Background

Mater Health Services (Mater) is experiencing significant change with the move of publicly funded paediatric services from Mater Children’s Hospital (MCH) to Lady Cilento Children’s Hospital (LCCH) in late 2014. The loss of paediatric services will have a major impact Mater wide and as such requires Allied Health as a Division to carefully plan moving forward.

In planning for the closure of MCH, Mater has been identifying opportunities for new and expanded services. Broadly known as the Mater Beyond 2014 group of projects, the ‘replacement’ activity includes:

- a new Neurosciences Centre,
- a private paediatric service,
- development of adolescent health services,
- ‘backfill’ of beds and theatre activity at Mater Private Hospital Brisbane (made available by shifting neurosurgery) and,
- expansion of some selected Mater Adult Hospital services.

In addition to the above, Mater is developing centres of excellence in Women’s Health and Newborn Services and Cancer Services. It must be noted that Mater Beyond 2014 has identified that these new services will take many years to build up to the capacities you may have heard discussed and even with time will be much smaller in size and activity than the current paediatric service. In addition, there will be no substantial increase in public funding at the end of 2014 to offset the loss of MCH. In fact the opposite will occur in that we will lose 30,000 Weighted Activity Units (WAU’s) for public children’s activity which will only be replaced by 3,000 WAU’s for public adult activity in 2014-15.

The key to the success of Allied Health being a core contributor to the achievement of Mater’s future strategic environment and delivering services that grow with Mater’s future focus areas, lies with our people. In order to achieve high quality and sustainable health services, we must build a future state that takes into account financial and other organisational drivers while ensuring high quality patient centred care. To this end, the Division of Allied Health is undertaking a review to ensure the ongoing effectiveness and sustainability of services in line with Mater’s Strategic Plan 2013 – 2018. The key deliverables for the Allied Health review over the next couple of months are:

**Deliverable 1:** Development and endorsement of productivity and workforce standards to guide workforce profiles into future

**Deliverable 2:** Review divisional structure and governance taking into account:
- loss of MCH,
- Mater’s centres of excellence, and
- financial sustainability

**Deliverable 3:** Review departmental structures, workforce numbers and workforce mix in line with:
- endorsed workforce standards and productivity targets as per Deliverable 1,
- benchmarking, and
- funded activity levels

**Deliverable 4:**Priority changes to models of care identified by:
- division
- department (in line with service and workforce trends, ABF and national agendas)

**Deliverable 5:** Implementation plans developed and signed off:
- divisional
- departmental

This document has been produced as a basis for discussion and to seek your feedback regarding future Allied Health models of care, governance and workforce structures, and workforce profile.

National and International Trends for the Health Workforce

The health landscape is changing. There is an increasing demand on services due to people generally living longer, technological and medical advances which mean that people are surviving with complex long term conditions, and health costs are increasingly age dependent with an exponential increase after age 50 years. At the same time, we are witnessing a decrease in supply across the workforce. Relative to the number of older people, by 2050, the
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working age population will fall by approximately half \(^1\), which will lead to greater competition for skills across all sectors.

Allied Health not only needs to respond to these issues of supply and demand, but must also provide patient driven service provision, and maintain quality of care whilst building efficiencies in a constrained fiscal environment. Through this, it is imperative that Allied Health ensures that health professionals undertake tasks appropriate to their roles and skills and are provided with the opportunity to enhance their scope of practice. In order to achieve this, Allied Health must have appropriate organisational governance structures in place.

Globally, health practitioner (HP) professions have grown in size and influence in the developed world over the last two decades. Data from the United Kingdom (UK) from late 1990s to date, indicates that Allied Health has grown more significantly than any other workforce group. Roles have expanded in scope to include the development of advanced practitioners. In addition to this, the role of a HP as first contact practitioner in diagnostics, treatment, rehabilitation and therapy has contributed to this growth. A similar theme is apparent in most developed countries.

The Mason Review of Government Health Workforce Programme (April 2013), recommended Australia changes its “focus on specialist medicine and acute care beds, to appropriate generalist skills, team based community care and the training and development of the nursing and allied health workforce”. The report identified specific priorities for allied health including greater multi professional education and working patterns, role development, and further development of Allied Health assistant roles.

Health Workforce Australia (HWA) is currently exploring how the development of Allied Health assistant roles can assist capacity and productivity as well as examining HP role development and innovation including expanded scope and prescribing pathways. This need for change in practice has been confirmed through the Queensland Health Ministerial Taskforce (May 2014) which found that opportunities exist to extend the scope of practice of Allied Health professionals in line with reforms in other Australian states and internationally, and that the support workforce can be used more effectively to enable Allied Health professionals to work to their full scope of practice \(^2\).

In recent years, Allied Health Professions Office of Queensland (Queensland Health) has published a number of workforce reports that identify opportunities for change in the utilisation of the HP workforce. While each report has a different focus, key themes have emerged including the development of Allied Health assistant roles, opportunities for multi professional pathways and team development, and the use of Allied Health clinical leadership roles in new team structures in areas such as emergency departments, sub-acute, general medical and cancer care. A Workforce Mix Framework published by the HR Branch of Queensland Health (2012), identified that there are clear indicators that a change in health care delivery models in Australia are required to meet the population health projections in a sustainable and affordable manner.

All indicators from sources within Australia and more globally indicate that changes and enhancements to work patterns and scope of practice are integral to the role HPs will play within a finite fiscal climate. To ensure that Allied Health continues to contribute to Mater achieving its strategic goals, Allied Health must embrace models of care and workforce structures that are efficient in practice and support clinicians working at full or extended scope. At the same time, it is critical to ensure that workforce guidelines enable Allied Health professions to innovate and create models of care that respond to patient needs.

**Issues to Consider: Deliverable 1 - Productivity and Workforce Standards to Guide Workforce Profiles**

1. **Workforce Profile**
   
   Allied Health must have the right people with the right skill level in the right jobs at the right time. To ensure future sustainability of services and support for our clinicians working at full scope, our aim is for all professions and teams to work towards the achievement of a balanced workforce.

   Over the last three years, several departments have initiated work to ensure clinicians are working at full scope and others have identified opportunities for clinicians to extend their scope of practice. In addition to this, considerable work has been undertaken to enhance the Allied Health assistant workforce across the division. This has included:

\(^1\) *Boyce RA 2000, “Transforming Allied”, Australian Health Review, Vol 23, No 4, pp 160 – 169*  

\(^2\) *Ministerial Taskforce on Health Practitioner Expanded Scope of Practice: Final Report (May 2014)*  


\(^4\) *Boyce RA 2003, “Beyond organisational design: moving from structure to service enhancement”, Australian Health Review, Vol 26, No 1, pp 175 - 183*
establishment of new Allied Health assistant roles in Social Work, Mater At Home, Speech Pathology and Audiology,
expansion of scope of practice for Allied Health assistants in most departments, and
a general increase in the proportion of Allied Health assistant roles. This work has seen the percentage of Allied Health assistants increase to represent approximately 14.29% of our workforce (please note: MCH staff, nursing and administration were excluded for this calculation). Of this, the majority of the assistant workforce is Nutrition Assistants.

In designing our future workforce profile, it is important to review and consider benchmarks that have been established across the health sector. In September 2013, Metro North Hospital and Health Service established a benchmark of 40% HP3 staff across the Allied Health workforce and identified the potential to expand clinical support worker FTE to between 20 – 30%. Similarly, in March 2014, the Children’s Health Queensland Hospital and Health Service employed the following principles in building their workforce: 41% of staff will be HP2 / HP3, 28% HP4, 20% HP5, 3% HP6 and 2% HP7. The extrapolation of data from our Allied Health Alternate Workforce Project (2012) indicates that up to 30% of tasks performed by Mater Allied Health professionals could be undertaken by suitably trained Allied Health assistant staff under a delegation model with appropriate supervision by clinicians.

In the future state, it is anticipated that Allied Health assistants would work across Allied Health in profession specific and multi-professional roles, be utilised to their full scope, and would be considered in all workforce planning to ensure the most cost effective workforce mix. It has been identified that opportunities exist to review activity and ensure a more efficient workforce mix through using greater numbers of Allied Health assistants and further develop existing roles for our current assistant workforce. Within our future workforce profile, further consideration also needs to be given to how Allied Health supports research and how the role of administrative staff supports the efficient delivery of services.

2. Productivity Standards

Clinical Care Ratios

Currently, Mater Allied Health has an average departmental clinical care ratio benchmark of 70% which is reported monthly through the allied health dashboard. It is important to note that this is an average across a department and as such includes research and clinical educator roles where clinical care would be lower. Individual clinicians clinical care and other activity is reported and available through the “My Activity” reports. Benchmarking across Australian hospitals (including Health Round Table data) provides a consistent indication of the expected productivity of the Allied Health workforce in relation to clinical care. At the National Health Round Table Conference (2013), where approximately 45 health services participated, it was identified that clinical care ratio expectations of Allied Health staff were as follows:

<table>
<thead>
<tr>
<th>Role</th>
<th>Clinical Care (CC) Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>HP3 workforce</td>
<td>Maintain an 80% CC Ratio</td>
</tr>
<tr>
<td>HP4 and above clinical roles</td>
<td>Maintain a minimum of 70% CC ratio</td>
</tr>
<tr>
<td>Team Leaders (mix of management and clinical responsibilities with &gt; 10 FTE)</td>
<td>Maintain a minimum of 50% CC ratio</td>
</tr>
</tbody>
</table>

These clinical care ratio expectations have been reinforced through benchmarking data received from Metro North Hospital and Health Service and Metro South Hospital and Health Service.

Clinical Duration Targets and Episodic / Consultation Time

While episodic duration time rather than individual consultation time is recognised as a useful indicator for considering Allied Health efficiency, difficulties arise in effective benchmarking of such data. Challenges include:

- Average episodic time per discipline benchmarked between organisations becomes indicative at best, given the differences in casemix that impact on episodic duration. For example, an organisation that has rehabilitation and cancer services would expect to have higher episodic duration times for many disciplines such as Social Work, Physiotherapy, Speech Pathology and Occupational Therapy than those without these services. Further, the degree to which the duration times are impacted will depend on the size of these services.

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2 Ministerial Taskforce on Health Practitioner Expanded Scope of Practice: Final Report (May 2014)
4 Boyce RA 2003, “Beyond organisational design: moving from structure to service enhancement”, Australian Health Review, Vol 26, No 1, pp 175 - 183
• Analysing data at a service level, as seen in Health Round Table, is helpful but would require large volumes of time to analyse in order to build up a total workforce picture. Furthermore, variations exist between facilities in what data is included which makes analysis difficult. For example, some organisations include student activity while others do not; incorporation of student activity increases the episodic duration time.

While being aware of these challenges, Health Round Table data provides the most comprehensive and reliable dataset and allows for the identification of differences in models of care and their relative efficiency.

Issues to Consider: Deliverables 2 & 3 – Changes to Divisional and Departmental Structures, Governance and Workforce Mix

As highlighted previously, Allied Health must ensure workforce structures and governance frameworks are efficient in practice, support clinicians working at full or extended scope, contribute to the achievement of Mater’s strategic direction and are sustainable. Currently at Mater, departments within Allied Health are generally structured in line with the broad areas of Adults, Mothers’ and Children’s Services with team leaders responsible for teams within each facility as well as some cross complex services/teams. Departments report through to the Director Allied Health through Departmental Directors. Allied Health’s current governance framework incorporates facility meetings to bring together Allied Health Team Leaders within each facility to address common issues and strategies, and also includes committees that oversee the functioning of various portfolios e.g. research and health and wellness.

In reviewing Allied Health’s organisational structure, the changes occurring at Mater need to be considered. These include:

- the loss of Mater public Paediatric Services
- establishment of Centres of Excellence in Cancer Services, Women’s Health and Newborn Services, Neurosciences and Adolescent and Young Adult Services
- increased Adult activity planned over the next four years
- changing models of care with anticipated increases in activity and workforce in alternative hospital settings.

There is a substantial body of literature that identifies structure and governance models for Allied Health workforces, particularly related to hospital based services. The four most commonly considered structures are summarised below:

- **departmental model with organisation wide professional governance** – Mater’s current Allied Health structure would best be described by this model with some exceptions such as CYMHS.
- **Allied Health multidisciplinary team (MDT) program model** 3 - where Allied Health staff are managed in Allied Health team structures that live within a division. This is supported by a head of discipline for each profession who has a dual operational role for a service stream program and a governance role for their specific profession across the organisation
- **fully devolved or unit dispersement model** 4 - where Allied Health staff are deployed across a broad range of clinical areas and are operationally managed by those areas. Professional governance is separate from line management.
- **service agreements** – where Allied Health continues to be managed through profession specific departments but negotiates internal service agreements with clinical units. Staffing arrangements are determined based on agreements for activity.

In considering future structure and governance frameworks for Allied Health, it is also important to consider what is working well with our current structure and what changes could be made to achieve better outcomes for the patients, staff and the organisation.

Issues to Consider: Deliverable 4 – Changes to Divisional and Departmental Models of Care

As indicated previously, Allied Health has, in the past few years, implemented initiatives to optimise HPs working at full scope and increased the utilisation of Allied Health assistants in the delivery of health care. In line with national and

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4 Boyce RA 2003, “Beyond organisational design: moving from structure to service enhancement”, Australian Health Review, Vol 26, No 1, pp 175 - 183
international trends, Allied Health must continue to investigate and participate in the development of models of care that:

- reduce length of stay,
- prevent admission, and
- enable appropriate sharing of skills and delegation of tasks, thereby increasing efficiency and reducing costs while maintaining quality care.

In response to these drivers, changes to models of care that can be found nationally and internationally include:

- skill sharing between Allied Health disciplines:
  - multidisciplinary approach to assessments: one Allied Health assessment conducted, followed by referral to appropriate disciplines rather than repeated assessments by each Allied Health profession. This model has been successfully implemented in MAPU, EDs and medical wards at various sites across Queensland and nationally,
  - identification and nomination of clinical leads / lead clinicians for particular caseloads (e.g. general medicine, general surgery, ED, stroke). The role of lead clinician (typically physiotherapy or occupational therapy) is to utilise their clinical skills as well as “generic” / interdisciplinary skills in the assessment and treatment of patients and to coordinate timely referral to other Allied Health disciplines as appropriate. This model is currently being implemented across various sites in Queensland to facilitate the safe and timely discharge of patients.
  - other skill sharing between health professions to optimise timeframes for patient attendances and occasions of service
    - Development of criteria led discharge to enable timely discharge of patients
- delegated practice through the utilisation of Allied Health assistants in profession specific and multi-profession settings;
- review and transfer of less acute services to community settings including GP’s, NGO’s etc as well as development of partnerships with community and other agencies to ensure patients receive the appropriate level of care in the appropriate setting
- use of student clinics as an adjunct to hospital services which would otherwise be considered out of scope. This provides additional access to services that would otherwise not be readily available, while also providing students and universities with access to quality training.

**Deliverable 5 – Sign-off and Implementation of Plans**

After considering your ideas and feedback throughout the review process, proposals will be made as to how best to ensure ongoing effectiveness and sustainability of Allied Health services in line with Mater’s Strategic Plan 2013 – 2018. Your further feedback will be sought on any specific proposals prior to any decision being made with respect to their implementation.

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2 Ministerial Taskforce on Health Practitioner Expanded Scope of Practice: Final Report (May 2014)