations, discipline specific findings and conclusion. The information noted in discipline specific findings is as per the information described by participants in the semi-structured interviews.

4 Key findings

4.1 Workforce Models and Governance

Workforce structures within TSH Inpatient, Outpatient and Southcare services are varied. Inpatient/outpatient services operate in a division of allied health model, whereas community services operate in a unit dispersement model.

Strategic governance for allied health was clearly identified in the inpatient/outpatient setting, however this was less clear in the community setting, particularly for smaller disciplines.

Operational governance in the community setting was clear in regards to reporting lines for operational and service specific responsibilities, however this was varied in terms of professional reporting specific to the services they deliver and not in line with the principles set out in the SESLHD Guiding Principles draft document. Operational governance was in line with these principles for the inpatient/outpatient allied health staff with the exception of psychology services. Further analysis of rostering and higher grade duties is required.

Clinical governance was generally well embedded in both settings, with good engagement in safety and quality programs (although it was noted that the COVID pandemic had limited opportunities to participate in quality improvement and education and training programs). Some gaps were noted in regards to discipline specific auditing and review in the community setting, and compliance with this in the inpatient/outpatient setting can improve for certain disciplines.

Credentialing is monitored by district workforce services for AHPRA registered professions. Registration is checked during recruitment and annually thereafter. Non-compliance is reported by the line manager to the district director of Allied Health, in addition to the requirements set out in SESLHDPD/191 Allied Health Registration / Enrolment / Authority to Practice. For non-registered professions, credentialling is checked at recruitment.

Performance reviews are an important component of clinical and operational governance. They are important in monitor safe patient care, and continuing professional development. Performance reviews in the community setting do not always include a profession-specific reviewer.

Scope of practice is defined by the discipline's professional body, with governance processes for extended and advanced scope of practice outlined in SESLHDPD/329 Extended and Advanced Clinical Practice Roles for Allied Health Professionals within South Eastern Sydney Local Health District. Some tasks completed by allied health staff in the community setting may be considered extended practice, and do not meet the requirements set out in the policy.

4.2 Clinical Supervision

Clinical Supervision was noted to be offered to Allied Health employees in different formats within TSH and Southcare. Some teams have formal structures in place that support these processes, with varying degrees of engagement reported. Workload was a significant barrier to staff prioritising this practice, despite its importance for staff wellbeing, professional growth, and patient care. In addition, the workload that comes with providing clinical supervision to employees who have different operational reporting lines may impact the delivery of this

practice. Although the HETI Super Guide and SESLHDGL/016 are available to support with structuring elements of clinical supervision, they are inconsistently used.

4.3 Professional Development

Opportunity for and engagement in professional development opportunities varied across disciplines and workplaces. Workload and prioritising patient care was the main reason staff reported they could not engage in professional development opportunities. In inpatient/outpatient AH departments professional development opportunities include both discipline specific and allied health focused content. Community allied health staff have access to a combined professional development program, however this program is disease or impairment focused and does not generally cover the range of each allied health discipline's learning needs. It was also identified that allied health staff in Southcare may be invited to participate in inpatient/outpatient discipline specific professional development opportunities, however this was not consistent across disciplines, and engagement varied. It was also noted that CPD sessions were often replicated for disciplines in the inpatient/outpatient and community settings.

The BUILD program exists to support the development of level 1/2 allied health professionals across a range of domains. This program was developed and is supported by the SESLHD AH Workforce committee. This program is optional with some of the smaller disciplines and disciplines managed within MDTs unaware of the program.

4.4 Other

Southcare Aged and Extended Community Care have an internet page that describes Southcare as an integrated health care centre offering a range of service predominantly for frail people and those with disability living in the Sutherland Shire. The page includes details on each service, referral criteria and contact details. Similarly, the Social Work and Occupational Therapy hospital based departments have internet pages. Outside of these, TSH Allied Health online resources and service information are limited and require updating.

During consultation it was identified that there is limited Allied Health specific patient feedback post admission for a health episode. The Occupational Therapy equipment installation and the Moving into Residential Aged Care videos are an example of information that is valuable and would support enhancing services from the patient perspective.

Hornsby Ku-ring-gai Hospital is a peer B1 hospital to TSH that has transitioned from a unit dispersement workforce model to a division of allied health model. Bronwyn Nolan (Rehabilitation & Aged Care, Allied Health and Outpatients Services Manager, Hornsby Ku-Ring-Gai Health Service) who led the transition was consulted to share experiences in each model and the process of transitioning from one to the other. Ms Nolan reported that the transition to a division of allied health model had been beneficial for their organisation. Advocacy for allied health increased, and staff were satisfied with the new structure. Discipline specific management of resources led to flexibility in service delivery and allowed the allied health leadership team to ensure appropriate governance of allied health staff. Staff continued to work in clinical teams across the service.

5 Recommendations

Alignment of all inpatient, outpatient and community allied health staff in a Division of Allied Health model

Contemporary evidence in allied health workforce leadership, management and development identify a division of allied health as the preferred workforce model for a number of reasons, including:

- Alignment with best practice governance structures for allied health

- Development of unified allied health culture to amplify the influence of AH across the spectrum of integrated care

- Effective management of profession specific risk and adherence to contemporary practice

- Ability to manage professional resources as service needs evolve

- Governance consistency and a clear point of contact for consultation regarding discipline specific policy and strategy

- Advocacy for allied health priorities

- Support for development and growth of the allied health workforce, including succession planning

- Capability development and workforce wellbeing through opportunities to enhance clinical knowledge and expertise across caseloads

- Increased awareness for AH staff of the whole patient journey and a systems approach to care delivery.

Division of allied health models are generally preferred by allied health professionals for the above-mentioned reasons, contributing to staff attraction and retention

Organising allied health staff at TSH in a division model will allow TSH to practice in line with the principles outlined in the NSW Health and SESLHD allied health workforce documents, and address the gaps identified in strategic, clinical, operational and professional governance within TSH allied health services.

Realignment of community allied health into discipline specific departments would need to ensure clear linkages with the Southcare leadership team to ensure the allied health leadership team can enhance allied health operations and service delivery within this service. This would most likely be supported by an integrated decentralisation approach.

Documentation of small team governance processes

In order to ensure transparency, consistency and safety the strategic, clinical, operational and professional governance of small allied health teams or sole practitioners working at TSH must be documented. These include psychology/neuropsychology and exercise physiology.

As services at TSH grow, creation of a psychology department should be considered. Processes for contracted allied health services should also be considered.

Clinical supervision requirements are identified and monitored

Clinical supervision enhances quality, safety and productivity and improves competence and confidence in clinical practice. Strong supervision programs are associated with improved job satisfaction, which can lead to improved staff retention rates (HETI – The Superguide, 2012).

Across a number of disciplines it was identified that clinical supervision is currently inadequate. This was multifactorial, and greatly influenced by the COVID pandemic.

Compliance with clinical supervision guidelines should be monitored for each discipline within the TSH allied health workforce. Review of the HETI Superguide and SESLHD Allied Health Clinical Supervision Guidelines, alongside clinical supervision processes within departments that appear to have successful engagement in this process may be an efficient starting point.

Professional development programs are developed and evaluated

Continuing professional development (CPD) is how health practitioners maintain, improve and broaden their knowledge, expertise and competence, and develop the personal and professional qualities required throughout their professional lives (AHPRA.gov.au). In January 2022 HETI released the revised Allied Health Education and Training Governance Guidelines, which include the following elements: patient driven, clinician focused, leadership, organisational factors, resources. These guidelines support clinicians, managers and senior leader to develop an action plan to meet clinician education and training needs. This framework was first released in 2011 and underpins the SESLHD Clinical Supervision Guideline SESLHDGL/016.

TSH allied health should utilise the above guidelines to develop a robust professional development program. This can be supported by the annual HETI workplace learning grants scheme.

6 Discipline specific findings (as at June 2022)

6.1 Physiotherapy

Inpatient and Outpatient

Workforce

The inpatient and outpatient Physiotherapy team is managed by a full-time Level 6 Head of Department (HOD). The team consists of a temporary Level 4 Educator, multiple Level 3 Clinical Seniors, Level 3 personal re-grade Clinicians, Level 1/2 rotational Physiotherapists, and physio-specific allied health assistants (AHAs).

The Level 6 HOD professionally and operationally manages TSH inpatient and outpatient services and workforce, while additionally having a clinical caseload as the outpatient Musculoskeletal (MSK) Clinical Senior.

A recent business case created a temporary Level 4 Educator position to facilitate increased access to student placements. This was funded through re-grading a Level 1/2 position with student revenue supporting the additional expense. The permanency of this position was yet to be established at the time of this review. This role holds no executive functions outside facilitation of the student placement program within the department.

Level 3 Clinical Seniors provide specialty-specific support in orthopaedics, rehabilitation, neuro/oncology, acute care services, and the Emergency Department. Currently, inpatient aged care services are managed by the Level 3 Acute Care Senior, with the Rehabilitation Senior providing additional support as required.

The Level 1/2 Physiotherapists rotate across clinical areas within the inpatient and outpatient department every four months. In addition, two staff members working within the Level 1/2 rotational positions have been personally regraded as Level 3 Senior Clinicians. They provide specialist advice in line with clinical senior expectations but are not required to manage or supervise staff.

Within the Level 1/2 workforce, two full-time FTE are temporary 12-month graduate roles. Where possible, these graduates are recruited to other roles at the end of their contracts.

In addition, the inpatient team is currently supported by physio-specific AHA's who support patient care, administrative duties, and the delivery of inpatient care plans. There are no AHA's supporting the outpatient program.

The Physiotherapy department also provided weekend services to inpatients based on prioritisation. This service has grown from 3 shifts prior to 2019 to currently 11 shifts a week. There have been minimal enhancements supporting this increase. To support weekend services FTE has been pulled from the weekday services either in terms of a change in shift pattern or weekday staff taking time in lieu arrangements resulting in some shortages throughout the week. There are nil physiotherapy specific AHA shifts rostered on weekends.

In 2017 the Physiotherapy Department received 0.86 FTE Level 3 for a new dedicated Emergency Department role. This was enhanced by 0.68 FTE in 2020. An additional 0.76 FTE Level 1/2 was allocated for General Medicine/RADIUS in 2019.

The inpatient/outpatient service does not share workforce with the community service.

Succession Planning and Professional Development

Please see Appendix B for workforce pathways within TSH inpatient and outpatient departments against the 2021 Allied Health and Allied Health Assistant Awards.

Career progression opportunities within inpatient and outpatient services come up every few years, with positions well sought after. There were no issues with recruitment or retention identified during consultation for this review.

Succession planning opportunities in the form of secondments occasionally become available and are encouraged. Level 3 Clinical Seniors can provide coverage for the HOD during periods of leave, supporting their professional development, however there are currently no development opportunities withing the department between the level 3 clinicians and level 6 HOD. Similar opportunities exist for Level 1/2 clinicians in level 3 roles.

The rotational structure that supports the Level 1/2 workforce promotes the cross-pollination of skills within the team, exposing clinicians to a range of clinical areas and associated professional development opportunities. Although this structure is in place, skill mix and confidence within specialities may still be an area of concern when managing unplanned leave.

The Physiotherapy department attend a team meeting weekly on a Wednesday. Meeting content rotates between group clinical supervision, professional development sessions, wellbeing sessions and team meetings. Professional development sessions were paused during 2021 Covid-19 and were being re-instated at the time of this review.

Casual staff must independently manage their professional development requirements with mandatory training monitored on My Health Learning.

Professional Governance and Operational Management

The Organisational Chart in Appendix C has been updated during this review and outlines current professional governance and operational management structures. TSH Physiotherapists must be registered with AHPRA as part of the Physiotherapy Board of Australia. Clinicians are responsible for meeting registration requirements.

The Level 6 HOD provides performance reviews to the department's Level 3 Clinical Seniors. The Level 3 Clinical Seniors conduct performance reviews for the Level 1/2 Clinicians, graduate staff, and AHA's. Areas of concern are reported back to the Level 6 HOD. Performance reviews are conducted yearly or more frequently as required.

Although workforce structures exist, engagement with these pathways appears to fluctuate amongst teams, with formal monitoring processes unclear. This may be due to workload, time constraints, Covid-19, and staff engagement/performance.

All staff receive weekly department and services update from the Physiotherapy HOD, allowing part-time and casual staff to be kept up to date with management issues. Casual employees are invited to team meetings with participation optional outside of their contractual working hours. Minutes are circulated to ensure staff are kept informed. In addition, casual staff are invited to attend performance reviews at a mutually convenient time for which they are paid.

Clinical Supervision

The Level 6 HOD independently seeks out clinical supervision and can be supported with this by the SESLHD Physiotherapy Advisor. The Level 3 Physiotherapists are supported with clinical supervision by the Level 6 HOD.

The Level 1/2 Inpatient and Outpatient workforce engages in 4 group clinical supervision sessions a year, aiming for one session every three months. Group clinical supervision is led by one of the Level 3 Clinical Seniors and is based on the HETI Super Guide. In the alternate months to group sessions, staff will have individual clinical supervision with their peers. This is opportunistic and can be at the bedside.

Clinical supervision has not occurred during the 2021 Covid-19 Pandemic due to accessibility and workload. As a result, formal clinical supervision was de-prioritised and, at the time of this review, was being re-instated. The clinical supervision structure appears to be in line with clinical case supervision rather than clinical supervision incorporating reflective practice.

Workload and Leave

The Physiotherapy team meets each day to coordinate patient flow and explore leave coverage. This meeting is led by the most senior staff member present. Although this aims to be a Level 3 Clinical Senior, unplanned leave can require Level 1/2 staff to coordinate this.

The Inpatient service manages referrals based on a prioritisation tool supporting the hospital's patient flow processes. During this review, there were mixed representations of workload reported. Covid-19 enhancements were acknowledged as helpful, with these often supporting the management of planned and unplanned leave. Concern was expressed regarding the outcomes related to the prioritisation tool used to manage workload which was suggested to focus more on hospital operations than the delivery of care in line with the Physiotherapy discipline values and motivations.

It was reported by staff that the number of referrals made to the Physiotherapy team did not match the number of staff available to deliver quality-driven care, with some concerns regarding discipline advocacy when bed base changes occur.

The cross-pollination of experience of level 1/2 staff supports unplanned leave coverage while allowing clinicians to take leave simultaneously. Collegial flexibility supports this process. Despite this, there are occasional gaps in skills and availability required to deliver services. Some casual staff can support with short-term contracts. At present, there is no casual pool to support unplanned leave with no backfill funding for such vacancies. Recruitment is currently underway to replete the casual pool.

Services

The integration of the Inpatient and Outpatient workforce into TSH services can be reviewed in Appendix D.

During the Covid-19 Pandemic, Outpatient services were impacted and converted to a telehealth program between 19/7/2021 and 8/9/2021. These services did not resume till 14/3/2022. Most referrals to this service originate from the elective joint replacement list which was impacted when non-essential surgeries were paused during the Covid-19 pandemic. As of April 2022, approximately 200 referrals for these services were outstanding and are being contacted to assess and engage in the program.

Southcare

Workforce

The Southcare Physiotherapy workforce is managed within their respective MDT teams, with operational management not always discipline-specific. There are multiple cost centres associated with the Southcare physiotherapy workforce.

The Community Rehabilitation Team (CRT), Respiratory Coordinated Care Program (RCCP), Southcare Outreach Service (SOS), and Sutherland Transitional Aged Care Service (STACS) have Physiotherapists integrated as part of their MDTs.

The Physiotherapy department workforce consists of a Level 5 Physiotherapy Unit Head, Level 3 Clinical Seniors, Level 1/2 Clinicians, and AHA's.

There are no graduate positions available in Southcare. Student placements are managed by the Unit Head and there is no educator.

There were no concerns regarding recruitment and retention identified within this workforce.

Professional Governance and Operational Management

The professional governance and operational management of the Southcare Physiotherapy clinicians can be viewed in the Organisational Chart provided by Southcare in Appendix E. Southcare Physiotherapists must be registered with AHPRA as part of the Physiotherapy Board of Australia. Clinicians are responsible for meeting registration requirements.

The Nurse Manager of Southcare & Rehabilitation operationally manages the Level 5 Physiotherapy Unit Head. The Physiotherapy Unit Head operationally manages the CRT, SHALT, pulmonary rehabilitation and RCCP services. Additionally, the Physiotherapy HOD operationally manages nurses, Occupational Therapists (OT), Social Workers (SW), and admin staff within the above MDTs. This is not reflected in the Organisational Chart displayed in Appendix E.

The Nurse Managers of STACS and SOS operationally manage Physiotherapists working within their MDTs.

The SESLHD Physiotherapy Advisor professionally manages the Level 5 Unit Head, as is consistent with all Physiotherapy HODs and Unit Heads in the district.

The Level 5 Unit Head conducts the performance review of the Level 3 physiotherapy staff member within the community and pulmonary rehab team. The Level 3 physiotherapist is responsible for the performance reviews of the Level 1/2 staff with any concerns escalated to the Unit Head or line manager. The AHA's within these services are similarly managed by the Level 1/2 staff.

The Physiotherapists operationally managed within SOS and STACS MDTs have their performance reviews with their respective Nurse Managers. The Physiotherapy Unit Head may be invited to attend these meetings to support the professional governance element of performance management processes.

The Level 3 Physiotherapy staff working within the STACS and SOS MDTs conduct the performance reviews for their respective Level 1/2 colleagues within the discipline. The Physiotherapy Unit Head may be invited to attend these reviews.

Southcare Physiotherapists who do not have discipline-specific operational management are encouraged to approach the Physiotherapy Unit Head for professional-based support as required.

The Southcare team have monthly privacy and access audits conducted, alongside quarterly documentation audits within all MDTs to support governance requirements.

Succession Planning and Professional Development

Please see Appendix B for workforce pathways within TSH Southcare team against the 2021 Allied Health and Allied Health Assistant Award.

Limited succession planning opportunities are available within TSH Southcare team. Besides the Unit Head, there are no positions available above a Level 3 Clinical Senior. The nursing profession mostly manages community MDTs with senior AH staff unable to apply for these roles.

There are no rotational opportunities for the Level 1/2 staff to support cross-pollination of skills. Within Physiotherapy, there are opportunities for Level 3 staff to cover for the Unit Head during periods of planned leave. Similarly, these opportunities arise for the Level 1/2 Physiotherapists when Level 3 Senior coverage is required.

The AHA's are encouraged to work across Southcare services to ensure they have a broad understating of the models of care offered. In addition, AHA's can work in the Equipment Pool and across additional administrative tasks to support their development.

Within the Southcare setting, an MDT CPD committee arranges group learning opportunities on a fortnightly-monthly basis. These are not discipline-specific and have been consistently reported to be nursing focused.

Physiotherapists working within the Southcare MDTs can obtain additional competencies including urinalysis and urgent equipment installation. Staff are deemed competent by their discipline-specific peers. Allied Health staff are required to report vital signs back to a CNC for review and clinical direction. Urgent equipment installation is checked by the appropriate discipline the next day.

Vital signs, urinalysis, and equipment installation do not appear to be included in the SESLHD Extended and Advanced Clinical Practice Roles for Allied Health Professionals policy.

Clinical Supervision

The Unit Head can have clinical supervision with the SESLHD Physiotherapy Advisor while additionally having monthly operational supervision with the Nurse Manager of Southcare.

The Unit Head reports providing clinical case supervision to the Level 3 staff on a 1:1 monthly basis.

The Level 1/2 Physiotherapists and AHA's engage in monthly group clinical case supervision. Level 1/2 staff and AHA's report they can seek out 1:1 supervision if they desire. The structure of these sessions is based on the HETI Allied Health Clinical Supervision Modules and content.

A discrepancy exists between the information collected within this review and the structure outlined in the Southcare Allied Health document (July 2021), with variation between staff regarding levels of supervision received.

Workload and Leave

RCCP services have been highlighted as challenging to manage within current FTE provisions. RCCP is a 7-day service consisting of a 0.52 FTE Physiotherapist, 2.8 FTE Nurses,

and 1 FTE admin. This service links in with TSH Inpatient Respiratory Medicine Unit which provides medical support as required.

During the review consultation, no issues were highlighted within the CRT or SOS services Physiotherapy workforce workload. Within the STACS service referrals were highlighted to be consistent due to the number of packages supported by the service with acuity and the complexity of referrals continuing to increase, impacting workload.

The CRT and RCCP teams work with an annual leave roster to support staff in taking leave while services are managed.

STACS and SOS have two of each Allied Health discipline working within each MDT team. They cannot take leave simultaneously to allow for sufficient cover.

There have been issues with having long-term planned leave covered. Unplanned leave is managed between Southcare services.

Services

The Southcare services can be reviewed in Appendix G, which visually depicts a range of patient journeys through services supported by the Physiotherapy discipline.

The current Southcare services supported by the Physiotherapy workforce include CRT, RCCP, STACS, and SOS.

Alternate Workforce Models

Throughout the consultation process of this review, stakeholders were asked about alternate workforce models that may benefit Allied Health Services. The pros and cons of change were explored and considered.

Inpatient, Outpatient and Community Service

A workforce structure that integrates the Inpatient, Outpatient, and Community services may support managing some of the gaps and enhance opportunities mentioned within this review. For example, succession planning, professional development and clinical supervision.

The Inpatient and Outpatient services saw benefits in an integrated model that would enhance their service's engagement with Southcare. This is currently limited due to current workforce structures restricting discipline-specific integration/interaction.

An integrated model may open up additional rotational positions for the Level 1/2 staff within Southcare, promoting the cross-pollination of skills, while encouraging TSH Physiotherapy to be flexible and ready to respond to service needs dynamically. Such flexibility may also support planned and unplanned leave cover. Such rotational opportunities may also support improved communication within the services.

Suggestions were made as to the hierarchical structure that would support an integrated workforce model. Disciplinary advocacy opportunities within an integrated model were highlighted with suggestions made that would include additional senior positions to support the operational and professional management of staff, the expansion of student placement opportunities and associated revenue, and the opportunity to realign the role of the HOD. The HOD would be able to offer an overarching view of the discipline and services to coordinate, allocate and advocate for resources, and guide the strategic movements of the Physiotherapy workforce within TSH service delivery, while streamlining referrals to enhance the patient

journey through TSH services, reducing re-referral processes. The inclusion of such a position across physiotherapy may be a powerful advocacy tool within the organisation, and would be supported by clinical seniors.

The enhancement of communication pathways was also suggested with an integrated team being able to take a collaborative approach to patient care, for example, receipt of referrals and enhanced awareness of the patient journey post-discharge.

It was additionally highlighted that an integrated model (or just enhanced communication) would allow the Inpatient team to have a better understanding of community resources and their wait times which may support referrals and thus prompt hospital discharges.

The cons of an integrated model identified by the Inpatient Outpatient team were the day-to-day management of a larger staff group. The Inpatient team did identify that resource allocation was a concern with staff highlighting they would not want community resources pulled into acute services, as this would impact the values-based care that the discipline is trained to provide.

Southcare Services

Increased advocacy was discussed as a potential benefit of an integrated workforce, though the ability to measure this benefit was raised. The ability to share resources to support and bolster KPI-driven services was identified as a potential benefit, allowing for the flexible use of resources within TSH services.

Concerns were raised regarding the funds that a change process would incur, alongside the introduction of new senior roles within the structure. The benefits of such additions were queried alongside using such funding to directly support service provision by adding in more staff, this was not discipline-specific. At present to obtain funding for additional staff to support service delivery grants must be applied for which are not easy to secure.

In addition, concerns were raised regarding the flexible use of resources an integrated workforce structure may allow. The current structure provides some protection to community resources. A situation where funds for clinicians have been re-purposed and drawn into Inpatient services resulting in a community deficit was reported during consultation. The benefits that may come with shared resources were not felt by the Southcare team, which may be explained by prior experiences mentioned above.

Concerns were also expressed regarding the potential loss of Allied Health Unit Heads managing nurses and other Allied Health Professionals within MDT services. The succession planning opportunities for Unit Heads were highlighted as a positive element of an integrated model that included additional senior positions.

The need for increased communication was highlighted by staff as a con and inefficiency of an integrated model, potentially impacting KPI achievement.

Although rotational opportunities within an integrated workforce would support succession planning and the cross-pollination of skills, concern was raised regarding staff not wanting to work in acute services with community positions being specifically desired by some staff.

The trans-discipline nature of MDT services was highlighted to be impacted by an integrated workforce as Physiotherapists would be pulled into discipline-specific services rather than have the capacity to support their MDT with non-discipline-specific elements of their service provision.

Update March 2023

Recruitment to the district physiotherapy casual pool has concluded, with casual staff now available for rostering.

In 2022 TSH Physiotherapy department received an additional 0.58 FTE as part of the Workforce Initiative funding. This included 0.37 FTE Level 3 to support acute clinical care and 0.21 FTE to transition weekend cover from COVID funding to permanent.

In mid-2022 temporary funding was approved for ED shift times on Saturdays and Sundays to be extended by an additional 2 hours (additional service from 1830-2030) to service the high volume of category 4 and 5 admissions suitable for primary care physiotherapy present in the department at these times. This has proven to be successful with decreased wait and discharge times for this cohort.

6.2 Exercise Physiology

Please note that the Exercise Physiology (EP) consultation process occurred concurrently with the Physiotherapy consultations due to the current workforce alignment within TSH.

There were no EP's working within the Inpatient team at the time of this review. This discipline has been reviewed as one group.

Workforce

Two Level 1/2 EP's work within Southcare and TSH Outpatient services. One works within the Sutherland Heart and Lung Team (SHALT), which is a Southcare service. The other works within the Cardiac Rehabilitation Team (CRT) which is an Outpatient service.

Currently, there is no EP-specific HOD or SESLHD Discipline Advisor. The EP workforce is advocated for within SESLHD by the Lead District EP and the District Director of Allied Health. The Lead EP role is a voluntary position determined internally by the EP Clinical Network (EPCN), which is responsible for coordinating clinical training and functions as a supervisory group. This role is not a paid position and is appointed to a nominated and endorsed EP within the district. This position comes with a workload that is additional to the EPs contractual clinical responsibilities.

Succession Planning and Professional Development

Please see Appendix B for workforce pathways within TSH Outpatient and Southcare teams against the 2021 Allied Health and Allied Health Assistant Award.

The BUILD program is utilised by TSH EP workforce to support succession planning and professional development planning.

Succession planning within the EP workforce is very limited. There are no HOD or management roles that this discipline is eligible to apply for. Within the district, there are 2 Level 3 and one Level 4 EP Clinical Senior positions available, with project management often the next step for this profession within SESLHD. EP's looking to remain in discipline-specific work are required to look for career progression outside of NSW Health. Personal re-grades can be applied for, though the process has been described by interviewees as lengthy and complex.

EPs can self-nominate for the unpaid role of District Discipline Lead as a professional development opportunity when this position is reviewed every 1-2 years.

Within the Southcare setting, an MDT CPD committee arranges group learning opportunities on a fortnightly-monthly basis. The SHALT EP is included in these sessions and reports that although they are interesting, they are not discipline-specific and consistently appear to be more in line with nursing CPD.

The EP Discipline Lead sends out discipline-specific professional development correspondence to TSH EP's. In addition, TSH EP's link in with the District EPCN for discipline-specific professional development. This group meet virtually every quarter and are governed by their own Terms of Reference.

New EP clinicians are identified on commencement are invited to the EPCN.

Professional Governance and Operational Management

The professional governance and operational management of the EP in CRT can be seen in Appendix F. This does not appear to be current with the Level 1/2 CRT EP reporting into the Cardiac Rehabilitation CNC is responsible for this position's performance reviews.

The CRT EP reaches out to the Physiotherapy HOD for professional support as required, despite there being no structure for this.

The professional governance and operational management of the SHALT EP can be viewed in the Organisational Chart in Appendix E and additionally in Appendix F. The SHALT EP is professionally and operationally managed by the Physiotherapy Level 5 HOD. Although these management lines are in place, the Level 1/2 EP independently leads the SHALT service with support from the nursing discipline.

TSH EP's undergo yearly accreditation by their professional body which requires them to provide proof of CPD supporting this discipline's governance. They are linked in with the SESLHD EP Lead for discipline-specific governance updates which come directly from the District Director of Allied Health.

The Southcare team has monthly privacy and access audits conducted alongside quarterly documentation audits within all MDTs to support governance requirements. The SHALT service is included in this.

Clinical Supervision

The SHALT Level 1/2 EP joins the monthly group clinical case supervision with the Physiotherapy discipline. The structure of these sessions is based on the HETI Allied Health Clinical Supervision modules and content.

The CRT Level 1/2 EP has clinical supervision with the Community Physiotherapy HOD. A clinical supervision contract exists for this. This meeting is arranged sporadically and based on a personal offering rather than structure.

The EP's can additionally connect to the District EPCN where they can independently seek out support and clinical supervision to discuss work-related issues, clinical conundrums, and career progression in a safe space. Although this is a good support network they only meet quarterly. Additionally, as EPs become more experienced it can be difficult to find an appropriately aligned peer to have clinical supervision with within this network. This had led to clinicians engaging in co-supervision rather than peer supervision.

When a new EP starts with the services there is no discipline-specific pathway of support, this is currently done on a person-to-person basis.

Workload and Leave

During consultation, no issues were highlighted within the SHALT EPs workload. Despite this, there is very limited EP coverage available, with planned leave taken strategically to support service provisions. Unplanned leave is not covered with a recent block of absence significantly covered by a student that had been on placement for 4 weeks. The Level 3 Pulmonary Rehab Physiotherapist will support SHALT services to allow the EP to take planned leave and do this in conjunction with their services caseload. In addition, the EP will cover planned leave for the Level 3 Pulmonary Rehab Physiotherapist, though they continue to be paid at a Level 1/2 while covering for this service.

The CRT EP has no coverage for planned or unplanned leave. Workload is currently manageable due to the introduction of telehealth/virtual services because of Covid-19 restrictions to face-to-face services. This has provided flexibility for appointments and groups allowing more referrals to be seen at the same time. Before the introduction of this service workload did not allow for non-clinical opportunities to be undertaken such as being the Discipline Lead, clinical supervision, and professional development.

Services

The integration of the EP workforce into TSH services can be reviewed in Appendix H.

There is no current wait list for SHALT referrals with patients being seen within 1-2 weeks. During Covid-19, the SHALT program adapted services to allow for virtual delivery. This supported the continued delivery of services but was at times difficult for patients to engage with due to the technology available and user ability.

CRT offers telehealth/virtual care to support engagement in services. Patients are contacted within 28 days of their referral being made. Referrals are triaged and seen for an assessment within 7 days of initial contact. Telehealth/virtual services have been very helpful and allowed the service to conveniently reach a larger cohort of patients while avoiding unnecessary hospital foot traffic. Pre Covid-19 the CRT team were able to see approximately 250-300 referrals per year which had to be strategically managed to ensure service provisions were met. Post Covid-19 the service can reach approximately 400 referrals a year with the utilisation of telehealth/virtual care. This has been specifically helpful to under 65 patients who are working, allowing them to engage with care from anywhere in the world.

Gaps and Opportunities

Succession planning and career development opportunities were highlighted as a significant gap for this discipline. Extending management positions to this discipline may support succession planning opportunities. Lack of research opportunities driven by the discipline was also suggested to be a gap in furthering hospital avoidance models of care in the chronic care domain. Further exploration into how EP's can contribute to the management of chronic diseases and healthy ageing in the community to support TSH efforts to enhance hospital avoidance models of care may be beneficial. Increased advocacy and education regarding the EP discipline was also identified as a significant opportunity within hospital avoidance models of care, and to support inpatient services to reduce incidence of hospital acquired deconditioning through services to acute wards and exercise programs.

During Covid-19, the SHALT and CRT programs adapted services to allow for virtual delivery. This was highlighted as a potential future service delivery medium, supporting the expansion

of services. Consideration of service group capabilities and virtual health would need to be further explored as this was a challenge during Covid-19 for SHALT service users.

The addition of an EP advocate at TSH was highlighted as a significant need and opportunity for this discipline within Allied Health services and the nursing and medical domain.

Alternate Workforce Structures

Throughout the consultation process of this review, stakeholders were asked about alternate workforce structures that may benefit the services. The pros and cons of change were explored and considered.

Due to the small EP workforce, changes to workforce structure were not seen to have significant impact unless this resulted in additional positions being made available to the EP discipline to support career progression and discipline advocacy. Should the EP workforce continue to align with the Physiotherapy discipline, consideration needs to be taken into opening up HOD roles to both professions.

6.3 Social Work

Inpatient Department

Workforce

At the time of consultation for this review, the Inpatient SW department was engaged in discussions related to a proposed cost-neutral workforce restructure. Therefore, this review is based on the existing structure with considerations for the potential changes shared during consultation.

The Inpatient SW department is managed by the Level 6 SW HOD and currently consists of three teams; Aged Care and Rehabilitation, Critical Care and Medicine, and Women, Children, Oncology, Cardiology, and Neurology.

The Aged Care and Rehabilitation team consists of a Level 4 Team Leader, Level 3 SW Clinical Senior, and several Level 1/2 clinicians. The Critical Care and Medicine team and the Women, Children, Oncology, Cardiology, and Neurology team consist of a Level 3 Team Leader and Level 1/2 clinicians. Level 1/2 positions within this department are not structured to be rotational. The Inpatient SW department has a SW Level 1/2 0.47 FTE to support leave relief; this position was vacant at the time of review. Inpatient SW is additionally supported by an Aboriginal Hospital Liaison Officer and a Level 5 SW Educator, both shared roles between TSH and St George Hospital (SGH). The shared Level 5 Educator supports student placements, education and the Graduate Support program and is allocated to TSH 1 day per week. Student placements within this discipline do not generate revenue. There is no official Graduate SW program within TSH Inpatient department. Despite this, Graduate Level 1/2 staff are often recruited to vacancies. The HOD and the SW Educator facilitate an informal Graduate Support program for these clinicians. The current SW workforce structure has no AHA FTE included.

The proposed restructure will result in the Inpatient SW department consisting of two teams, Aged and Chronic Care and Urgent Care, which two Level 4 Team Leaders will lead. Within each team, Level 3 Clinical Seniors will focus on specialty areas, including aged care, oncology, emergency & disability, and women & children. The FTE contribution for Level 1/2 clinicians will decrease by 3 FTE. In addition, these teams will be supported by a shared 1

FTE of AHA. The leave relief FTE will be enhanced to 0.63 FTE. No other changes were identified.

TSH Inpatient SW department currently provides a weekend service with two 8-hour positions funded for Saturday and Sunday. These positions service aged care and the Emergency Department and will remain the same in the proposed restructure.

In addition, the Inpatient SW department provides TSH with after-hours services. After six months of working within the department, staff are required to contribute to this roster with additional "On Call" in-house training provided by the SW Educator and After-hours Coordinator. The training for this roster is run over multiple days and includes speakers from various services, including Child Protection, The Coroner and Organ Donation. Clinicians can be excluded from this service provision with appropriate medical certification. SW staff from SGH can additionally support TSH SW after-hours roster. Short-staffing impacted TSH after-hours SW service at the time of this review, which is hoped to improve with the proposed restructure and the department having a stable workforce.

The use of casual staff within the weekend and after hour's services has been ceased due to clinical governance concerns.

Succession Planning and Professional Development

Please see Appendix I for TSH Inpatient SW department workforce pathways against the 2021 Allied Health and Allied Health Assistant Award.

Succession planning opportunities within the SW Inpatient department include secondments and higher-grade duties to cover planned and unplanned leave. District-wide secondment opportunities are also available and encouraged, despite the risk of losing good staff to other services. The proposed restructure will increase the number of senior and specialty positions available, which aims to improve succession planning, career progression opportunities and the retention of TSH SW workforce. The current structure has limited succession planning and career progression opportunities for the SW workforce, which may impact turnover rates.

The Inpatient SW department has monthly scheduled professional development sessions, which all staff are to attend. These are on different weekdays to support staff working on part-time contracts. In addition, Level 3 and 4 staff are encouraged to engage in management training and mentoring of less experienced clinicians. There are no official rotational opportunities for the Level 1/2 staff to support the cross-pollination of skills, though this is done informally to support workload.

Level 1/2 clinicians are encouraged to participate in the BUILD program to maximise their capacity and plan for future career goals. They are additionally encouraged to join committees within TSH and the District to provide learning opportunities. Level 1/2 clinicians can also supervise students on clinical placements. Engagement in the after-hours roster additionally supports clinicians' professional development and skill enhancement.

TSH SW Educator runs a journal club several times a year on a face-to-face basis. This has not occurred over the last few years due to Covid-19 restrictions and workload increases. There have been similar ad-hoc sessions run online in collaboration with the Prince of Wales Hospital (POW), but this was not a regular practice at the time of this report.

Although there is a range of professional development opportunities available for staff to pursue, time constraints and workload appear to impact this. Understanding that there is some

expectation for clinicians to drive their professional development independently, the ability to do this outside of working hours is not always possible.

Engagement in professional development opportunities, secondments and acting up duties can be limited for part-time staff due to their working hours/days.

Professional Governance and Operational Management

The current and proposed professional governance and operational management of the Inpatient SW department can be seen in Appendix J.

All TSH Inpatient SW department staff have yearly performance reviews, which are in line with the operational management structure shown in Appendix J. Concerns are escalated to the Level 6 HOD for further consultation.

SW is not required to hold registration with AHPRA or a discipline-specific board. However, TSH ensures all staff have qualifications eligible for membership with the Australian Association of Social Workers (AASW) during the recruitment process. In addition, regular attendance to the SW department's monthly professional development sessions is compulsory, with attendance logs reviewed as a professional governance requirement.

Clinical Supervision

The Level 6 HOD receives clinical supervision from the District SW Advisor and provides clinical supervision to the Level 3 and 4 Team Leaders. The Level 6 HOD allocates staff with a supervisor when they are recruited to the team. After a period, clinicians can request to change supervisors should they feel their learning needs may be better suited to another supervisor. This process is driven by the clinician and must be done in consultation with their current supervisor.

The frequency of clinical supervision sessions is dependent on personal needs and years of experience. Clinical supervision contracts are maintained and include expectations and confidentiality agreements. The supervisee leads these sessions and focuses on clinical challenges, career goals and skill progression. Both parties keep agendas as documentation.

Workload and Leave

The Inpatient SW workload was reported to increase yearly due to the complexity of their cases. Although TSH sees changes within its bed base, SW FTE remains unchanged since the 0.37 FTE enhancement for General Medicine/RADIUS in 2019. The Inpatient SW department manages referrals to the service and workload using a prioritisation tool. The team are required to work dynamically to balance service needs and expectations.

Staff report that the high workload within this department may cause staff turnover, with less experienced staff at risk of burning out and leaving due to this. In addition, although non-clinical opportunities for career development exist, staff lack time to engage due to clinical workload.

Planned leave is strictly managed to support service delivery. A leave diary maintains the coordination of this, which allows for each team to cover their colleagues during periods of planned leave. The leave relief position, which was vacant at the time of this report, additionally supports workload and leave coverage.

A casual pool exists but is not commonly used to support vacancies due to poor staff availability, location, and experience.

Services

The integration of the Inpatient SW workforce into TSH services can be reviewed in Appendix K.

It is important to highlight that the Inpatient SW department has been offering case management-type services to support hospital discharges for patients while they wait for their referrals to be accepted by community services.

Gaps and Opportunities

Through the consultation process of this review, a range of non-clinical professional development opportunities were identified, with staff expressing that workload made it difficult to engage. Embedding these opportunities into workforce practices may support skill acquisition while reducing the incidence of burnout and encouraging staff retention. In addition, finding an adequate space for the team to have professional development sessions was highlighted as a challenge impacting attendance. Many of the current professional development opportunities are difficult to access for part-time staff due to their work days. Introducing new technology may support part-time staff accessing such learning opportunities while broadening audience capacity.

Level 1/2 rotational opportunities were mentioned as a possible option to support the cross-pollination of skills. However, this structure would need to prove efficient due to the department's high workload.

Including AHA's in the proposed restructure was highlighted as a positive method that may support workload. Evaluation of impacts of this workforce addition would need to be conducted to determine the benefits of this workforce inclusion on workload and service provision. Adding AHA's may also prove to be an opportunity to allow the Level 1/2 clinicians to engage in supervisor and mentoring roles.

In addition, communication pathways with TSH Southcare team were highlighted as an opportunity to streamline services. Currently, communication is based on personal relationships and formal handover processes. Suggestions were made regarding the benefits of regular structured meetings that would allow both services to outline their workload and referral wait times while providing each other education on the roles and responsibilities of each service, acknowledging the differences within their work. However, there was some concern regarding the overall benefits of an additional meeting being included within the department's workload. The benefits of integrating the Inpatient and Southcare SW clinicians into one team were suggested to be an alternative which will be discussed in a later section.

There is a gap in service provision for patients under 65 who are not supported by NDIS funding. Due to their referral criteria, it isn't easy to have these referrals accepted by Southcare services. A SW Outpatient team may address this gap while providing enhanced service to support efficient hospital discharge planning. In addition, the Inpatient SW team currently provides a case management service that helps discharge patients while they wait for community referrals to be accepted. This impacts the Inpatient team's workload. In addition, a dedicated seven-day service with the enhancement of senior staff after hours and on weekends was highlighted as an opportunity with current weekend provisions limited.

Flexible work arrangements were also highlighted as an opportunity for staff to have a better work-life balance, which may support burnout prevention and be an attractive workforce

benefits supporting retention. Should a seven-day service eventuate, such workforce models may support the provision of these services.

Southcare

Workforce

The Southcare SW workforce is managed within their respective MDT teams, with operational management not required to be discipline-specific. There are multiple cost centres associated with the Southcare workforce.

The Community SW Team, Southcare Outreach Service (SOS), Sutherland Transitional Aged Care Service (STACS) and Aged Care Assessment Team (ACAT) have SW integrated as part of their teams.

The Level 4 SW Unit Head manages the Community SW team. This team currently consists of Level 3 Clinical Seniors and Level 1/2 clinicians. All positions within this team are part-time. The Acute service's shared Level 5 SW Educator supports community student placements (although this is not part of their responsibilities, it is an agreed way of working). Students are often shared between the Inpatient and Southcare teams due to the part-time nature of the Southcare SW workforce.

Within the Community SW team, a temporary 0.63 FTE Level 3 Research position has been funded through Sphere until 2023 in the aged care space, exploring Advanced Care Directives. This was initially funded as a nursing position, but with advocacy from the SW Unit Head, was recruited by SW.

STACS and SOS are operationally managed by nurses and consist of a Level 3 Clinical Senior and a Level 1/2 clinicians. ACAT, which a nurse manages, has one Level 1/2 SW within their team. It is important to note that ACAT is a federally funded service with ACAT positions requiring further training for disciplines to become assessors or delegates. The ACAT SW did not respond to invitation to participate in this review.

SOS SW supports the SOS weekend service and works on an Allied Health rotating roster for this, supported by nursing colleagues. There were no other weekend SW services within Southcare at the time of this review.

There are no graduate positions within the Southcare for the SW discipline, with management seeking experienced staff during recruitment due to the nature and complexity of their work. No discipline-specific AHA's are working within Southcare SW.

Professional Governance and Operational Management

The current professional governance and operational management of the Southcare SW discipline can be seen in Appendix E. Please note that the temporary Level 3 Research position within the Community SW team has not been added to the Organisation Chart provided during this review.

The Level 4 Unit Head professionally and operationally manages the Community SW team. The Level 4 Unit Head conducts yearly performance reviews for all staff within this team. In addition, Level 3 Clinical Seniors can be present for Level 1/2 clinician's performance reviews where necessary and appropriate.

The Level 4 Unit Head additionally provides professional support to the SW clinicians in STACS and SOS. Clinicians working within these MDTs are operationally managed separately

by the nursing profession. Although these clinicians have yearly performance reviews with their respective nurse managers, the Level 4 SW Unit Head attends these.

SW is not required to hold registration with AHPRA or a discipline-specific board. However, the Southcare service manager is responsible to ensure all staff have an eligible qualification for membership with the Australian Association of Social Workers (AASW) upon recruitment. Membership is not compulsory, but eligibility is at the time of recruitment. In addition, Southcare SW is required to complete Child Protection Training and Abuse of the Older Persons training. Although staff are encouraged to renew this training, there is no requirement to do so post initial completion.

The Social Work Unit Head manages compliance with the above professional governance requirements.

Succession Planning and Professional Development

Succession planning opportunities appear to be available through secondments, which are encouraged and supported. The District SW Advisor sends such opportunities to the Southcare team, which are not limited to SESLHD opportunities. Opportunities come up frequently and are encouraged where they can be facilitated. There were no concerns reported regarding recruitment into vacancies.

Level 3 Clinical Seniors working within the SOS team act up rotationally with other Allied Health Clinical Seniors, providing management coverage on Mondays and Tuesdays to support the CNC3's flexible working arrangements. This opportunity offers the Level 3 Clinical Seniors with MDT management experience, however there is no change in pay rate associated.

The Community SW team have bi-monthly meetings where speakers often present on discipline-specific topics and issues. These meetings also provide a space for quality improvement discussions, committee feedback and other department updates. In addition, clinicians within SOS, STACS and ACAT attend their relevant MDT professional development sessions. These are not discipline-specific.

Social Workers working within Southcare MDTs have the opportunity to obtain Additional Competencies including vital signs (automatic BP, pulse oximeter application, and tympanic thermometer), urinalysis, and urgent equipment installation. Staff are deemed competent by their discipline-specific peers.

Vital signs, urinalysis, and equipment installation do not appear to be included in the SESLHD Extended and Advanced Clinical Practice Roles for Allied Health Professionals policy.

Southcare SW clinicians attend a journal club the Level 5 SW Educator runs when topics are relevant. The frequency of engagement with this opportunity is unclear as the journal club has not been regularly run over the last few years due to workload and Covid-19. The District SW Advisor circulates all relevant professional development information and succession planning opportunities to the SW Unit Head in Southcare.

Southcare SW is encouraged to participate in District-wide and local committees representing the SW discipline and Southcare services. In addition, Southcare SW often represent Health within the Sutherland Shire community delivering professional development education to other services, while participating in community engagement opportunities to build relationships with other services.

Clinicians can externally seek out professional development opportunities in their own time. In addition, there are occasional grants applied for to support staff attending conferences.

Clinical Supervision

The Nurse Manager of Southcare provides non-discipline-specific clinical supervision to the Level 4 Unit Head. The Level 4 Unit Head does not receive discipline-specific clinical supervision. The Level 4 Unit Head ensures all Southcare SW staff receive clinical supervision. Peer clinical supervision, run by the Level 4 Unit Head, occurs monthly for all Level 3 Clinical Senior staff working in Southcare. These sessions are based on an informal structure allowing clinicians to bring complex cases to the meeting for discussion. 1:1 clinical supervision for Level 3 Clinical Seniors does not occur as part of Southcare SW clinical supervision structure. Level 3 Clinical Seniors provide 1:1 clinical supervision to the Level 1/2 staff with frequency dependent on individual needs. STACS and SOS clinicians are included in the above.

The allocation of supervisors and supervisees is reviewed yearly to determine if changes are required. The Level 4 Unit Head will supervise clinicians requiring additional support. Clinical supervision contracts are put in place for 1:1 clinical supervision, which outlines expectations, scope and documentation processes based on the HETI Super Guide's critical reflection templets.

Workload and Leave

A prioritisation tool is used to triage Community SW referrals accordingly. The maximum wait time for a category three referral (non-urgent) within the SW Community team is six weeks. The only time this has been difficult to achieve was during periods of high unplanned leave. The workload can fluctuate due to the service provision not being time-bound or limited to a clinical load capacity. The complexity of cases continues to increase irrespective of FTE, with it being challenging at times to manage new referrals and long-term clients requiring ongoing support to keep them out of the hospital. It was reported to be challenging to count each patient as a number due to their individualised complexities varying the workload.

SOS can take on patients for six weeks diverting admissions from the Emergency Department. The workload is high but is time-bound. After these six weeks, SOS refer patients to the SW Community Team for ongoing support with unresolved goals or longer duration cases such as those awaiting Guardianship appointment. SW positions were introduced into the SOS team three years ago due to the high SW workload other Allied Health clinicians were experiencing, which required ongoing input from Community SW. Due to this, the CNC3 advocated for funding to introduce SW to this hospital avoidance model of care.

There is currently no coverage for unplanned leave, with the SW team in Southcare supporting each other when staff shortages occur. Within the Community SW team, annual leave is negotiable and pre-planned to support service provisions; this was reported as easy to manage with a small team. Due to the Community SW team's close-knit nature, most clinicians understand their colleague's clients, which supports them in managing tasks while other clinicians are absent. High-level and up-to-date documentation additionally supports this.

The Level 3 and Level 1/2 clinicians in SOS and STACS do not take leave simultaneously to allow for service provision. However, for leave requests longer than four weeks, EOIs are circulated to explore short-term secondments to cover this. The Community SW team can also support by prioritising SOS referrals.

Services

The integration of the Southcare SW workforce into TSH services can be reviewed in Appendix L.

Clinicians in the Community SW Team, SOS and STACS, are required to support the "Duty Roster". The Duty Roster acts as an additional community service that takes calls from various services, community members, families and patients in the Shire community. This service supports hospital avoidance by managing SW concerns within the community, providing advice and signposting, supporting hospital avoidance. Although this is a long-standing service, it has no additional funding and is an extra workload for this discipline. A logbook documents this service's activity.

Gaps and Opportunities

During the consultation process of this review, discipline-specific clinical supervision for the Level 4 Unit Head was identified as a gap with their possibly being an opportunity for this position to engage with the District SW Advisor for clinical supervision and strategic support. In addition, group peer clinical supervision for the Level 3 staff may not be sufficient considering the increasing complexity of cases.

Level 3 Clinical Seniors that act up on a Monday and Tuesday to provide management coverage for the CNC3 cannot apply for secondments in this position, despite providing regular coverage, due to the award this position is currently aligned with. Opening this position up to Allied Health employees may be a discipline advocacy opportunity and an opportunity for succession planning and professional development.

Alternate Workforce Structures

Throughout the consultation process of this review, stakeholders were asked about alternate workforce structures that may benefit Allied Health Services workforce. In addition, the pros and cons of change were explored and considered.

Inpatient

Integrating the Inpatient and Southcare SW teams was highlighted as a method of streamlining services and improving communication lines to benefit patient care by allowing for flexible work, related to referrals. Integrating the SW services workforce may additionally open up professional development and succession planning opportunities while allowing for the cross-pollination of skills, shared resources, and opportunities to collaborate on new models of care. The alignment of projects would also be a potential benefit avoiding overlap/inefficiencies while utilising a wider team of experts to troubleshoot clinical and operational issues. Co-working on high-risk clients may also reduce some of the clinical burdens, mitigating burnout risks. In addition, collaborative care for patients may reduce the risk of patients re-presenting to acute services.

Southcare

Shared recruitment processes were highlighted as a potential benefit of an integrated SW department at TSH. Concerns were raised regarding reporting lines and the loss of current management, which was identified as innovative, advocating for Allied Health within the Nursing and Medical structures. The loss of Southcare staff members was highlighted during

a discussion regarding an integrated model or a model that included rotational positions. Staff in the community apply for these positions as career progression or personal preference.

Additional concerns were raised regarding shared funding provisions. It was highlighted that Southcare funding might be prioritised for Inpatient services that can produce supportive quantitative service data, acknowledging that it is difficult to measure hospital avoidance, which is one of the primary Southcare objectives.

Update March 2023

TSH Inpatient SW department has successfully implemented the restructure in 2022, with staffing now aligned with the organisational chart in Appendix J. The revised structure has:

- Improved governance of social work services
- Increased specialised social work positions in oncology, emergency and women's and children's health
- Enhanced safe care for vulnerable patient groups to include the provision of improved inpatient management of National Disability Insurance Scheme (NDIS) matters, and
- Provided a more efficient utilisation of resources

A new workforce model incorporating allied health assistant tasks has also been implemented, currently supporting aged care services.

In 2022 TSH SW department received an additional 0.42 FTE as part of the Workforce Initiative funding. This included 0.37 FTE Level 3 to support aged care services.

SESLHD SW are participating in the Rotational Allied Health Program. This includes 2 positions which roles rotating through several clinical areas across the district. TSH SW have the opportunity to participate in this program if appropriate.

6.4 Occupational Therapy

Inpatient and Outpatient

<u>Workforce</u>

The Inpatient and Outpatient OT department is managed by a Level 8 HOD who is supported by a Level 5 Deputy Department Head/Clinical Lead. The Level 8 HOD position includes 0.5FTE as district Occupational Therapy Advisor. Within this team, there are three subspecialties which are led by Level 3 Clinical Seniors in ACAU, Acute Care and Acute Stroke & Rehabilitation. These teams are supported by Level 1/2 clinicians and AHA's. A Level 4 Student Educator also exists and supports the coordination of student placements. Student placements within this discipline do not create revenue.

Within the Level 1/2 FTE, two part-time staff members have been re-graded as Level 3 Seniors. Level 1/2 clinicians rotate clinical specialities every 9 months to support the cross-pollination of skills. A rotation into Southcare's STACS MDT commenced on the 27th of June 2022 as a new rotational opportunity.

The Inpatient and Outpatient OT Department provide a weekend service in the ACAU, Jara and Killara Rehabilitation units. The department is funded for 12 hours on Saturday and Sunday.

There is no official FTE allocated to Graduate OT positions. Despite this, temporary vacancies and maternity leave opportunities are often recruited by Graduate OTs as these positions appear to be less attractive to experienced staff due to their temporary nature. As a result, the department have piloted a Graduate Rotational Program in collaboration with Mental Health Services as part of their strategy to attract applicants to vacancies. Graduates are recruited on temporary 12-month contracts and have two six-month rotations in Mental Health and Inpatient Outpatient OT services. This pilot program was commenced in September 2021 with evaluation pending at the time of this report.

The OT service received 0.37 FTE enhancement for RADIUS/General Medicine in 2019.

Professional Governance and Operational Management

The Organisational Chart in Appendix M was provided by the Inpatient and Outpatient OT Department and outlines current professional governance and operational management structures. TSH OTs must be registered with AHPRA as part of the OT Board of Australia. Clinicians are responsible for meeting registration requirements, and the HOD reviews registration annually.

Performance reviews are conducted annually. Clinicians have these meetings with the same senior colleague they would have clinical supervision with. Concerns and issues are escalated to the HOD and Deputy for further review and management.

In addition to performance reviews, the OT Inpatient and Outpatient Department run a separate annual meeting with either the HOD or Deputy. Here employees are encouraged to explore work or professional-related experiences that bring them joy or that may be causing them discomfort. These sessions are based on the “Joy at Work & Pebble in Your Shoe” methodology.

The Level 8 HOD, Level 5 Deputy Department Head and all Level 3 Clinical Seniors meet weekly as part of the leadership huddle to plan the workforce for the following week and discuss strategic planning for the department.

Succession Planning and Professional Development

Please see Appendix N for workforce pathways within TSH Inpatient and Outpatient OT Departments against the 2021 Allied Health and Allied Health Assistant Award.

Succession planning opportunities exist within the Inpatient and Outpatient OT department in the form of secondments. EOIs are circulated for these to support equal opportunity. In addition, clinicians are encouraged to participate and represent the department on committees within TSH and the district.

Graduate staff are linked in with a District-Wide OT network which is managed by the District OT Advisor. Within this network monthly, CPD sessions are run with mentoring also provided by the District OT Advisor as part of TSH Graduate OT Program.

The Level 8 HOD and the Level 5 Deputy Department Head email the department with professional development updates and opportunities. In addition, the Inpatient and Outpatient OT Department have at least two half-day in-services every year. The half-day in-services have replaced regular shorter professional development sessions aiming to encourage attendance. Shorter more frequent sessions can be difficult to attend due to competing clinical demands. In addition, there is a District-wide OT event for all clinicians which occurs once a year.

Each speciality team within the Inpatient and Outpatient OT Department have a monthly team meeting. Half of this meeting is dedicated to professional development, case study discussions and journal reviews. Leave, rosters, and data audits are also discussed.

Despite the succession planning and professional development opportunities offered there appears to be limited opportunity for career progression within TSH Inpatient and Outpatient OT Department due to a lack of senior staff turnover. As a result, there is a high turnover of Level 1/2 clinicians, with many moving to larger facilities.

Clinical Supervision

The Level 8 HOD provides clinical supervision to the Level 5 Deputy Department Head with staffing issues and workforce conundrums discussed rather than clinical concerns. This department has a clinical supervision chart that outlines the department's supervisee and supervisor structure. This has not been included in the appendices of this review due to the level of clinician detail on the chart. This chart is updated periodically as changes are made to guide this process.

Clinical supervision for Level 3 Clinical Seniors, Level 1/2 clinicians and AHA's explore clinical issues, ward and department concerns, and ongoing learning and professional development goals. There have been some issues with casual weekend AHA's scheduling in clinical supervision due to availability.

New staff members may initially have clinical supervision fortnightly and progress to monthly sessions as required once they settle into the role. Informal clinical supervision is encouraged with management employing an "open door" policy providing a safe space for staff to seek timely support. In addition, management encourages staff to reach out to peers within SESLHD for speciality advice they may not be able to provide.

As mentioned, each speciality team within the Inpatient and Outpatient OT Department have a monthly team meeting, half of this meeting is dedicated to peer supervision where issues impacting the team are discussed.

Workload and Leave

Within the Inpatient and Outpatient OT department, an annual leave calendar is released three months in advance and relies upon staff roster requests. Leave requested after the cut-off date may not be approved with only one clinician within each speciality team being able to have leave at any given time. This system works well when the team has no vacant FTE and before Covid-19. Staffing can become tight at times when staff are on planned leave and unplanned leave simultaneously occurs. There is no backfill or leave cover provisions for this team. The workload is absorbed by colleagues during periods of leave. One or two days of unplanned leave can be absorbed, more than this puts pressure on the department.

The workload is managed using appropriate prioritisation tools that consider who is going home in the next 48 hours, who needs a home visit to support discharge planning, urgent therapy, and pressure area care. AHA's support with lower priority referrals. During periods of unplanned leave Inpatient and Outpatient groups may need to be cancelled.

A short morning huddle is held within each team to review new referrals and coordinate staffing to support the workload. Due to skill cross-pollination staff can be flexed across teams to support during times of high demand or inadequate staffing to meet hospital needs. Level 3

Clinical Seniors will touch base with teams covering unplanned leave during the day to provide support as required.

Services

The integration of the Inpatient and Outpatient OT workforce into TSH services can be reviewed in Appendix O.

Temporary Covid-19 funding supported the Inpatient and Outpatient OT department providing TSH with a time-limited post-acute outpatient service that reduces inpatient length of stay. This funding has ceased, but the department continues to routinely follow up with post-acute patients after they leave the hospital. Data provided by the department indicates that this service uses approximately 10 hours of workforce FTE a month.

TSH Inpatient and Outpatient department has 0.5 FTE allocated to Outpatient services. Referral into this service is supported by a clinical business rule. This is not a discrete workforce with staff managing inpatient and outpatient responsibilities.

Patients requiring Outpatient input from multiple disciplines are referred to Rose Cottage as this provides patients with a MDT.

TSH Inpatient and Outpatient departments have recently had additional training to support people presenting to the Emergency Department with Benign Paroxysmal Positional Vertigo (BPPV). This will support the development of an Outpatient clinic and a hospital avoidance model of care. The current 0.5 FTE allocated to Outpatient services will support this but will need to be monitored to ensure the workload is suitable for service delivery under the current FTE.

A Level 3 Clinical Senior 0.1 FTE position has been temporarily funded till June 2024 to provide Outpatient lymphedema services. This service supports the prevention of lymphedema post breast cancer treatment/diagnosis. If patients present with lymphedema, they are referred to SGH for specialty services, as this provision is not available at TSH.

Gaps and Opportunities

Stroke presentations to TSH have significantly increased in the last 2 years. The increase in presentations has also come with an increase in patient acuity and complexity. The OT FTE is unable to meet the needs of this demand resulting in delayed therapy which may impact patient outcomes. It was suggested that this may be rectified by including an AHA into this service at 1 FTE to increase the availability of therapy time. The AHA could develop their skills in OT, Physiotherapy and Speech Pathology to specifically support stroke services rather than a discrete discipline. This inclusion would also enhance the professional development opportunities for the AHA workforce. In addition, it may be of benefit to the department if there was a dedicated Level 3 Clinical Senior position at 0.5 FTE rather than having this specialty combined with Rehabilitation Services. TSH Inpatient and Outpatient OT department reported they are unable to meet current stroke guidelines which indicate all patients must be seen by an OT within the first 24 hours of their admission. The aforementioned opportunities as well as true 7-day services would support the department in meeting these requirements.

There appear to be gaps within TSH Oncology Outpatient services and Palliative Care services with it reported that TSH is not meeting current evidence-based guidelines in this space. It was reported that SGH and POW recently received funding as part of the Embedded

Care Program to support advancing these services. TSH was not included in this. There is also a deficit in OT presence in the Emergency Department due to workforce capacity.

With consideration for TSH Theatre Re-Development as a high-volume short stay unit, a pre-rehabilitation model of care was highlighted during consultation to enhance outcomes. The Enhanced Recovery After Surgery (ERAS) approach may support this and allow for comprehensive pre-assessments to be coordinated by Allied Health to ensure patients have robust plans and support in place for their discharge and recovery before surgery, reducing post-op hospital admission durations.

Communication with the Southcare OT services was identified as a gap during consultation. To rectify this gap quarterly inter-service meetings have commenced and aim to provide a space where the teams can work on better understanding each other's services by discussing waitlists, referral pathways and barriers to service delivery. This meeting has been introduced based on personal relationships with there being no hospital requirements or governance structures related to this. In addition, Southcare wait times for referrals were highlighted as a significant barrier for the Inpatient and Outpatient OT Department. There have been issues with having patients accepted to Southcare due to referral criteria which leaves some patients without support acknowledging that some of this is due to the My Aged Care referral process.

The Inpatient and Outpatient OT Department has multiple Level 3 Personal Regrade staff and although they bring senior knowledge to the team, they do not have any management or clinical supervision responsibilities. There may be an opportunity to provide these staff with opportunities to engage in such responsibilities as Level 3 Clinical Seniors, should additional positions become available.

The potential use of an Allied Health Educator working across TSH Allied Health Services was mentioned as a possible efficiency supporting professional development opportunities and the management of graduate employees and students.

During the heightened period of the Covid-19 Pandemic, AHA's were onboarded very quickly with limited orientation due to the demand of the health system at the time. There has been some opportunity to backtrack and provide training, but this may need to be reviewed to ensure all AHA's onboarded at this time are competent and confident within their roles and the required tasks.

Southcare

Workforce

The Southcare OT workforce are managed within their respective MDT teams, with operational management not required to be discipline-specific. There are multiple cost centres associated with the Southcare OT workforce.

The Community OT Team, Southcare Outreach Service (SOS) and Sutherland Transitional Aged Care Service (STACS) have OTs integrated as part of their teams.

The Community OT Team is managed by a part-time OT Level 5 Unit Head and consists of one part-time Level 3 Clinical Senior, multiple Level 1/2 clinicians and one AHA. The OT to AHA ratio within this team was reported to be sufficient with AHA workload limited due to the service this team offers.

The SOS and STACS services have Level 3 Clinical Seniors and Level 1/2 clinicians as part of their MDTs. There are no OT specific AHA's working within these services with Assistants in Nursing (AIN's) supporting these teams.

OT weekend services are limited to the SOS Team, as part of this MDT's rotating weekend roster where Allied Health Clinicians rotate alongside their nursing colleagues.

Permanent positions within the Southcare OT team do not come up frequently with temporary contracts more common due to temporarily funded positions, maternity leave and part time working arrangements. As a result, these positions can be difficult to recruit to, leaving vacancies unfilled. The Inpatient and Outpatient OT team have supported with unfilled vacancies in the past where they have had the capacity to do so. Although this support has been appreciated there have been some issues with staff being pulled back into acute services to meet demands in their substantiative positions.

Professional Governance and Operational Management

The Organisational Chart in Appendix E was provided by the Southcare OT Department and outlines current professional governance and operational management structures. Southcare OT's must be registered with AHPRA as part of the OT Board of Australia. Clinicians are responsible for meeting registration requirements.

Within the Community OT team weekly team meetings occur for operational purposes with case reviews conducted. The day of the week this meeting is held on rotates to allow for part-time staff to regularly attend. All OTs in Southcare meet monthly for a business meeting which there is an agenda for, and minutes are circulated.

Within STACS and SOS, OTs seek support from their nurse managers for operational support including leave approval, service issues, staff member concerns and equipment. Staff are encouraged to reach out to the Level 5 Unit Head for discipline-specific support.

Performance reviews are conducted yearly and done so within clinician's respective teams. The Level 5 Unit Head has their performance review with the Nurse Manager of Southcare. Within the Community OT team, the Level 5 Unit Head and the Level 3 Clinical Senior conduct the performance reviews for all staff.

OTs working within the STACS and SOS MDTs have their performance reviews with their respective nurse managers. The Level 5 OT Unit Head attends the STACS and SOS Level 3 Clinical Seniors performance reviews for discipline-specific support. The Level 3 Clinical Seniors within each of these MDT's do this for the Level 1/2 clinicians' performance reviews.

Succession Planning and Professional Development

Please see Appendix N for workforce pathways within the Southcare OT Department against the 2021 Allied Health and Allied Health Assistant Award.

Succession planning opportunities for the OT's working within Community OT, SOS and STACS appear to be limited to discipline-specific secondments. There are no succession planning or career development opportunities within Southcare for the Level 5 Unit Head. Level 3 Clinical Seniors can act up or apply for secondments to the Level 5 Unit Head role when they become available, which is not often due to the part time nature of the role and funding limitations. Level 3 Clinical Seniors working within the SOS MDT may have professional development opportunities allowing them to act up and provide their MDT with short term CNC3 management coverage. At the time of this report Allied Health professionals

were not eligible to apply for secondments for this position due to the award the position is aligned with.

Level 1/2 clinicians can apply for Level 3 secondments as they become available. In addition, Level 1/2 clinicians are encouraged to participate in local and district wide committees. Where appropriate this group of staff are also included in roster management, high level admin and supervision of AHA's.

AHA's are supported to learn new skills within the department and trained in admin, the equipment pool and discipline-specific tasks. Due to the junior nature of employees attracted to AHA positions, workplace skill development is also prioritised.

All staff are encouraged to attend the monthly Southcare CPD sessions which are not discipline-specific. In addition, all OTs in Southcare attend a discipline-specific monthly CPD sessions where staff can present on topics or external speakers provide education. The inclusion of all Southcare OTs to this professional development meeting was highlighted as a successful method keeping the OTs connected. All staff are invited to district OT events with Level 1/2 clinicians and AHA's are encouraged to attend the Southcare OT journal club which occurs twice a year. The Inpatient and Outpatient team is not invited to this.

Occupational Therapists working within Southcare MDTs can obtain additional competencies including taking vital signs (automatic BP, pulse oximeter application, and tympanic thermometer) and urinalysis. Allied Health staff are required to report urinalysis back to a CNC for review and clinical direction.

Urinalysis do not appear to be included in the SESLHD Extended and Advanced Clinical Practice Roles for Allied Health Professionals policy, although sample collection would be considered in scope.

The BUILD program is available for all Allied Health professionals working within TSH and its services. Despite the availability of this program staff lacking discipline-specific operational management appears to have limited exposure to this with discipline-specific colleagues introducing the program once personal relationships have been formed.

Clinical Supervision

The Level 5 Unit Head managing the Community OT Team has access to the SESLHD OT Advisor for professional support and is a member of the SESLHD OT Leadership Team. Informal clinical supervision occurs as required with nursing management. The Level 3 Clinical Senior within this team gets 1:1 clinical supervision from the Level 5 Unit Head on a monthly or bimonthly basis. The Level 5 Unit Head and the Level 3 Clinical Seniors provide 1:1 monthly clinical supervision to the Level 1/2 clinical supervision. The Level 5 Unit Head provides this to the AHA.

Clinical supervision sessions within this department include KPI reviews, quality improvement, HR issues, clinical concerns, and coaching conversations. Any issues or concerns from these meetings are escalated up appropriately. A proforma is used to guide these sessions and keep records. There are no supervision contracts in place for clinical supervision to outline expectations, though a supervision sheet is kept for documentation purposes.

Level 1/2 clinicals working within the STACS and SOS MDTs have clinical supervision with their respective Level 3 Clinical Seniors. The Level 3 Clinical Seniors engage in clinical supervision with the Level 5 OT Unit Head.

All OTs working within Southcare are encouraged to seek out discipline-specific support from the OT Level 5 Unit Head as required.

Workload and Leave

The current wait time for non-urgent referrals to the Community OT team is 14-18 weeks. The largest proportion of referrals coming into these services are non-urgent and less acute which additionally increases the backlog. This wait list has grown recently due to workforce limitations, the aging community in the Shire area and the increasing number of referrals received by the services from My Aged Care during the Pandemic. It is important to note that My Aged Care had stopped face to face assessments for a period due to Covid-19 which may have contributed to the increase in referrals made. Additionally, during this time it was reported that the number of inappropriate referrals made by My Aged Care increased. Referrals are triaged via a prioritisation system to ensure urgent referrals are seen within 1-2 weeks. TSH Inpatient services can directly refer through EMR with post-acute care prioritised where needed.

Unplanned leave within the Community OT team results in appointments being re-scheduled and re-prioritised. Those that need to be seen will be handed over with the workload absorbed by colleagues. Planned leave is coordinated so that coverage is adequate, longer periods of leave are advertised as secondments. Clinicians will consolidate their caseloads prior to periods of leave and hand tasks over accordingly.

The STACS workload fluctuates but overall is manageable when the workforce is fully recruited to and staff are not on leave. Engaging in additional tasks and professional development opportunities can be difficult to find the time for, due to clinical obligations. To meet KPIs, clients in the 3-month program are seen once a week, with clinicians seeing 3 clients a day on average. The STACS team must absorb workload when unplanned and planned leave occurs which can result in services being pulled back. There is no cover allocated for this service. When the Level 3 Clinical Senior is absent the Level 1/2 clinician supports their clinical workload. Level 1/2 clinicians do not absorb management tasks as the duration of leave is unlikely to be long enough for this to be required.

It is difficult for OTs in the Community team to support STACS and SOS MDTs during periods of unplanned leave due to the differences within services being offered, which is reported to be quite different. There is no opportunity for skill cross-pollination within Southcare OTs, therefore skills may not align, and cover may be inefficient considering the Community OT waitlist.

Services

The integration of the Southcare OT workforce into TSH services can be reviewed in Appendix O.

The current Southcare services supported by the OT discipline include Community OT, SOS and STACS. Referral criteria apply.

Gaps and Opportunities

During consultation it was identified that the referral and intake system within the Community OT team may benefit from an upgrade. Currently TSH inpatient teams make referrals via EMR. Anyone else making a referral into this service will need to go through intake where the referral is done on paper. Waitlists for this service are coordinated via a paper system.

In addition, it was highlighted that navigating My Aged Care was very tricky for the ageing population (especially for those without family support). The Community OT's and AHA spend a lot of time guiding people through this complex system, which is required for service funding. This takes up a large portion of clinician's time. Suggestions were made regarding a dedicated staff member to support with this process which may support reducing service wait times. In addition, this role may reduce the number of incorrect referrals received while supporting patients navigate My Aged Care coding errors on referrals. A Welfare Officer does exist within Southcare SW and can at times help in this domain, but due to their workload they can not prioritise this.

The STACS services does not currently have any OT specific AHA's, nor do SOS. The team utilises the AIN workforce to support with personal care. The inclusion of AHA's into this workforce should be considered in future as they would be able to support with personal care while delivering Allied Health discipline-specific treatment plans increasing patients therapy time and access to services.

Increased communication with TSH OT Inpatient and Outpatient Department was highlighted as an opportunity to learn from each other and better understand each other's roles, barriers to services delivery and discipline-specific information.

Alternate Workforce Structures

Throughout the consultation process of this review, stakeholders were asked about alternate workforce structures that may benefit Allied Health Services workforce. The pros and cons of change were explored and considered.

Inpatient and Outpatient

The Inpatient and Outpatient team saw multiple benefits to an integrated workforce model, suggesting this may help both services with workforce supply and service demand. An integrated model may also open succession planning and career development opportunities. Patient referral may be streamlined supporting service accessibility, while the allocation of resources as one team may prove to be an efficiency. Optimisation of the patient's journey could be provided by a seamless OT service with continuity of care from community to hospital and back to the community.

Reflecting on the demands of Covid-19 an integrated model may support the OT disciplines future response to crisis as the team would be one cohesive unit with discipline-specific priorities.

The challenges to an integrated model may be the physical location of each service and clinician's expertise and skills.

Southcare

OTs in Southcare were able to provide historical interpretations of previous workforce structures. There were no significant benefits identified to having an integrated workforce model. Clinicians felt that the current structure was working well but that there was room to make some changes to strengthen this for the discipline.

Update March 2023

In 2022 TSH OT department received an additional 0.63 FTE as part of the Workforce Initiative funding. This included 0.47 FTE Level 3 to enhance their comprehensive care role, 0.05 FTE

Level 1/2 and 0.11 FTE AHA to enhance weekend services. In 2023, existing FTE was reallocated to a senior palliative care role in anticipation of palliative care funding, and the temporary reduction in rehabilitation bed base.

6.5 Dietetics

Inpatient and Outpatient

Workforce

TSH Inpatient and Outpatient Dietetics department is managed by a Level 5 Head of Department. This role is currently job shared with an FTE split of 0.4/0.6. The team consists of a Level 3 Clinical Senior, multiple Level 1/2 clinicians, and discipline-specific AHA's. This team is additionally supported by a Dietetics Office Coordinator contracted at 0.5 FTE (AO5). There are no Graduate positions allocated within this team.

Within the Level 1/2 workforce, 0.21 FTE is allocated to the Garrawarra Centre. This clinician is often required to support TSH workload in periods of unplanned leave.

The Inpatient and Outpatient Dietetics department provides TSH with a weekend service which is staffed by AHA's and allows the department to offer a seven-day service with screening, education and supplement reviews conducted. AHA's are emailed by Dietitians working during the week before the weekend with a priority list to guide their workload. A casual pool of AHA's is available to support this service in times of leave, but utilisation is dependent on budget.

Succession Planning and Professional Development

Please see Appendix P for workforce pathways within TSH Inpatient and Outpatient Dietetics Department against the 2021 Allied Health and Allied Health Assistant Award.

Succession planning opportunities within the Inpatient and Outpatient Dietetics department exist, but due to the small workforce structure, there are limited career progression opportunities. The small workforce structure exposes Level 1/2 clinicians to many non-clinical opportunities in which they may not have had the opportunity to engage in if they were in a larger team. As a result, the department sees a high turnover of Level 1/2 staff, with staff moving to larger facilities for more senior opportunities. Secondment opportunities are circulated and encouraged as they become available.

Clinicians working in the Inpatient and Outpatient Dietetics Department can be upskilled in speciality areas such as paediatrics, renal, eating disorders, enteral feeding, residential aged care, oncology, surgery and CCM. Training in these areas requires clinicians to shadow specialised staff. This opportunity is not always available due to workload and availability.

Within the department, a monthly professional development session is organised by the Level 3 Clinical Senior. All Dietitians rotate through to present a topic of interest to the discipline. External speakers or staff from speciality areas with TSH may also present at these sessions. AHA's do not attend these sessions unless they are relevant or based on team building as they have their own professional development meetings. In addition, webinars get sent out by the HODs from professional affiliations. Staff also seek out independent professional development and education. Level 1/2 clinicians are encouraged to participate in the BUILD program.

Although professional development opportunities exist within the department this may not be prioritised due to workload and competing demands within management and the clinical team.

Professional Governance and Operational Management

The current professional governance and operational management of the Inpatient and Outpatient Dietetics Department can be seen in the Organisational Chart provided by the department in Appendix Q.

The Level 5 HOD's conduct yearly performance reviews for all staff. The Level 3 Clinical Senior has conducted these meetings for the AHA workforce in the past.

Dietitians are not required to hold registration with AHPRA or a discipline-specific board. TSH ensure all staff hold qualifications that are eligible for membership with Dietitians Australia. Membership is not compulsory, but eligibility is at the time of recruitment. An attendance record for professional development sessions is maintained with the expectation that staff comply with an 80% attendance rate. Failure to do so is managed by the HOD's. In addition, staff are required to identify professional learning goals as part of their performance reviews. These goals are managed and reflected upon to ensure staff are engaged in contemporary discipline-specific education.

Clinical Supervision

Within the Inpatient and Outpatient Dietetics department there are two clinical supervision structures. The Level 3 Clinical Senior is responsible for ensuring all staff within the department are engaged in clinical supervision, in consultation with the HOD.

Staff that have been in the department for five years or more attend monthly group peer clinical supervision. HOD's are excluded from these sessions. Senior staff in Southcare and the Diabetes Centre are invited to attend. A clinical supervision agreement is in place with minutes taken as a record of the sessions. A structure for these meetings has been created by the HODs to support the flow of sessions and is reviewed yearly to ensure its fit for purpose. Attendees rotate responsibilities with one person bringing a topic to discuss which may focus on a discipline-specific issue or a quality improvement area. This discussion also provides a place for clinicians to discuss clinical relationship issues, troubleshoot clinical issues and debrief. The quality of these sessions has been described as "varied" due to the attendee's participation and expectations of the sessions. Experienced staff often seek out speciality-specific support from district-wide peers.

Staff who have less than five years of experience within the team have 1:1 clinical supervision with experienced dietitians within the department. These sessions are based on the HETI Super Guide and occur every 4-6 weeks depending on department activity. A clinical supervision contract is in place with the supervisee bringing an agenda to meetings while being responsible for keeping minutes as documentation.

Experienced Dietitians additionally support the AHA workforce by providing monthly clinical supervision and support with competency training. The clinician is responsible for arranging these sessions. Learning goals, training opportunities and departmental processes are discussed.

All staff are encouraged to reach out for support as required with an open-door policy employed.

Workload and Leave

Every morning the Inpatient and Outpatient Dietetics department have a team huddle to discuss workload allocation and patient flow.

A high number of Dietitians have recently resigned from TSH Inpatient and Outpatient Dietetics Department to pursue career progression opportunities. In addition, maternity leave has impacted staffing. As a result, workload is reported to be high with Dietitians working at capacity. The current workload has made it difficult for Dietitians to engage in quality improvement projects, clinical supervision, and professional development opportunities. When the department is fully staffed workload appears to be generally manageable within the current structure. The AHA workforce has supported this. Before the recent loss of clinical staff, speciality area coverage was available as a result of staff skill mix. At the time of this report, staff vacancies have highlighted gaps in speciality training within the remaining workforce.

In addition, there is a deficit in Dietetics FTE within the mental health speciality. Eating Disorder presentations have been increasing over the last few years with no additional funding allocated to meet this need and the associated workload. TSH Inpatient and Outpatient Dietetics Department can offer a limited-service having approximately five children and three adults on their outpatient list at any given time. Referrals are triaged with a strict referral criterion in place to safeguard care provisions.

The AHA workload appears to be well managed when the team are fully staffed. Issues have come up in the past with inadequate staffing due to temporary maternity relief contracts. When this occurs, the department manages workload via a prioritisation matrix.

There is currently limited leave cover within the Inpatient and Outpatient Dietetics Department (inclusive of AHA's) with workload absorbed by colleagues. There is no backfill funding available and no casual pool of Dietitians to support. Outpatient services are generally not covered with clinicians required to re-schedule appointments during unplanned leave and block out periods of planned leave to avoid appointments being booked. A Nutrition Care Process document exists within each clinical speciality to support the handover of work for new staff or staff required to support during planned and unplanned leave.

Services

TSH Dietetics Department cover TSH Inpatient and Outpatient services, Acute Mental Health and the Garrawarra Centre.

The integration of the Inpatient and Outpatient Dietetics workforce into TSH services can be seen in Appendix R. It is important to note that the Inpatient and Outpatient services are supported by one workforce, with clinicians having inpatient and outpatient responsibilities. There are no AHA's working within outpatient services.

Gaps and Opportunities

During consultation for this review, it was reported that there was an increase in the number of patients requiring Dietetics support within Mental Health Services. Eating Disorder presentations have increased with limited speciality supports available to meet demand. There is currently no funding for this service with current services supported by FTE pulled from other speciality areas.

A Nutrition Access or Surgical CNC was highlighted as a possible opportunity to support with clinical tasks and education to patients and their families regarding tube changes, tube care

and troubleshooting tube issues. At present, the Dietitians are consulted on this which was reported to be outside of their scope of practice. SGH has a Nutrition Support CNC that can assist in a consultative role if issues arise.

TSH Community Paediatric Complex Care MDT consists of a Physiotherapist, OT and Speech Pathologist. This team often calls upon the Paediatric Dietitian for support as this discipline is not represented within the MDT. Further exploration into the benefit of including the Dietetics discipline in this service may be beneficial.

The current workforce structure only has one Level 3 Clinical Senior position which is a generalist role. There are no Level 3 Clinical Senior speciality opportunities and very limited career progression opportunities to support TSH holding onto its workforce.

There is no on-call provision for the weekend service, which results in admissions coming in after-hours on a Friday or over the weekend having to wait to be seen for an assessment by a Dietitian till Monday. This can also result in a backlog of new referrals on a Monday.

One of the clinician's job sharing the Level 5 HOD positions also works as TSH Director of Shared Clinical Services. The competing demands of this role impact the FTE percentage dedicated to this portion of the HOD responsibilities which results in a high proportion of the management task left to the other clinician supporting the HOD role.

The inclusion of the AHA workforce has been a good addition to this department and the services they deliver. Their place within other disciplines' workforce structures may be a future opportunity. Although the inclusion of AHA's in the Dietetics workforce has supported service provision, additional training to extend AHA's clinical capabilities may be of future benefit to workload while also enhancing opportunities for this growing workforce.

Communication with Southcare Dietitians is limited. Although they are invited to professional development opportunities they are not required to attend. Communication is siloed with engagement optional.

Due to the recent loss of workforce, gaps in speciality training within the remaining workforce have become apparent. Opportunities to support succession planning, such as professional development opportunities and strengthening department documentation, may support addressing this deficit.

The AHA's working within the Inpatient Dietetics department currently have a separate office from the rest of the team on a different level of the facility, causing a physical disconnect within the service. In addition, the AHA's don't have a printer in their office and are required to go to the dietetics office to use this, which they use frequently.

Southcare

Workforce

At the time of consultation for this review, two Dietitians were working within the Southcare team. A full-time Level 3 Clinical Senior supports the STACS MDT with a Level 1/2 0.42 FTE supporting Commonwealth Home Support Programme (CHSP).

Succession Planning and Professional Development

Please see Appendix P for workforce pathways for Dietitians working within Southcare against the 2021 Allied Health Award.

There are no succession planning or career progression opportunities for Southcare Dietitians within TSH and its services. The only two positions available have been held by long-term employees.

The Dietitians in Southcare used to be invited to the Inpatient and Outpatient professional development sessions and receive emails about professional development opportunities for the discipline, this appears to have dropped off over time. Professional development opportunities are self-initiated by the clinicians in this department.

Professional Governance and Operational Management

The current professional governance and operational management of the Southcare Dietitians can be seen in Appendix E.

There appears to be either an error on the Southcare Allied Health Organisational Chart provided during consultation or miscommunication of information regarding professional reporting lines. The STACS and CHSP Dietitians currently seek out discipline-specific support that would align with a professional reporting line from the District Dietetics Advisor. The Southcare Allied Health Organisational Chart found in Appendix E outlines that both Dietitians in Southcare have a professional reporting line to TSH Dietetics Senior Clinicians. There was no connection identified during consultation between these services.

The STACS and CHSP Dietitians have their yearly performance reviews within their operational management lines with their respective Nurse Managers. Discipline-specific representation in these meetings has occurred previously but was not found to have a specific benefit to clinicians due to the competing priorities of historical management.

Dietitians are not required to hold registration with AHPRA or a discipline-specific board. TSH ensure all staff hold qualifications that are eligible for membership with Dietitians Australia. Membership is not compulsory, but eligibility is at the time of recruitment. Performance concerns within the MDT are reported back to the Nurse Manager.

Clinical Supervision

The Dietitians in the Southcare service are invited to attend the group peer clinical supervision offered to the Inpatient Outpatient Dietetics department as they have both been working within TSH services for more than 5 years.

As part of the wider district network of Transitional Care Dietitians, the STACS Dietitian was part of an attempt to create an email-type clinical supervision model to extend support structures. This was unsuccessful. At the time of this review, the STACS Dietitian was in the process of creating a co-clinical supervision arrangement and structure with the Transitional Care Dietitian at Calvary.

The CHSP Dietitian additionally has bi-monthly clinical supervision with their Nurse Manager. This has only recently been formalised, before this time clinical supervision was informal but did occur.

Workload and Leave

The CHSP 0.42 FTE was reported to be insufficient to deliver the required service. The STACS Dietitian supports this workload where possible. The current STACS workload appears to be manageable. It is important to note that the introduction of My Aged Care processes has increased the workload per new patient by approximately 30 minutes. Reasons for this include the complexities of funding pathways and the requirement for the “My Aged Care Charter of

Aged Care Rights" to be completed by each discipline that engages with clients. In addition, Southcare-specific screening has increased per patient which has also added to clinicians' workload.

There is no leave coverage available to cover planned or unplanned leave for Dietitians within Southcare. The workload is absorbed where possible or appointments are re-scheduled. New referrals are prioritised, and follow-up appointment intervals are increased to support service delivery.

Staff were not able to comment on processes for large durations of leave as this has not occurred.

Services

The integration of the Southcare Dietetics workforce into services can be seen in Appendix R.

The My Aged Care referral pathway has reduced the influx of referrals to this team. Concerns were raised regarding the reduction in referrals being due to GP's not making referrals as a result of the complex referral process, rather than service need reducing. All referrals to this service must come through My Aged Care.

Gaps and Opportunities

The Southcare Dietitians spend a significant portion of their FTE managing administrative duties and engaging in screening. These tasks may be able to be done by an AHA. The introduction of an AHA role may allow the Southcare Dietitians to increase service capacity.

Clarification around professional reporting lines for the Southcare Dietitians is required. In addition, re-instating the inclusion of Southcare Dietitians in the Inpatient and Outpatient department's professional development sessions may enhance communication lines while also filling this professional development gap for the Southcare Workforce.

The CRT program identified that the provision of a Dietitian one day a week would have a significant impact on service delivery and outcomes as some of the information that would be beneficial to service users can't be delivered due to scope of practice limitations.

Alternate Workforce Structures

Inpatient and Outpatient

The additional reporting lines an integrated workforce structure would provide was the only benefit highlighted by the Inpatient and Outpatient department. This may support expanding their workforce structure and opening further succession planning and career development opportunities.

Southcare

During consultation, it was highlighted that the Southcare Dietitians were once managed by the Inpatient and Outpatient HOD. This was not found to be a beneficial line of management due to there being a lack of community service understanding from the Inpatient Outpatient manager at the time.

Historically there was an Allied Health Manager within Southcare who provided community Allied Health Advocacy within TSH. All discipline HODs reported into this position with the smaller disciplines directly reporting to this position in place of a HOD. This was reported to be an asset to the workforce structure which was lost during a re-structure.

Update March 2023

In 2022 TSH Dietetics department received an additional 0.13 FTE AHA as part of the Workforce Initiative funding. This has enabled clinical capacity for the Dietetics AHA on weekends, improving the 7 day service for dietetics.

The senior Level 3 Dietitian is currently enrolled in the RPAH Gastrostomy Training Program, which will enable the clinician to manage and replace gastrostomy tubes post initial placement. This is a recognised extended scope of practice for Dietetics and can offset the previously identified gap in service for this patient cohort.

In early 2023 the Dietetics Allied Health Assistants relocated to the Allied Health Department on Level 2.

6.6 Speech Pathology

Inpatient and Outpatient

Workforce

TSH Inpatient and Outpatient Speech Pathology department is managed by a Level 4 HOD (1 FTE). At the time of this report, this position was temporarily filled at 0.84 FTE while permanent recruitment occurred. TSH Inpatient and Outpatient Speech Pathology department consists of 0.5 FTE Level 3 Clinical Senior and multiple Level 1/2 clinicians. An additional Level 3 Clinical Senior is based at the Garrarwarra Centre (0.2 FTE). No AHA's are working within this department nor is there FTE dedicated to Graduate positions. Graduate Speech Pathologists are often recruited to temporary contracts.

Staff working within TSH Speech Pathology department support a weekend on-call roster for patients that do not pass the ASSIST Swallow Screen. If staff are called in, they are required to remain onsite for four hours and additionally review other referrals made to the department over the weekend. If clinicians do not get called in weekend referrals go unseen till Monday.

It is important to note that most of the employees working within this department are working part-time. In addition, there are some casual staff that work within this department to support leave coverage within budgetary constraints.

Succession Planning and Professional Development

Please see Appendix P for workforce pathways within TSH Inpatient and Outpatient Speech Pathology department against the 2021 Allied Health and Allied Health Assistant Award.

Succession planning and career progression opportunities are limited in TSH Inpatient and Outpatient Speech Pathology department due to the small workforce structure. Secondments may become available to support maternity leave and flexible work arrangements, with many of these opportunities external to TSH.

Professional development sessions are run monthly within the department. These sessions alternate days of the week to support equitable opportunities to attend by the part-time workforce. Professional development sessions explore topics of interest, journals and case studies while also providing the department with the opportunity to discuss external learning opportunities clinicians may have engaged in. A range of professional development opportunities exist for the Speech Pathology discipline, time constraints within the department restrict engagement within the workplace. In addition, there is no funding to support staff

engaging in these opportunities. The SESLHD Speech Pathology Advisor circulates professional development opportunities and information to the HOD for further distribution.

TSH Level 3 Clinical Senior is responsible for supporting new staff with competency training which includes the Modified Barium Swallow competency, which can take up to a year to obtain, and Dysphagia accreditation.

Professional Governance and Operational Management

The Organisational Chart in Appendix S outlines the current professional governance and operational management of the Inpatient and Outpatient Speech Pathology department. This Organisational chart was updated during this review as the previous version was from November 2016.

Speech Pathologists are not required to hold registration with AHPRA or a discipline-specific board. TSH ensure all staff hold qualifications that are eligible for membership with Speech Pathology Australia. Membership is not compulsory, but eligibility is at the time of recruitment.

Performance reviews are conducted annually by the Speech Pathology HOD. Performance concerns are managed within this space with the HOD able to obtain support from the SESLHD Speech Pathology Advisor as required. The HOD's performance review is conducted by both the Speech Pathology Advisor and Director of Shared Services.

Clinical Supervision

Although the Speech Pathology HOD professionally reports to the District Speech Pathology Advisor this link does not facilitate clinical supervision. At the time of this report, the Speech Pathology HOD was not formally engaged in a clinical supervision process. They have informally self-initiated this type of support and meet on a monthly basis.

The clinical supervision structure within the Inpatient and Outpatient Speech Pathology department suggests that the Level 3 Clinical Senior provides this to the less experienced Level 1/2 staff. The more experienced Level 1/2 Speech Pathologists have this with the Level 4 HOD. Clinical Supervision should be occurring monthly with professional goals and clinical conundrums discussed. At the time of this review, there were no clinical supervision contracts in place, but a structure was reported to be used to support consistency. Although this structure exists it is unclear whether this was regularly occurring at the time of this report. Formal clinical supervision appeared to be de-prioritised to support the clinical workload. All staff within the Inpatient and Outpatient Speech Pathology department are encouraged to reach out for support as required with an "open door" policy employed.

In addition to clinical supervision, the Level 4 HOD has a monthly catch-up/report from all staff, this can be via email.

A district Speech Pathology network exists for clinicians to engage with for specialist advice and support.

Workload and Leave

There is no funding to support leave cover within TSH Inpatient and Outpatient Speech Pathology department. Planned leave can be difficult to take with the department trying to avoid having more than one staff member on planned leave at any given time. The Outpatient workload is deprioritised during periods of planned and unplanned leave with the Inpatient workload absorbed by colleagues where appropriate using a prioritisation system. Due to the

part-time nature of this workforce, there is some workforce flexibility to support planned and unplanned leave, within funding limitations.

Due to the high incidence of unplanned leave, it's not uncommon for the department to be working short-staffed with there being some cases of staff working alone or in pairs while required to provide discipline-specific services to all areas of TSH. SGH Speech Pathology can be called upon for support in these cases if they have the capacity and with approval from both sites. In addition, the Level 3 Clinical Senior based at the Garrawarra Centre one day a week is often called to support TSH workload.

Workload within TSH Inpatient and Outpatient Speech Pathology Services appears to be high with increasing demands on the service not reflected in FTE increases. Some Outpatient clinics have been deprioritised or discontinued due to Inpatient workload exceeding workforce capacity. Monday workloads can be high when the on-call clinician isn't called in, as the 4-hour shift that is required when the on-call service is used supports seeing new referrals made over the weekend, significantly impacting workflow for the remainder of the week.

Services

TSH Speech Pathology department provides Inpatient and Outpatient services to TSH and Garrawarra Centre. The integration of TSH Speech Pathology Inpatient and Outpatient workforce into services can be seen in Appendix T. Referrals into Inpatient services can be made by any clinician from within TSH via EMR. Outpatient referrals must come from GPs or TSH acute services.

The Outpatient workload is split between clinicians to support speciality services within the department rather than this being a discrete workload. At the time of this report, low-priority referrals had a 12-month wait with priority determined using a prioritisation tool.

The Inpatient and Outpatient Speech Pathology department provides a weekend on-call service for new acute stroke presentations that do not pass the ASSIST Swallow Screen. There is a strict criterion for access to this service with anything outside of this required to wait for the weekday service. With the support of Covid-19 funding, this service has temporarily become a rostered 4-hour shift on Saturday and Sunday. This funding will cease in September 2022 and the on-call services will resume. Rostering for this shift is in addition to existing clinician shifts, requiring staff to work a weekend shift every 3-4 weeks.

Gaps and Opportunities

There appears to be a disconnect between Inpatient and Outpatient Speech Pathology and some medical teams within TSH. This has resulted in a lack of acceptance of the discipline's advice and recommendations concerning patient care. Opportunities to promote the discipline within the medical domain are required.

Group peer clinical supervision was suggested to be an efficient opportunity to re-prioritise clinical supervision conversations within a workforce that is restricted by a high workload.

The 4-hour Inpatient weekend service on Saturday and Sunday established by Covid-19 funding has allowed Speech Pathology referrals to be managed over the weekend supporting workflow and timely access to services. When funding ceases this will go back to a weekend on-call service that can only be accessed by patients who do not pass the ASSIST Swallow Screen. This leaving new referrals unseen over the weekend and potentially causes patients to be kept nil by mouth for up to 48 hours. Weekday workflow will also be impacted which

needs to be considered alongside staff wellbeing and risk of clinician burnout considering the high workload that has been consistently reported during consultation with this discipline.

There appears to be a gap in Outpatient services with lengthy wait times due to the workforce limitations and inpatient workloads prioritised. In addition, outpatient groups have been impacted by workforce limitations. The benefits and efficiencies of these groups need to be further explored considering outpatient referrals continue to increase alongside the department's wait times.

At the time of this review, TSH did not have a paediatric feeding service. Paediatric feeding is an advance scope of practice in Speech Pathology, as such there are no current clinicians at TSH who are skilled in providing this service. When this speciality is required SGH Speech Pathologists attend TSH to review referrals and provide care. SGH charge TSH for this service and must prioritise local SGH referrals which can delay access to services for TSH patients resulting in an inadequate service. There has been an increase in paediatric referrals that can no longer be managed through SGH Speech Pathology. Paediatric patients with feeding-related concerns are increasingly being sent back to TSH from special care nurseries despite this gap in service provision.

Lack of leave cover impacts service provisions with wait times increased and review intervals prolonged. In addition, there is an unmet need in service provision for acute stroke patients due to staffing levels. A Covid-19 enhancement funded a six-month full-time position to support the discipline's high demand which was reported to support these gaps in service and workforce.

It was reported during consultation that working as a Speech Pathologist in health is less desirable within the wider discipline. Opportunities for succession planning and professional development were highlighted as improvement areas that may attract staff. Further exploration into how TSH can be a more attractive employer within the Allied Health Workforce would be beneficial.

Southcare

Workforce

One Level 3 Clinical Senior Speech Pathologist is working in Southcare. They are funded by the STACS service for 0.4 FTE. This position is also required to support Southcare referrals for patients who are housebound and require Speech Pathology input.

Succession Planning and Professional Development

Please see Appendix P for workforce pathways for Speech Pathologists working within Southcare against the 2021 Allied Health Award.

There are no succession planning opportunities for the Speech Pathology discipline within Southcare. There are no other positions this clinician can apply for without leaving the service or going back into the acute hospital setting.

The Speech Pathologist working in STACs is invited to the STACS (monthly) and Southcare (fortnightly) MDT professional development session. These are not discipline-specific. There have been periods where this clinician has been included in the Inpatient and Outpatient Speech Pathology departments' professional development opportunities, but the invitation appears to fluctuate.

The SESLHD Speech Pathology Advisor meets with the Southcare Speech Pathologist three times a year for discipline-specific updates in the network. This has not occurred recently due to Covid-19.

STACS have a monthly team meeting which the Speech Pathologist is invited to attend. Due to the part-time nature of this role, they may not attend these meetings and have minutes circulated to them in place of this.

Professional Governance and Operational Management

The current professional governance and operational management of the Southcare Speech Pathology team can be seen in Appendix E.

TSH Speech Pathologists are not required to hold registration with AHPRA or a discipline-specific board. Southcare ensures all staff hold qualifications that are eligible for membership with Speech Pathology Australia. Membership is not compulsory, but eligibility is at the time of recruitment.

Performance reviews are conducted yearly with the STACS Nurse Manager. There is no discipline-specific representation in this meeting, the addition of this not seen to add value during consultation. Performance concerns within the MDT are reported back to the Nurse Manager from Allied Health and nursing colleagues.

Clinical Supervision

The Speech Pathologist working within Southcare has received Clinical Supervision from the Inpatient and Outpatient Speech Pathology HOD on a bi-monthly basis. This has not occurred recently. This clinician seeks out support from personal professional connections within the SESLHD Speech Pathology network. There does not appear to be an active structure supporting engagement in clinical supervision of this clinician despite their role being isolated from discipline-specific colleagues.

Workload and Leave

The STACS Speech Pathologists' workload fluctuates in response to the STACS referral needs. Not all patients referred to the program will need to be seen by the Speech Pathologist. Southcare referrals for housebound patients are seen as workload permits, with the wait list generally only being a few weeks.

There are no backfill provisions to support planned or unplanned leave for the Speech Pathologist working in Southcare. As STACS is a 12-week program, patients requiring Speech Pathology input can be seen within this time frame with appointments being arranged around leave provisions. Southcare referrals for housebound patients living in the community will be deferred till the Speech Pathologist is available. Referrals related to swallowing are often less acute and have often already had involvement with other clinicians managing their care and can be put on a waitlist. Referrals for Communication concerns are seen as soon as practical. Where required patients of concern are handed over to the Nurse Manager for ongoing support.

Services

The integration of the Speech Pathology workforce into Southcare services can be seen in Appendix T. The Southcare Speech Pathologist is funded by the STACS service. They additionally support housebound patients referred to other areas of the Southcare service.

Gaps and Opportunities

The Outpatient wait list was identified as a gap within TSH Speech Pathology Services. In addition, some referrals decline Outpatient services due to accessibility difficulties. The Southcare Speech Pathologists can only see patients receiving care under the STACS program or if they are housebound and have been referred via other Southcare services. All other referrals are diverted to TSH Outpatient clinic.

In addition, some STACS referrals from TSH Inpatient units have been referred to the Inpatient Speech Pathology services but have not been seen due to the high Inpatient demand and prioritisation tool used to support this. These referrals are often for patients with communication issues.

The lack of discipline-specific advocacy within Southcare was identified as a gap, though this was attributed to the small FTE held by the discipline.

Alternate Workforce Structures

Inpatient and Outpatient

There were no disadvantages to an integrated workforce structure reported by the Inpatient and Outpatient Speech Pathology department. A collaborative service that can streamline Inpatient, Outpatient and Southcare services were seen to be a benefit and opportunity to find efficiencies to support service delivery and workforce gaps.

Southcare

An integrated workforce may support the Southcare Speech Pathologist being connected to the discipline and receive consistent support in this space. Support has been offered in the past but appears to be intermittent due to workforce structures.

Update March 2023

The SP HOD position has been successfully recruited to in a full-time, permanent basis.

In 2022 TSH SP department received an additional 0.42 FTE as part of the Workforce Initiative funding. This included 0.21 FTE Level 3 to enhance the existing 0.5 FTE senior role, and 0.21 FTE to support permanent weekend rostering, which will service all patients requiring speech pathology input on a prioritised basis.

Options to address gaps in paediatric feeding continue to be explored. This has included active engagement with community services and the SCHN to identify solutions to this complex issue.

6.7 Psychology

Inpatient and Outpatient

Workforce

The Psychology discipline has permanent FTE within TSH Oncology and Rehabilitation services. There is no provision for this discipline within any other area of TSH.

A 0.42 FTE Clinical Psychologist works in Oncology, and a 0.84 FTE in the Rehabilitation department.

The Clinical Psychologist working in Rehabilitation coordinates student placements within this service. This service can take on two students a year who have 5-month placements. Although Psychology students don't create revenue, they enhance our workforce and support quality improvement projects and new models of care.

Succession Planning and Professional Development

The Psychologist working in Rehabilitation informally acts as the discipline representative at TSH as there is no HOD or alternative advocacy role available.

Due to the limited Psychology workforce succession planning and career progression do not exist within TSH.

The District Principal Psychologist circulates discipline-specific professional development information and updates from the district to TSH Psychologists. A learning plan is required as part of a Psychologist's registration requirements.

The Rehabilitation Psychologist is part of the SESLHD Psychology Education and Supervision Committee which holds at least four free professional development opportunities each year and this contributes to any formal requirements.

Due to the small FTE held by the Oncology Psychologist engagement in professional development often occurs outside of the workplace to ensure registration requirements are met. This position links in with TSH/SGH Cancer Services for Oncology-specific updates and professional development, though workload impact's ability to engage.

Professional Governance and Operational Management

TSH Psychologists are required to be registered with AHPRA and the Psychology Board of Australia. Clinicians are responsible for meeting registration requirements.

TSH Psychologists operationally report to the Director of Shared Clinical Services, this reporting line is relatively new. In addition, they report to the MDTs they work within regarding patient care and workflow. The SESLHD Principal Psychologist provides professional management and support.

Clinical Supervision

The Psychologists working in Rehabilitation and Oncology independently organise their clinical supervision with an appropriate peer. There are also opportunities for clinicians to participate in group peer clinical supervision. The Principal Psychologist can support these clinicians in identifying an appropriate supervisor as needed.

Clinical supervision is a mandatory practice for the Psychology discipline and part of their registration requirements. Documentation of hours spent engaging in clinical supervision are maintained to support registration processes.

Clinicians are engaging in this practice outside of their working day due to time constraints acknowledging that this is a registration requirement.

Workload and Leave

The Rehabilitation Psychologist self-manages workload and prioritises referrals. In addition, there are some presentations that the Psychologist is required to offer their services which include patients who have had a life-altering health episode (stroke, amputation). Referrals can be made informally by other staff in the department. The Rehabilitation Psychologist will

attend MDT meetings within the department and identify patients who may require the discipline's input. This service is restricted to Rehabilitation services and cannot extend into other areas that may request Psychology input.

The Oncology Psychologists' workload is stretched even with Covid-19 funding supporting additional FTE. Although the additional FTE has eased the workload referrals are waiting two weeks to be seen. This role supports a full Outpatient clinic limiting capacity to accept Inpatient referrals. Enhancements to support demand have recently been requested with the outcome pending at the time of this report.

There is no backfill or leave coverage to support the Psychology discipline during periods of planned and unplanned leave. Patients in the Rehabilitation unit will not be seen during periods of leave with those who are discharged during this time offered brief follow-up when the psychologist returns. Urgent Oncology referrals can be supported by the Oncology Social Worker with all other referrals having to wait till the Oncology Psychologist returns from leave.

High workload and limited Psychology FTE in the Oncology department prevents engagement in professional development opportunities in the workplace.

Services

The integration of TSH Psychology workforce into TSH services can be reviewed in Appendix V.

At present, TSH is only funded to have Psychologists working in Oncology and Rehabilitation services.

Gaps and Opportunities

The lack of cover for planned and unplanned leave is a gap in the delivery of this service as patients go unseen during this time. With increasing mental health presentations within the Australian population enhancements to this service may support a holistic approach to service delivery supporting people in the Shire to access mental health services for support.

In addition, the Oncology Psychology FTE has not increased alongside service increase and demand limiting the capacity of the service. The Cancer Institute is rolling out the Patient-Reported Measures Program within TSH Oncology Clinic encouraging new patients to complete screening tools for psychosocial distress supporting timely referral to the Oncology Psychologist. Although this initiative aims to encourage early intervention and safeguard patients from being missed it may further increase referrals to the service.

There is a lack of collaborative opportunities for this discipline to connect with other departments and share knowledge. With the incidence of mental illness on the rise strategies to use the expertise already with TSH may prove to be beneficial.

The Psychologist in Rehabilitation with support from students is in the process of developing and implementing a Cardiac Rehabilitation Outpatient service offering appropriate referrals three Psychology sessions a week to support symptom management. The outcomes of this service will need to be evaluated.

Southcare

A 0.37 FTE Neuropsychology position exists within Southcare. At the time of this review, the position was vacant with recruitment processes ongoing. Advertisement for this position commenced in January 2021. Although this position sits within Southcare they operationally

report to the Director of Shared Clinical Services. Please see Appendix U for the relevant organisational chart updated as part of this review. Further exploration into the structure of this role will be required upon recruitment to the position.

Alternate Workforce Structures

During consultation for this review, an integrated workforce model was discussed. The benefits of Allied Health professionals being managed by their discipline were seen to be a benefit for this workforce. With consideration of the small Psychology workforce at TSH and limited discipline-specific interaction a workforce model that promoted discipline advocacy and collaboration was suggested to be beneficial.

Update March 2023

In 2022 the ODC psychology position was enhanced with an additional 0.32 FTE as part of the Workforce Initiative funding. This has enabled the previous temporary enhancement to become permanent and decreased wait times for oncology patients requiring access to the psychologist.

Work is currently underway with SGH Psychology to enhance governance of contracted psychologists.

7 Conclusion

This review has outlined the current state of the Allied Health Services workforce within TSH. TSH currently provides high quality allied health services to the community of the Sutherland Shire across the spectrum of care. Staff consulted are passionate about their roles and committed to high quality patient centred care.

The recommendations outlined in section 5 have been made in order for allied health services at TSH to meet workforce challenges, ensure strategic, operational, clinical and professional governance and contribute to the organisation's strategy and future planning, in line with current evidence. The recommendations aim to enhance the ability of allied health services to provide excellent patient centred care from the community, across the continuum of care. An integrated workforce model puts the patient's journey at the centre of allied health services, enhancing consistency of care and service provision.

Alignment of Allied Health services in a directorate model will enable disciplines to address the themes identified throughout the consultation process by staff members across services, including succession planning and career progression, leave cover, professional development, and supervision. A centralised approach to professional development and supervision will reduce duplication of effort and evaluation can be reported at both discipline and directorate levels.

Support for smaller teams and sole practitioners would be strengthened by enhanced discipline-specific governance. Risks associated with engagement of externally contracted allied health professionals can be mitigated by ensuring a process in in place to ensure these AHP's credential appropriateness and currency, and that engagement with these services monitored and evaluated.

To implement the recommendations outlined above detailed workforce planning and change management support is required. This would include further consultation with staff, line and senior managers, and discipline advisors.

The authors would like to acknowledge the staff who generously gave their time to share information and provide insights throughout the review process.

Appendices

Appendix A - Questions Guiding Semi-Structured Meetings

Department and Unit Heads

- Outline of workforce structure (FTE/Org Chart)
- Outline of services (including weekend service?)
- Succession planning/professional development opportunities
- Clinical supervision opportunities
- Swim lanes – guide me through the patient experience of the services offered
- Are there gaps in your service or workforce?
- Opportunities for your department?
- Is the current model working? If not, are there models you would prefer?
- Would an integrated model between TSH services offer anything to your team? Pros and Cons? Efficiencies/threats?

Nurse Managers

- What are the pros and cons of a nurse managing an MDT/Allied Health workforce?
- Are there any challenges when you operationally manage an employee but don't professionally manage them?
- What clinical supervision and professional development opportunities are offered to the allied Health members of your MDT team?

Level 3, Level 1/2 staff and Allied Health Assistant workforce

- What does clinical supervision look like for you?
- How do you find your current workload – do you think the existing workforce structure supports services and the flow of patients?
- What happens to your workload when you are on planned and unplanned leave?
- Are there any areas where you can see gaps/opportunities/efficiencies for the workforce and services?

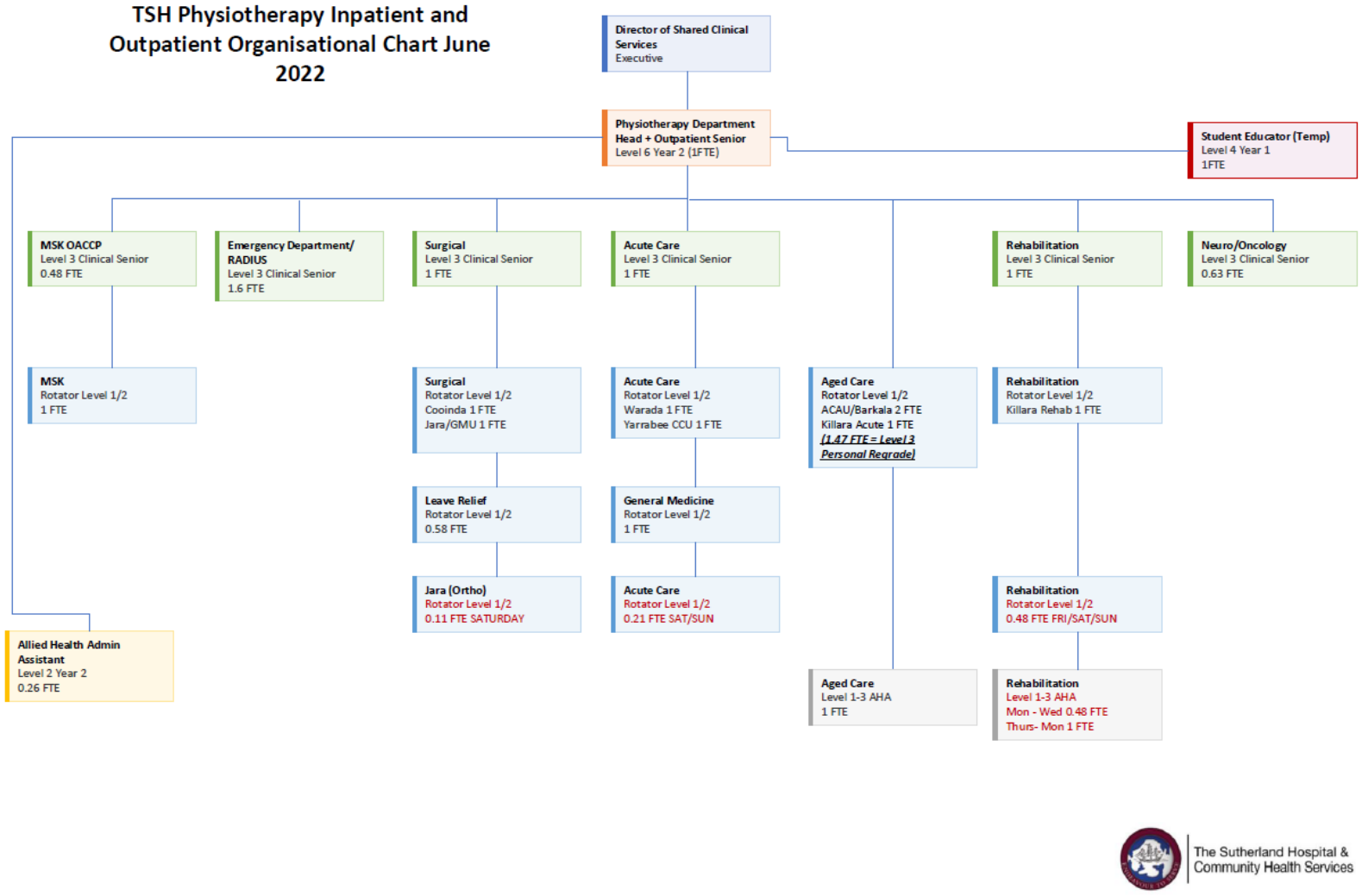
Additional for staff who are separately managed for operational and professional purposes

- Do you feel well supported by being managed separately for professional and operation aspects of your role?
- Are there changes that would make this management plan better?

Appendix B – TSH Physiotherapy Workforce Progression

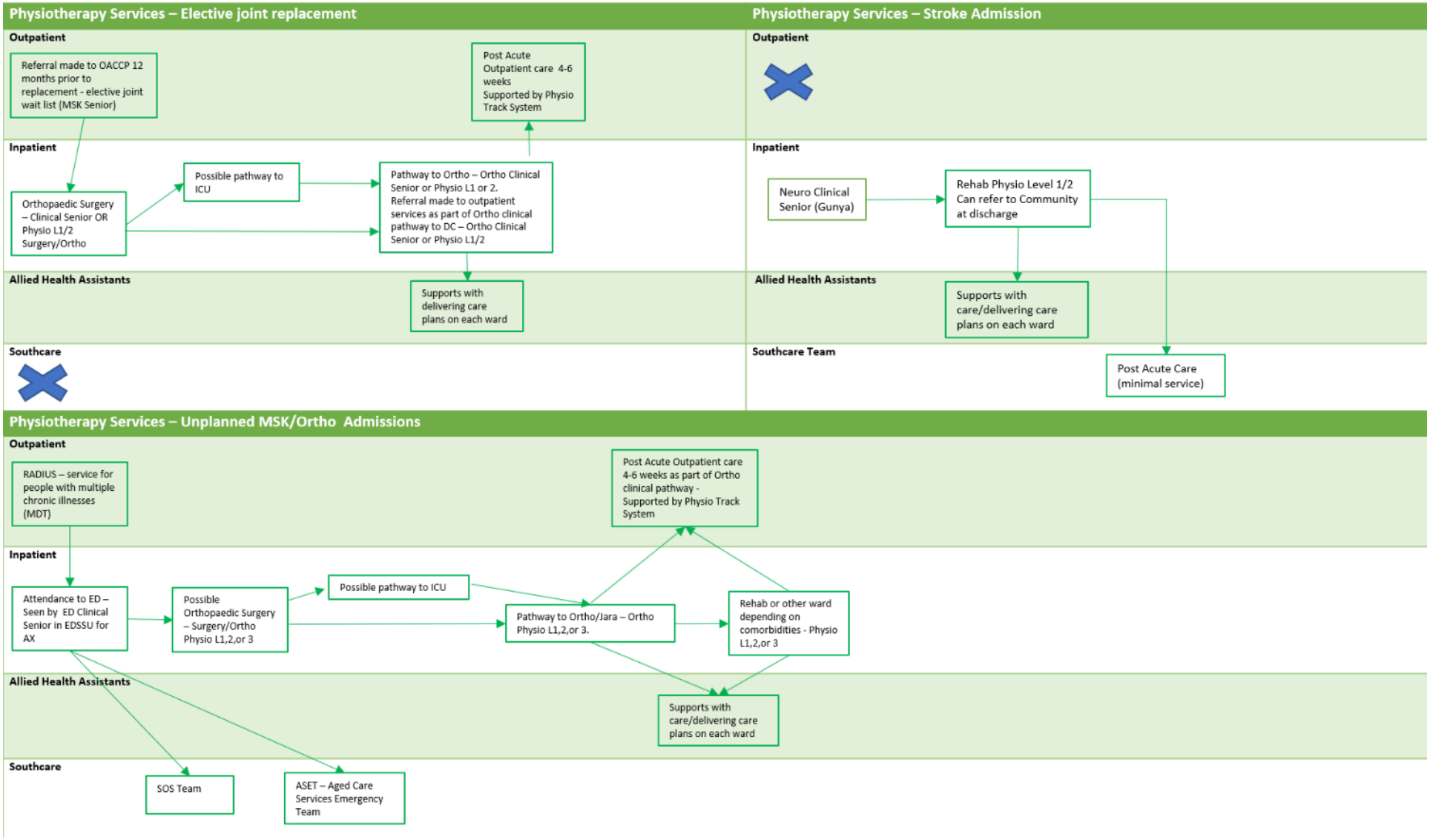
PHYSIOTHERAPY - Allied Health Workforce Progression (2021 Award)						
Inpatient Outpatient Physiotherapy ✓ Southcare Physiotherapy ✓ Exercise Physiology ✓ = Positions available at TSH						
Allied Health Assistant	Level 1 - working towards Cert IV qualification or student Physio/EP Student may apply for grad program. ✓✓	Level 2 – Progress after 12 months in level 1 role or has completed Cert III qualification or equivalent. ✓✓	Level 3 – Has completed the Cert IV qualification or equivalent (includes overseas trained physios without registration). ✓✓	**Responsibilities include basic patient care, administrative duties, delivering care plans.**		
Graduates	Level 1 year 1 - 12 month rotational program. On completion of the program employees are encouraged to apply for local vacancies. ✓					
Level 1/2	Level 1 - natural succession occurs for the level 1 staff from year 2 – 4. After 12 months working in a level 1 year 4 role clinicians progress to level 2. ✓✓✓	**To move from level 1 to level 2 clinicians must have obtained respective new practitioner competencies and perform these in addition to level 1 duties.**	Level 2 - natural succession occurs for the level 2 staff from year 2 – 4. ✓✓✓	**Level 2 year 4 staff can make an application for a personal re-grade to a level 3 Senior Clinician if they meet the criteria.**		
Level 3/4	**Senior Clinician (regrade)** Level 3 year 1 regraded into this position. Natural progression to level 3 year 2. ✓✓✓	**Senior Clinician (L3)** Recruited into this position with natural progression from year 1 – year 2. ✓✓	**Level 3 year 2 staff can make an application for a personal re-grade to a level 4 Senior Clinician if they meet the criteria.**			
Level 3/4	**Senior Clinician (regrade)** Level 4 year 1 regraded into this position. Natural progression to level 4 year 2.	**Senior Clinician (L4)** Recruited into this position with natural progression from year 1 – year 2.	**Deputy Department Head (L3/L4)** Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load.	**Unit Head or Team Leader (L 3/4)** Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load.	**Department Head (L4)** Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load.	**Student Educator (L4)** Recruited into this position with natural progression from year 1 to year 2. Can have clinical load. ✓
Level 5/6	**Department Head (L5/6)** Recruited into this position with natural progression from year 1 – year 2. May have clinical, educational or management duties (or a combination). ✓✓	**Deputy Department Head** Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load.	**Unit Head or Team Leader** Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load, provides leadership, guidance and line management. ✓✓	**Health Professional Educator (L5)** Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load provides leadership, guidance and line management.	**Clinical Specialist (L6)** Recruited into this position with natural progression from year 1 – year 2. Needs clinically relevant post graduate qualification or has peer recognition.	
Level 7	**Deputy Department Head** Recruited into this position. Grading dependent on FTE managed.	**Unit Head or Team Leader** Recruited into this position. Grading dependent on FTE managed Grade 1 – 30 – 45, Grade 2 – 45-60.	**Department Head** Recruited into this position. Grading dependent on FTE managed Grade 1 – 25-40, Grade 2 – 40-55, Grade 3 - <55.			
Level 8	**Discipline Specific Director/Advisor (L8)** Recruited into this position. Grading dependent on FTE managed. Grade 1 - <25, Grade 2 -25-55, Grade 3 – 55-100, grade 4 - >100. ✓✓					

Appendix C – Inpatient & Outpatient Physiotherapy Organisational Chart

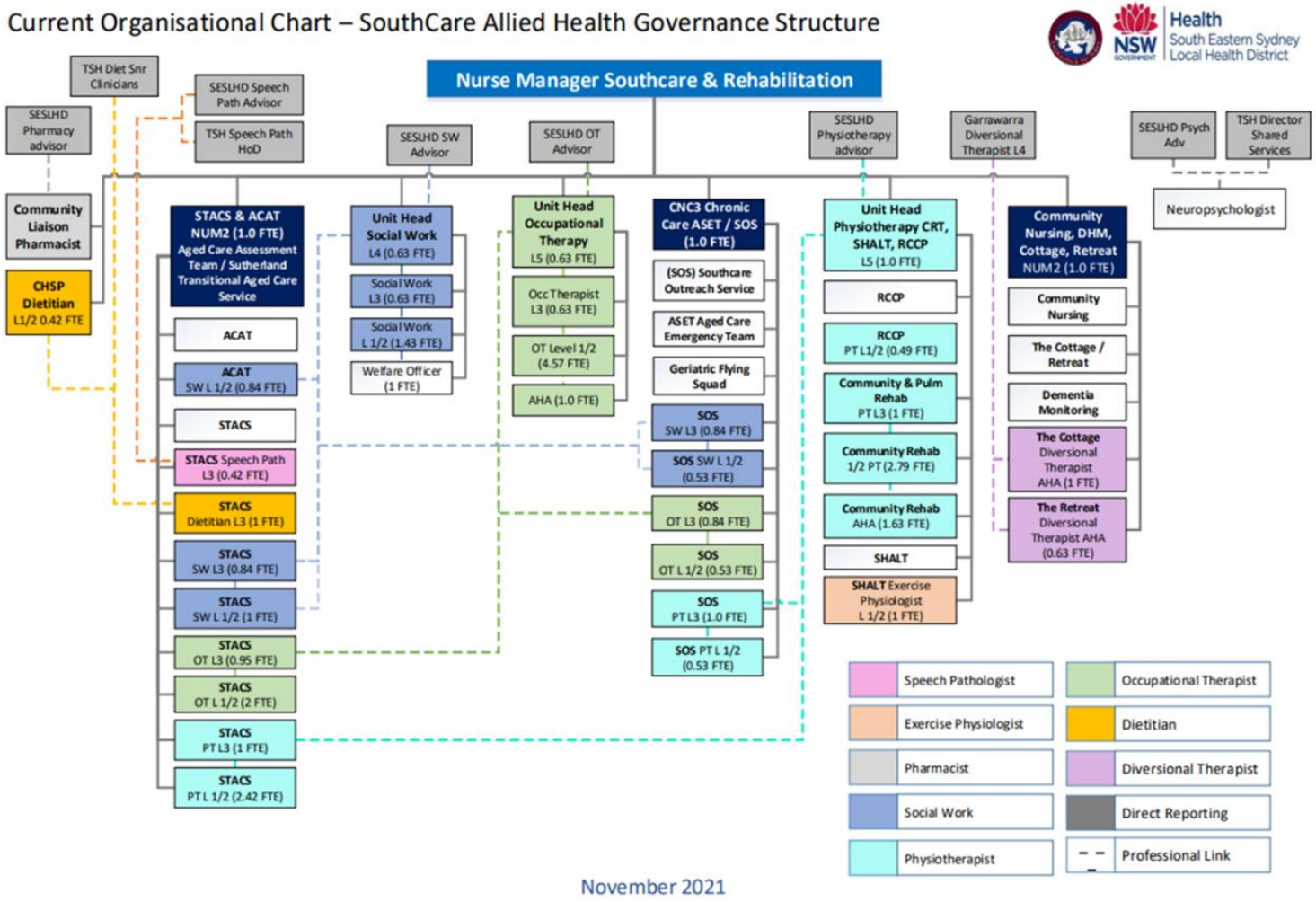


The Sutherland Hospital & Community Health Services

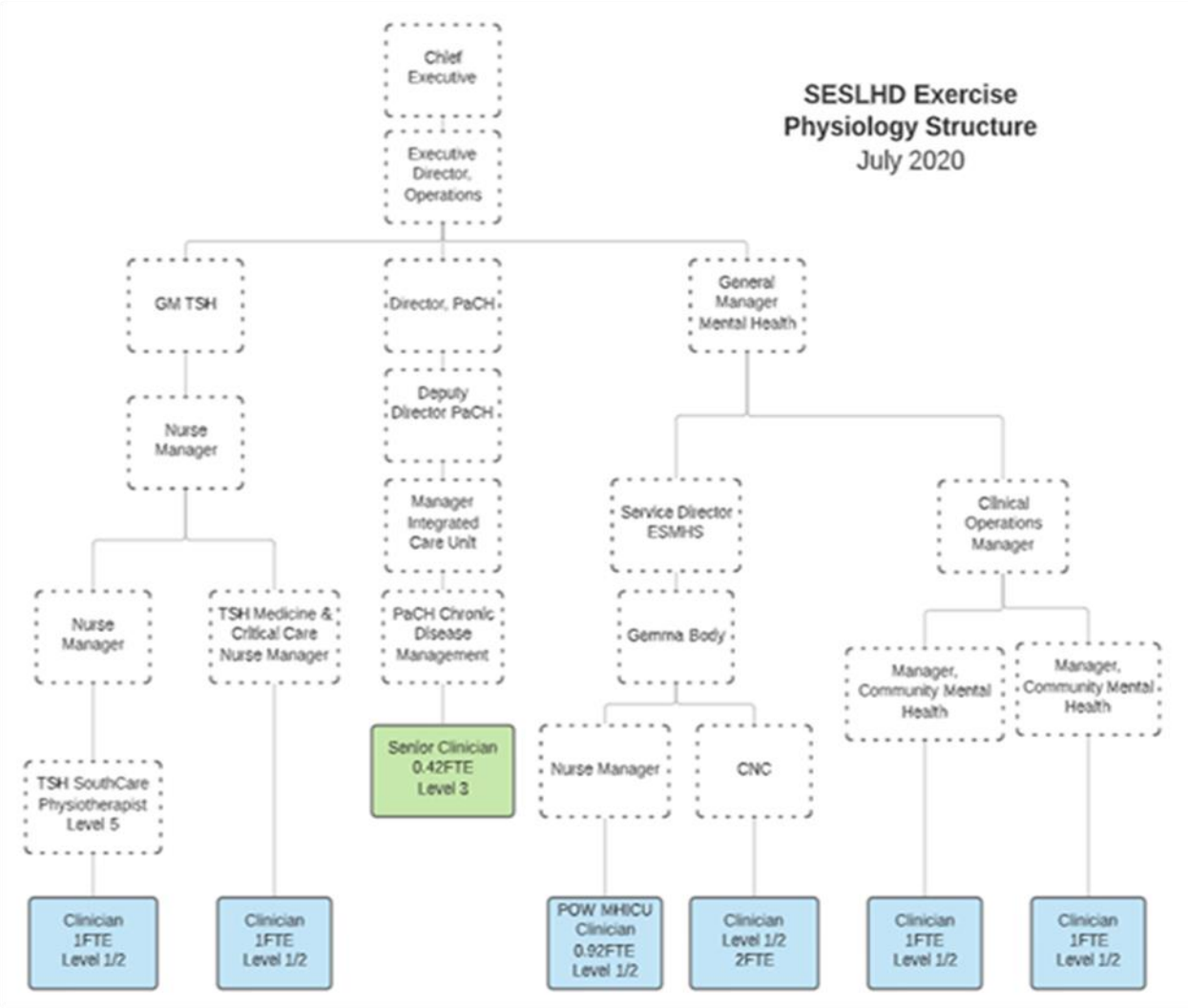
Appendix D – Inpatient & Outpatient Physiotherapy Service Swim Lanes



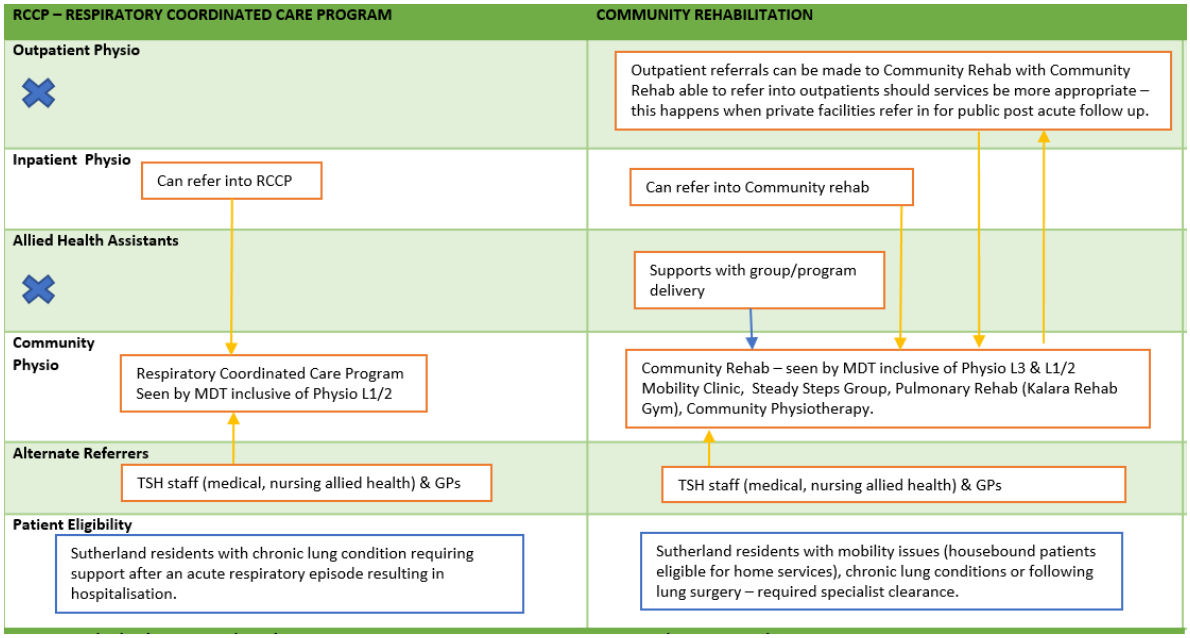
Appendix E – Southcare Allied Health Organisational Chart

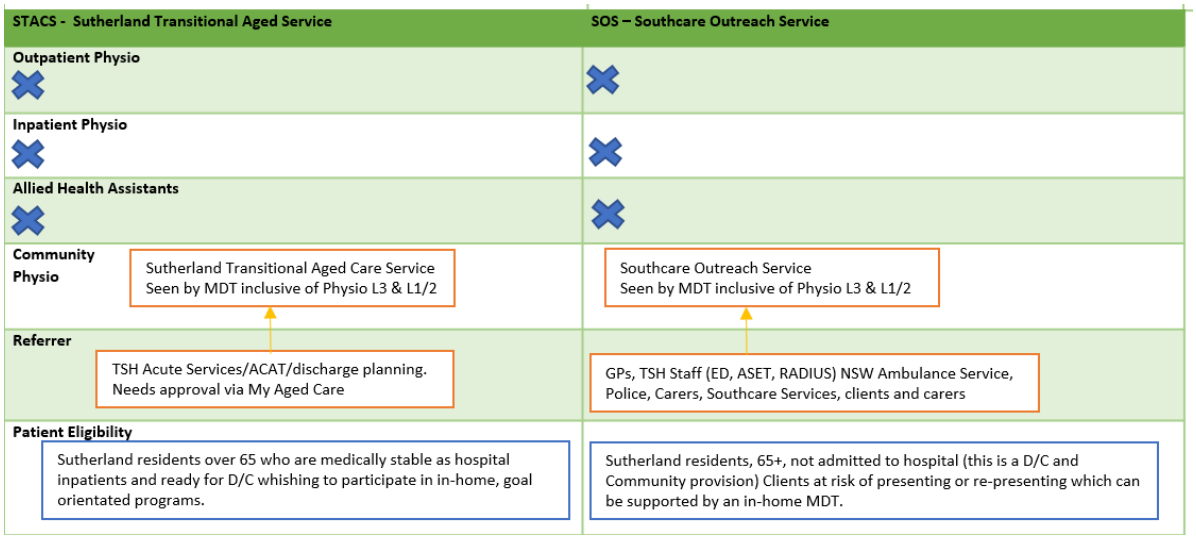


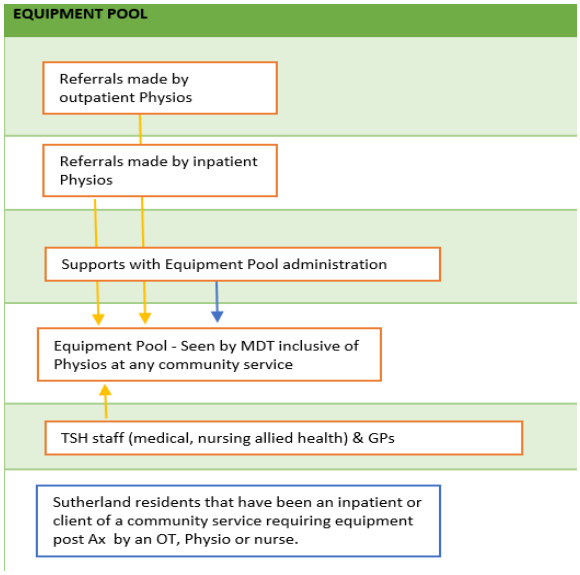
Appendix F – TSH Exercise Physiology Organisational Chart



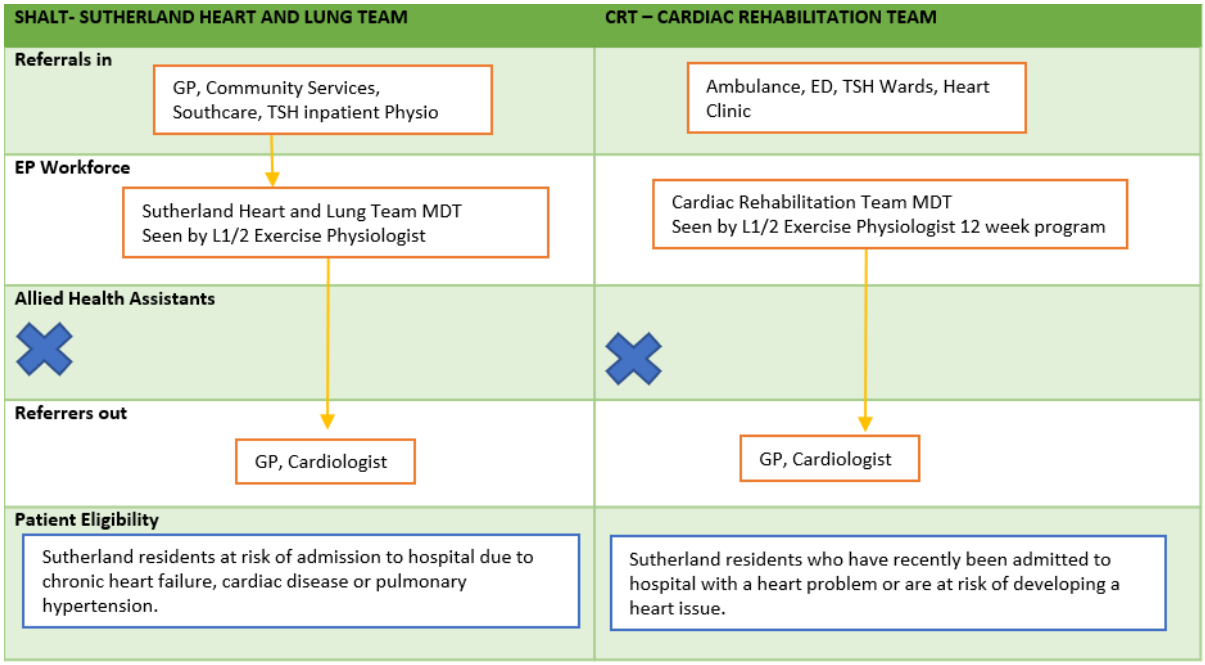
Appendix G – Southcare Physiotherapy Service Swim Lanes







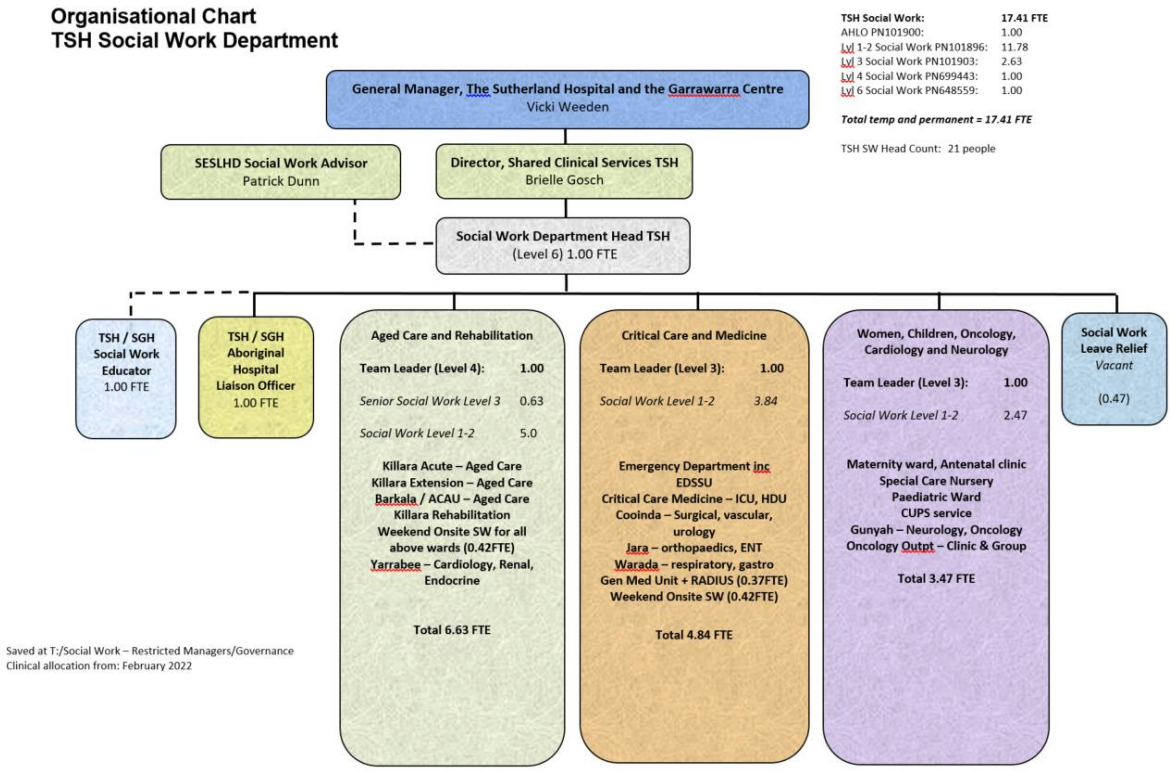
Appendix H - TSH Exercise Physiology Services Swim Lanes

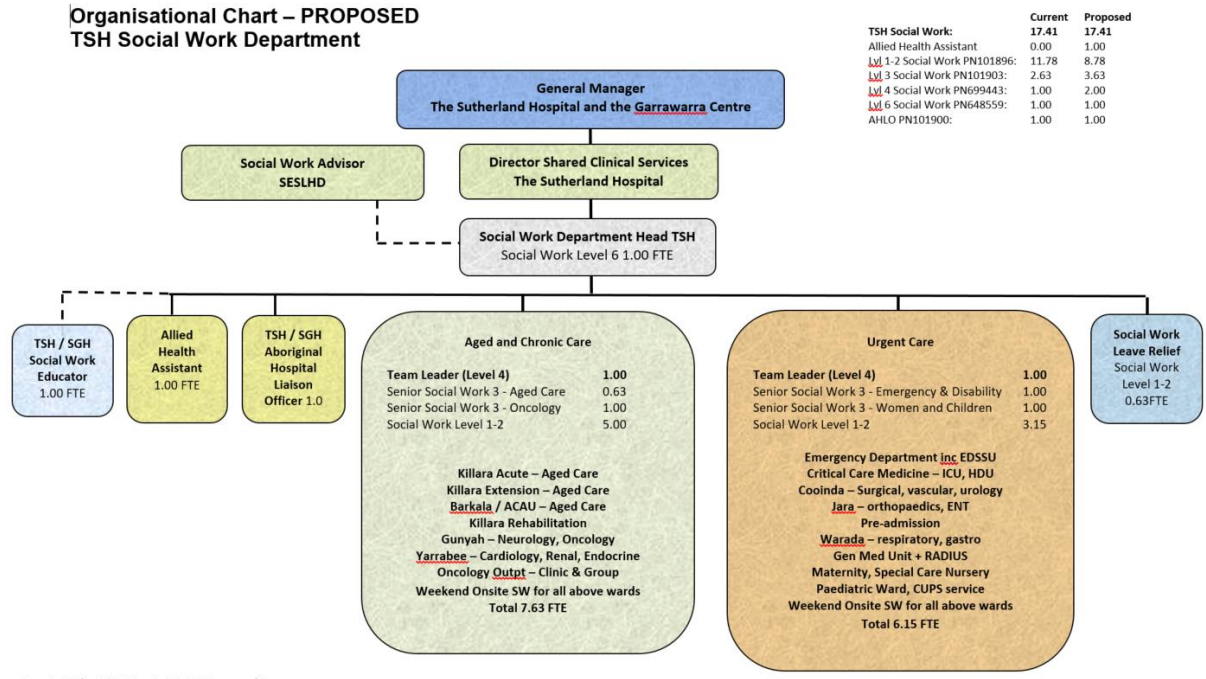


Appendix I - TSH Social Work Workforce Progression

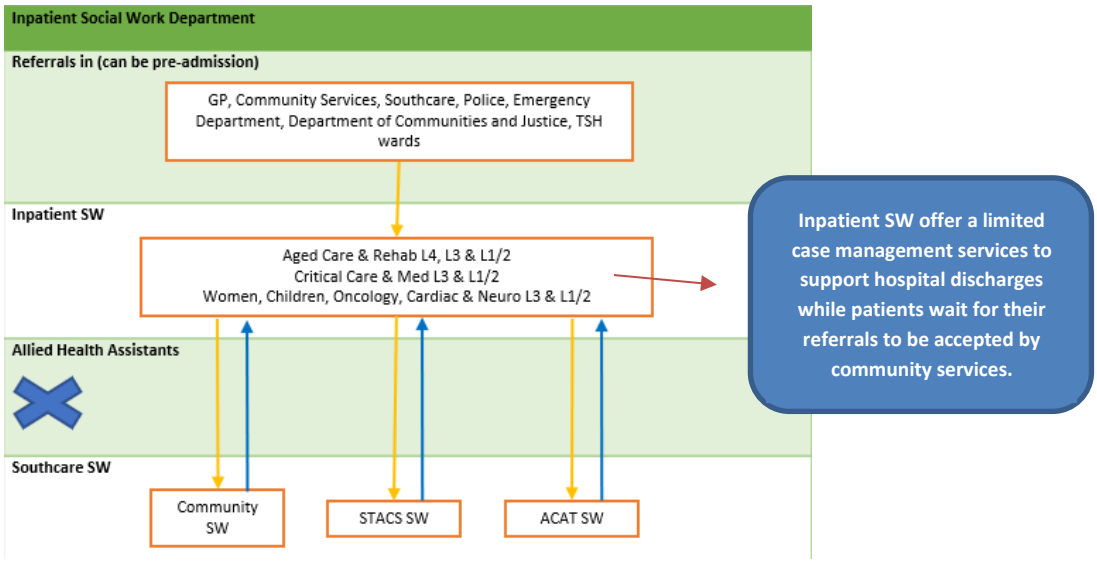
SOCAIL WORK - Allied Health Workforce Progression (2021 Award)						
Social Work Inpatient ✓ Southcare ✓ = Positions available at TSH						
Allied Health Assistant	Level 1 - working towards Cert IV qualification or student Physio/EP Student may apply for grad program.	Level 2 – Progress after 12 months in level 1 role or has completed Cert III qualification or equivalent.	Level 3 – Has completed the Cert IV qualification or equivalent (includes overseas trained physios without registration).	Responsibilities include basic patient care, administrative duties, delivering care plans.		
Graduates	Level 1 year 1 - 12 month rotational program. On completion of the program employees are encouraged to apply for local vacancies.					
Level 1/2	Level 1 - natural succession occurs for the level 1 staff from year 2 – 4. After 12 months working in a level 1 year 4 role clinicians progress to level 2. ✓✓	To move from level 1 to level 2 clinicians must have obtained respective new practitioner competencies and perform these in addition to level 1 duties	Level 2 - natural succession occurs for the level 2 staff from year 2 – 4. ✓✓	Level 2 year 4 staff can make an application for a personal re-grade to a level 3 Senior Clinician if they meet the criteria.		
Level 3/4	Senior Clinician (regrade) Level 3 year 1 regraded into this position. Natural progression to level 3 year 2.	Senior Clinician (L3) Recruited into this position with natural progression from year 1 – year 2. ✓✓	Level 3 year 2 staff can make an application for a personal re-grade to a level 4 Senior Clinician if they meet the criteria.			
Level 3/4	Senior Clinician (regrade) Level 4 year 1 regraded into this position. Natural progression to level 4 year 2.	Senior Clinician (L4) Recruited into this position with natural progression from year 1 – year 2.	Deputy Department Head (L3/L4) Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load.	Unit Head or Team Leader (L3/4) Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load. ✓✓	Department Head (L4) Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load.	Student Educator (L4) Recruited into this position with natural progression from year 1 to year 2. Can have clinical load. ✓
Level 5/6	Department Head (L5/6) Recruited into this position with natural progression from year 1 – year 2. May have clinical, educational or management duties (or a combination). ✓	Deputy Department Head Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load.	Unit Head or Team Leader Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load, provides leadership, guidance and line management.	Health Professional Educator (L5) Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load provides leadership, guidance and line management.	Clinical Specialist (L6) Recruited into this position with natural progression from year 1 – year 2. Needs clinically relevant post graduate qualification or has peer recognition.	
Level 7	Deputy Department Head Recruited into this position. Grading dependent on FTE managed.	Unit Head or Team Leader Recruited into this position. Grading dependent on FTE managed Grade 1 – 30 – 45, Grade 2 – 45-60.	Department Head Recruited into this position. Grading dependent on FTE managed Grade 1 – 25-40, Grade 2 – 40-55, Grade 3 - <55.			
Level 8	Discipline Specific Director/Advisor (L8) Recruited into this position. Grading dependent on FTE managed. Grade 1 - <25, Grade 2 -25-55, Grade 3 – 55-100, grade 4 - >100. ✓✓					

Appendix J - Inpatient Social Work Department Organisational Chart

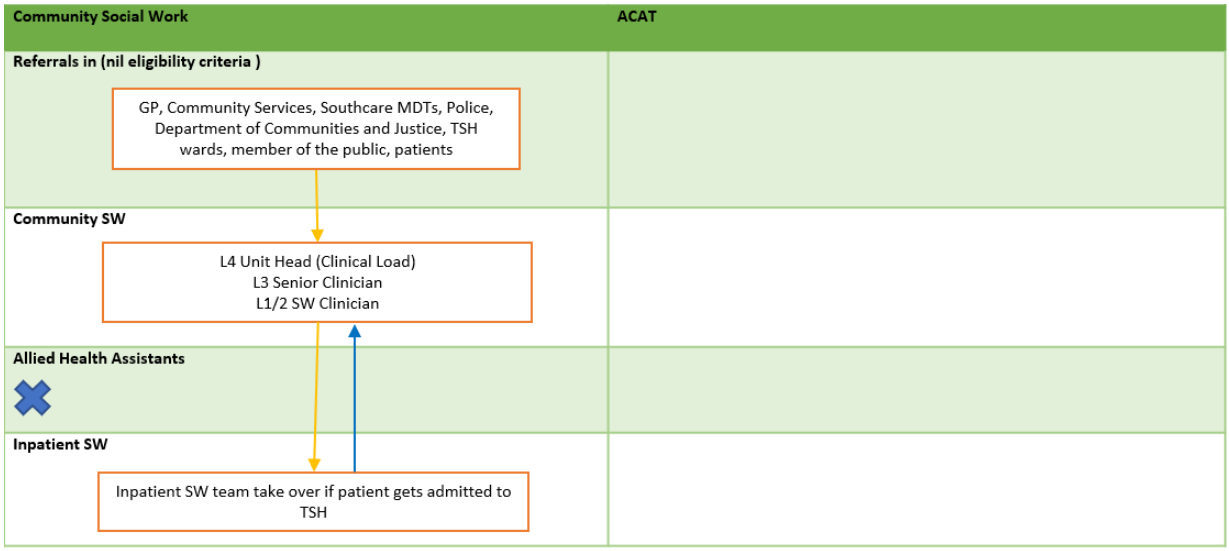


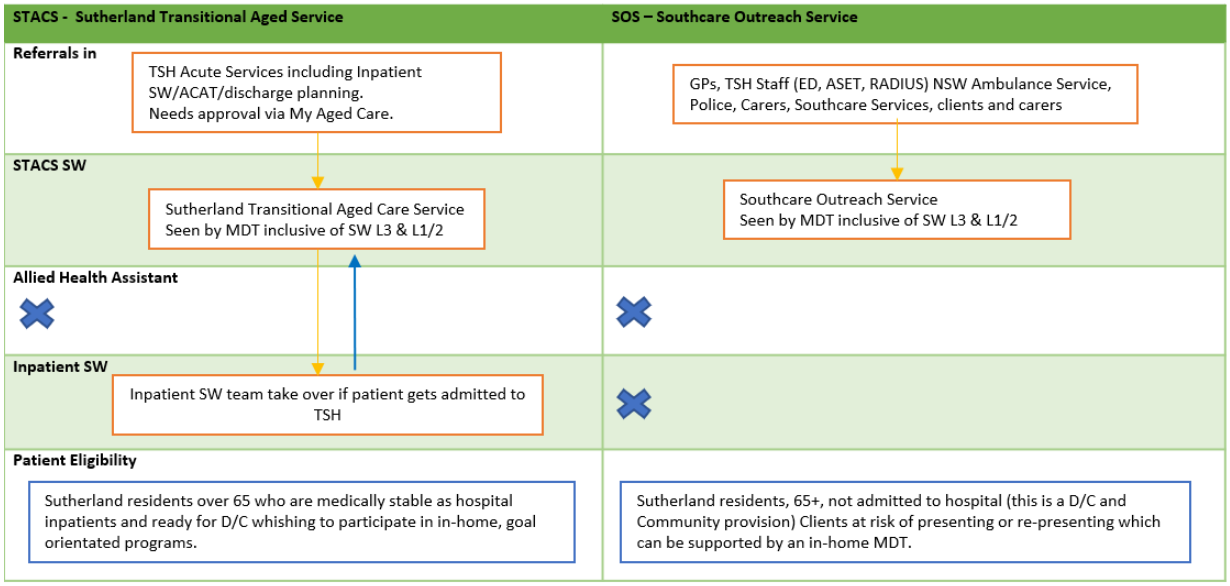


Appendix K - Inpatient Social Work Department Service Swim Lanes



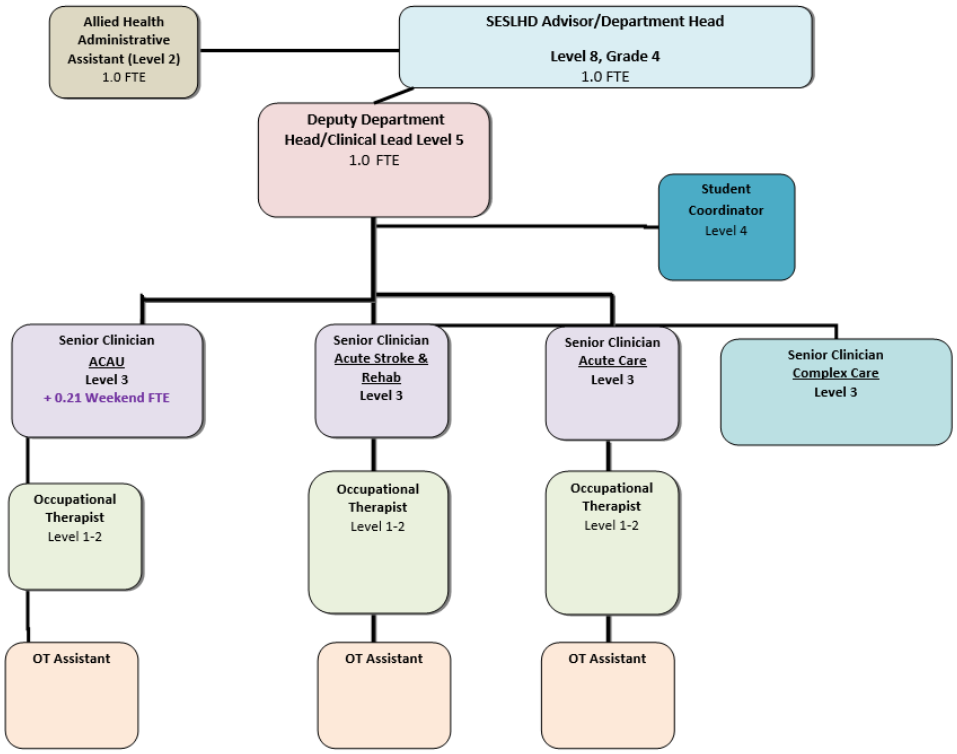
Appendix L – Southcare Social Work Department Service Swim Lanes





Appendix M - Inpatient Occupational Therapy Department Organisational Chart

Sutherland Hospital Occupational Therapy Service

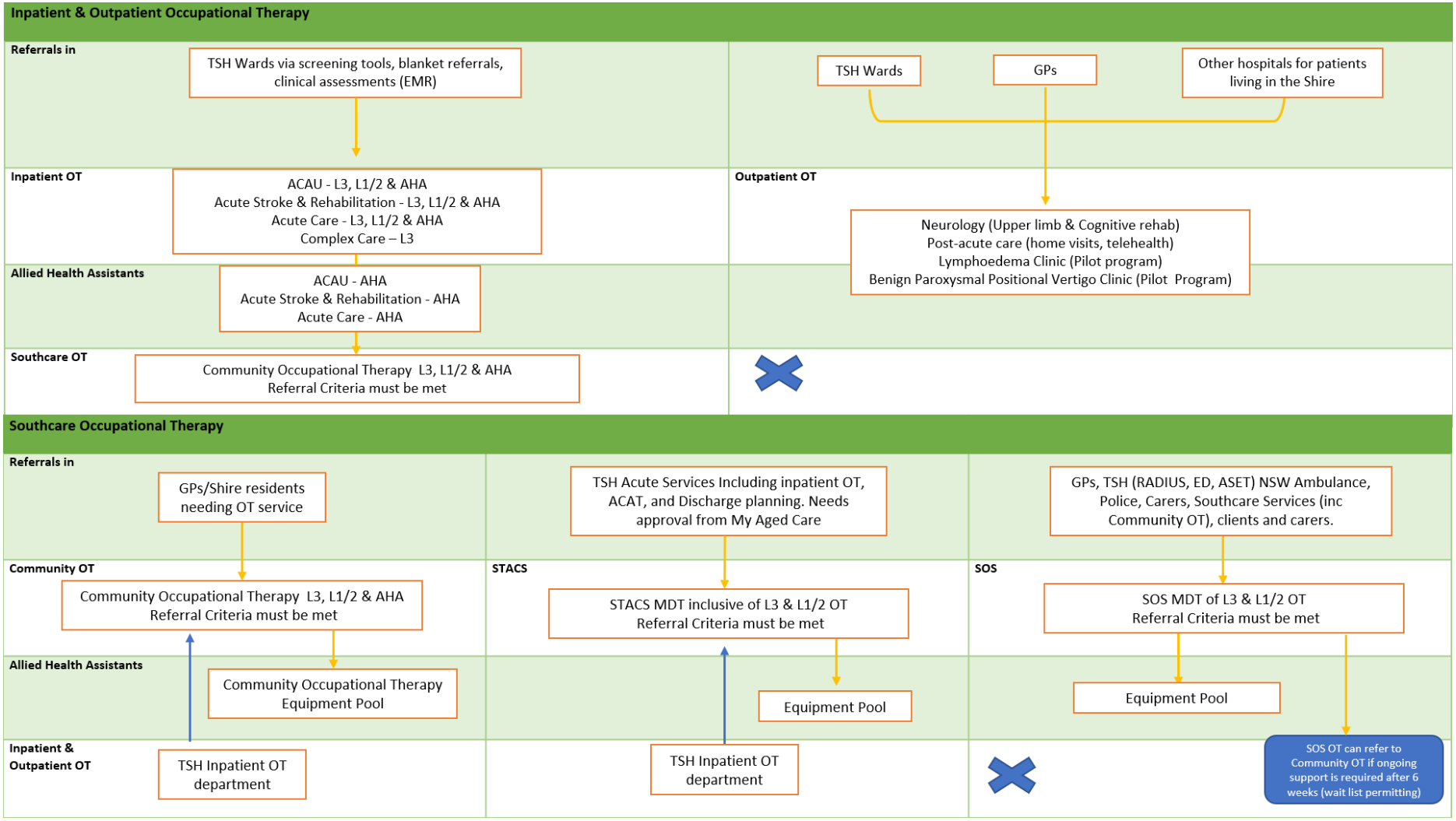


April 2022

Appendix N - TSH Occupational Therapy Workforce Progression

Allied Health Workforce Progression (2021 Award)						
Occupational Therapy Inpatient/Outpatient ✓ Southcare ✓ = available at TSH						
Allied Health Assistant	Level 1 - working towards Cert IV qualification or student Physio/EP Student may apply for grad program. ✓✓	Level 2 – Progress after 12 months in level 1 role or has completed Cert III qualification or equivalent. ✓✓	Level 3 – Has completed the Cert IV qualification or equivalent (includes overseas trained physios without registration). ✓✓	Responsibilities include basic patient care, administrative duties, delivering care plans.		
Graduates	Level 1 year 1 - No formal program, workforce used to support temporary contracts and maternity leave vacancies. Encouraged to apply for permanent positions if they become available. ✓					
Level 1/2	Level 1 - natural succession occurs for the level 1 staff from year 2 – 4. After 12 months working in a level 1 year 4 role clinicians progress to level 2. ✓✓	To move from level 1 to level 2 clinicians must have obtained respective new practitioner competencies and perform these in addition to level 1 duties.	Level 2 - natural succession occurs for the level 2 staff from year 2 – 4. ✓✓	Level 2 year 4 staff can make an application for a personal re-grade to a level 3 Senior Clinician if they meet the criteria.		
Level 3/4	Senior Clinician (regrade) Level 3 year 1 regraded into this position. Natural progression to level 3 year 2. ✓	Senior Clinician (L3) Recruited into this position with natural progression from year 1 – year 2. ✓✓	Level 3 year 2 staff can make an application for a personal re-grade to a level 4 Senior Clinician if they meet the criteria.			
Level 3/4	Senior Clinician (regrade) Level 4 year 1 regraded into this position. Natural progression to level 4 year 2.	Senior Clinician (L4) Recruited into this position with natural progression from year 1 – year 2.	Deputy Department Head (L3/L4) Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load.	Unit Head or Team Leader (L 3/4) Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load.	Department Head (L4) Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load.	Student Educator (L4) Recruited into this position with natural progression from year 1 to year 2. Can have clinical load. ✓
Level 5/6	Department Head (L5/6) Recruited into this position with natural progression from year 1 – year 2. May have clinical, educational or management duties (or a combination).	Deputy Department Head Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load. ✓	Unit Head or Team Leader Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load, provides leadership, guidance and line management. ✓	Health Professional Educator (L5) Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load provides leadership, guidance and line management.	Clinical Specialist (L6) Recruited into this position with natural progression from year 1 – year 2. Needs clinically relevant post graduate qualification or has peer recognition.	
Level 7	Deputy Department Head Recruited into this position. Grading dependent on FTE managed.	Unit Head or Team Leader Recruited into this position. Grading dependent on FTE managed Grade 1 – 30 – 45, Grade 2 – 45-60.	Department Head Recruited into this position. Grading dependent on FTE managed Grade 1 – 25-40, Grade 2 – 40-55, Grade 3 - <55.			
Level 8	Discipline Specific Director/Advisor (L8) Recruited into this position. Grading dependent on FTE managed. Grade 1 - <25, Grade 2 -25-55, Grade 3 – 55-100, grade 4 - >100. ✓					

Appendix O – Occupational Therapy Service Swim Lanes



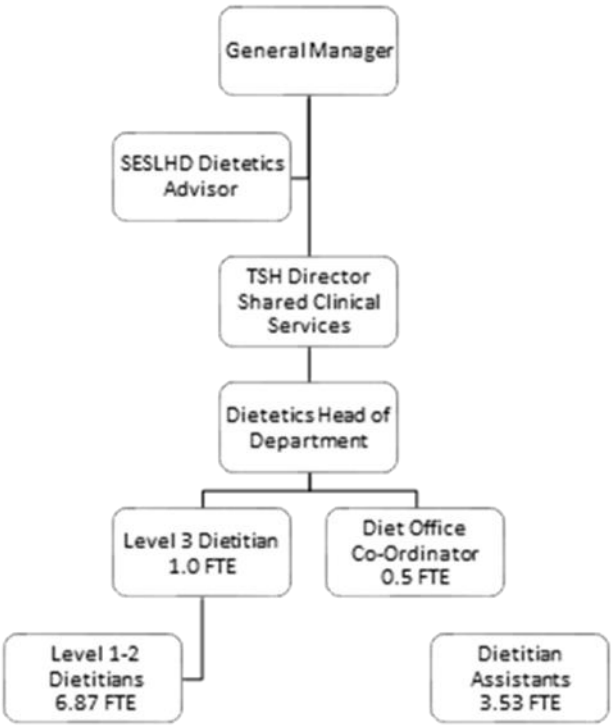
Appendix P - TSH Dietetics & Speech Pathology Workforce Progression

Dietetics & Speech Pathology - Allied Health Workforce Progression (2021 Award)

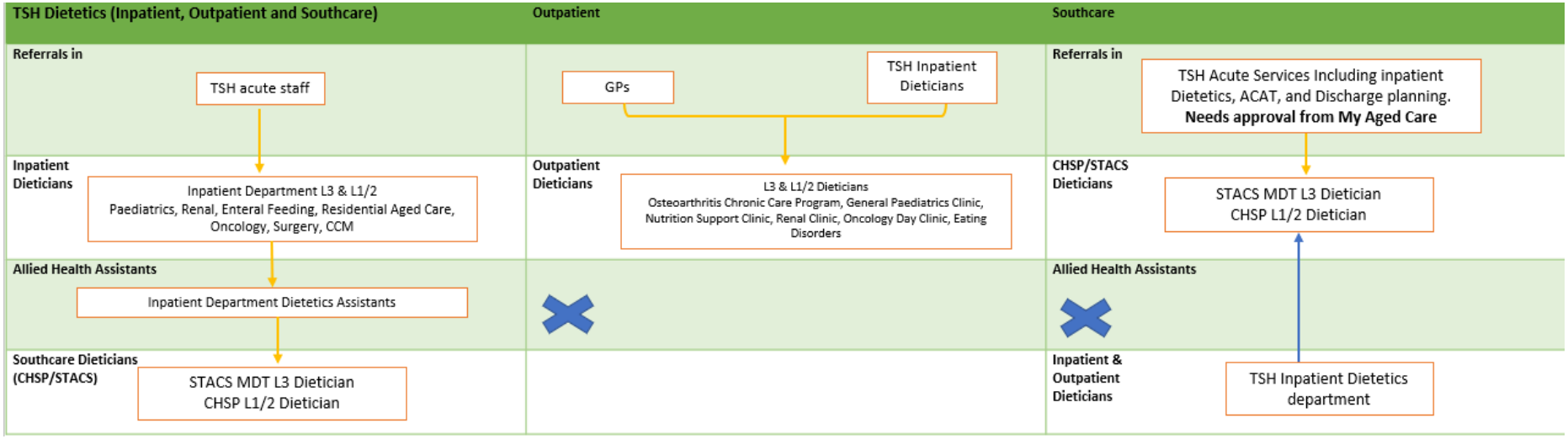
Dietetics Inpatient Outpatient ✓ **Southcare Dietetics** ✓ **Speech Pathology Inpatient Outpatient** ✓ **Southcare Speech Pathology** ✓ **= Positions available at TSH**

Allied Health Assistant	Level 1 - working towards Cert IV qualification or student Physio/EP Student may apply for grad program. ✓	Level 2 – Progress after 12 months in level 1 role or has completed Cert III qualification or equivalent. ✓	Level 3 – Has completed the Cert IV qualification or equivalent (includes overseas trained physios without registration). ✓	Responsibilities include basic patient care, administrative duties, delivering care plans.		
Graduates	Level 1 year 1 - 12 month rotational program. On completion of the program, employees are encouraged to apply for local vacancies.					
Level 1/2	Level 1 - natural succession occurs for the level 1 staff from year 2 – 4. After 12 months working in a level 1 year 4 role clinicians progress to level 2. ✓ ✓ ✓	To move from level 1 to level 2 clinicians must have obtained respective new practitioner competencies and perform these in addition to level 1 duties.	Level 2 - natural succession occurs for the level 2 staff from year 2 – 4. ✓ ✓ ✓	Level 2 year 4 staff can make an application for a personal re-grade to a level 3 Senior Clinician if they meet the criteria.		
Level 3/4	Senior Clinician (regrade) Level 3 year 1 regraded into this position. Natural progression to level 3 year 2.	Senior Clinician (L3) Recruited into this position with natural progression from year 1 – year 2. ✓ ✓ ✓ ✓	Level 3 year 2 staff can make an application for a personal re-grade to a level 4 Senior Clinician if they meet the criteria.			
Level 3/4	Senior Clinician (regrade) Level 4 year 1 regraded into this position. Natural progression to level 4 year 2.	Senior Clinician (L4) Recruited into this position with a natural progression from year 1 – year 2.	Deputy Department Head (L3/L4) Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load.	Unit Head or Team Leader (L3/4) Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load.	Department Head (L4) Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load. ✓	Student Educator (L4) Recruited into this position with natural progression from year 1 to year 2. Can have clinical load.
Level 5/6	Department Head (L5/6) Recruited into this position with natural progression from year 1 – year 2. May have clinical, educational or management duties (or a combination). ✓	Deputy Department Head Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load.	Unit Head or Team Leader Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load, provides leadership, guidance and line management.	Health Professional Educator (L5) Recruited into this position with natural progression from year 1 – year 2. Maintains a clinical load provides leadership, guidance and line management.	Clinical Specialist (L6) Recruited into this position with natural progression from year 1 – year 2. Needs clinically relevant post graduate qualification or has peer recognition.	
Level 7	Deputy Department Head Recruited into this position. Grading is dependent on FTE management.	Unit Head or Team Leader Recruited into this position. Grading dependent on FTE managed Grade 1 – 30 – 45, Grade 2 – 45-60.	Department Head Recruited into this position. Grading dependent on FTE managed Grade 1 – 25-40, Grade 2 – 40-55, Grade 3 - <55.			
Level 8	Discipline Specific Director/Advisor (L8) Recruited into this position. Grading dependent on FTE managed. Grade 1 - <25, Grade 2 -25-55, Grade 3 – 55-100, grade 4 - >100.					

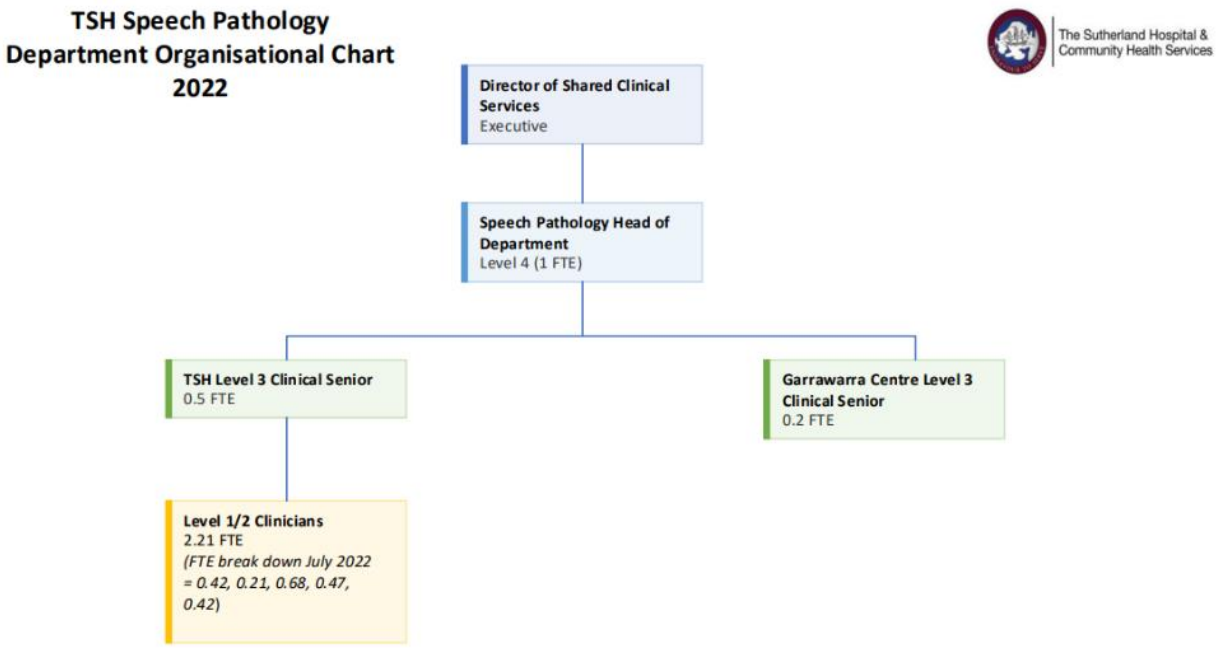
Appendix Q – Inpatient Outpatient Dietetics Department Organisational Chart



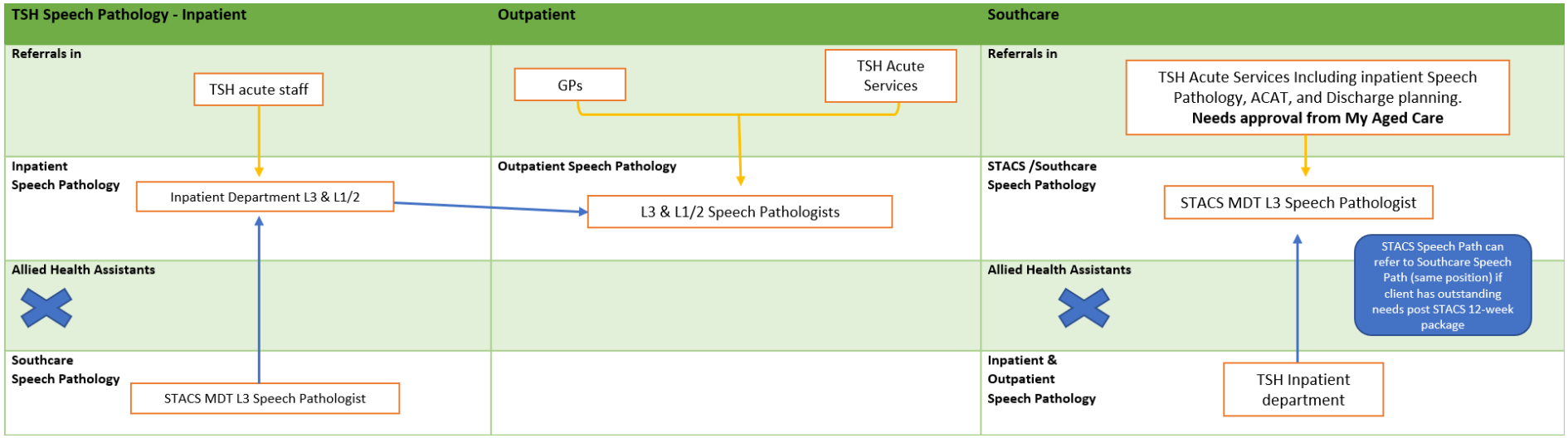
Appendix R – Dietetics Services Swim Lanes



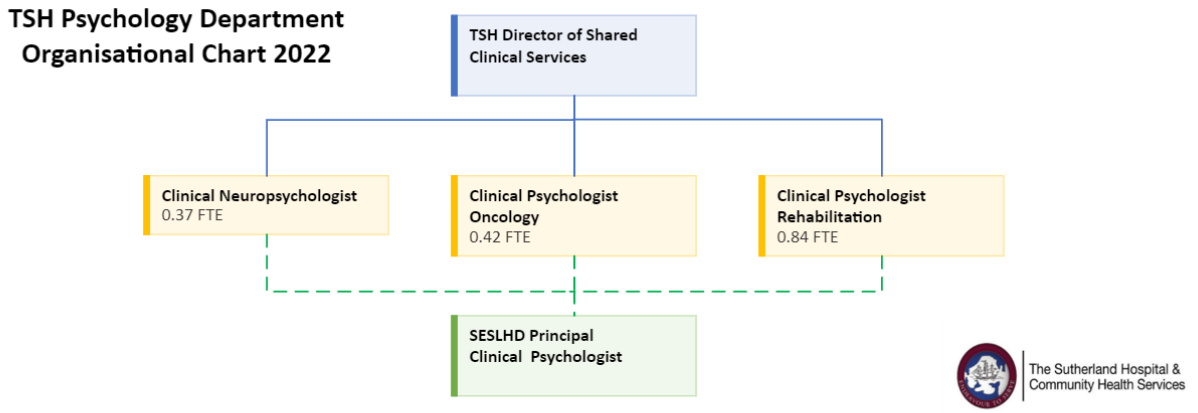
Appendix S – Speech Pathology Organisational Chart



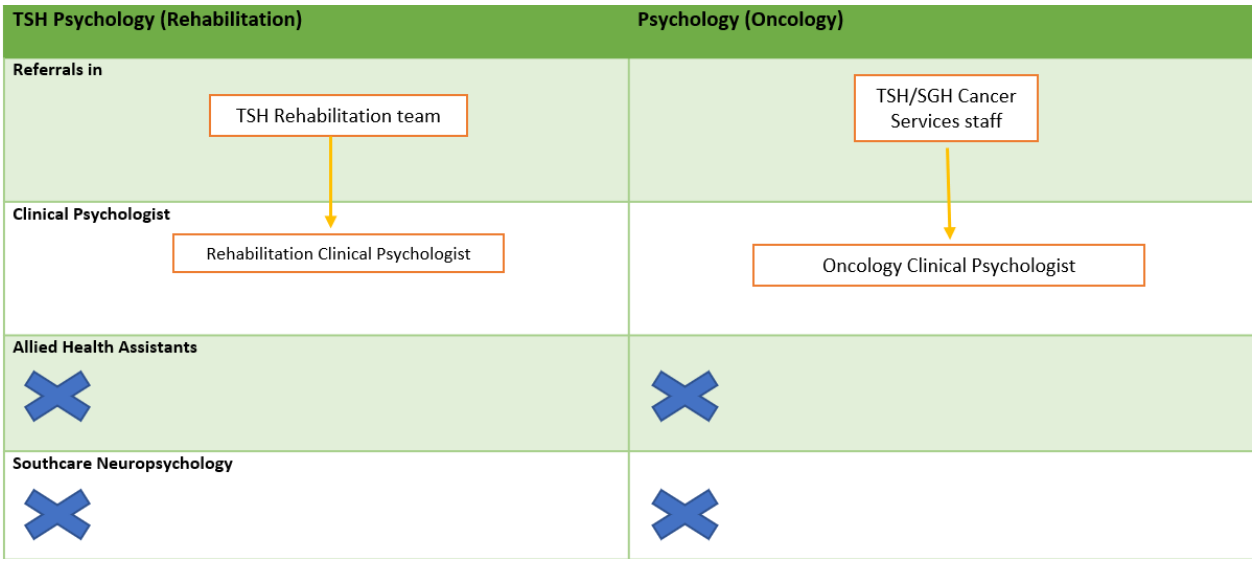
Appendix T – Speech Pathology Service Swim Lanes



Appendix U – Psychology Organisational Chart



Appendix V – Psychology Swim Lanes



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