



Is it a bird? Is it a plane? No ... it's an allied health professional

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Having lived in North Qld now for a while I have actually gotten a little used to being called a bird, better a bird than a 'sheila' I suppose and definitely better than being called a boeing 747.

So I am quite happy to be an allied health professional. But we a rare breed- and being a physio I may be on the list of endangered species. Somehow if I am not careful this talk is going to end up entirely about birds. Those who know me will appreciate that I do find it fairly easy to get off the track ...

So! allied health professionals are often a rare breed- and this group more than most will know that in rural and remote Australia we are rarer still. There would most often be far more chance of spotting that bird or plane in remote Australia than spotting an allied health professional. So how did we get to the stage where in Mt Isa at an aerobics class at the gym 2 weeks ago I casually observed that we had three physios and one OT in the class at the same time ... how did we get to find that once in a building that was big enough to rattle around in, so that we did contemplate only moving into one floor of that building- how did we go from that to now busting at the seams with over 35 staff in that office- 21 of which are allied health professionals? You are in danger of opening a cupboard door and some psychologist falling out- trying to find a private space to talk ...

Well the story starts in 2000 when North and West Queensland Primary Health Care (NWQPHC) was funded to develop models for the provision of holistic, coordinated, multidisciplinary primary health care in North West Qld. We are a division of general practice, which to those of you not familiar with divisions—we are one of a network of divisions which were established in 1994 to improve health outcomes for patients by encouraging GPs to work together and form links with other health professionals to upgrade the quality of health service delivery at the local level.

At that time one of the main barriers for our GP membership to practice within a PHC framework was the lack of any allied health practitioners to refer to. To practice holistic care in a multidisciplinary team in an environment where you had a distinct lack of many others to be in fact part of that team- was the biggest challenge our membership felt at that time. And the division felt that this was something we may be able to exert some influence over by seeking funding if the opportunity arose. So in 2001 the division worked with the venerable Kris Battye to formulate a funding proposal to the regional health service program of the health services branch of the Australian Government. Subsequently, in 2001 we were funded to establish an outreach allied health service in Mount Isa to provide services to remote communities in the region. It was recognised in the planning phase of the service that recruitment and retention of the Allied Health workforce was crucial to the implementation of a sustainable outreach service. There was evidence to work with, and a comprehensive raft of key recruitment and retention strategies were identified and incorporated into the model. There were the doomsayers of course, but there is nothing to great at shutting up doomsayers as proving them wrong. In fact it's even more fun.

The original model had 7.75 fully funded AHPs, 1 administration officer and a manager. The first staff started work in the managers house, we had trouble finding anywhere suitable to locate but eventually moved into what had been a catholic girls dormitory. We had no trouble getting those original staff, of which I was one and we have a few floating around at the conference. Advertisements were designed to be innovative, trying to attract people looking for an adventure and something new. The R&R package had had a lot of thought put into it, and had been designed to address the key issues that research had highlighted as the main issues experienced by rural and remote AHPs. You can see what I have listed as the big ticket items rural and remote practitioners had voiced at that time

- ▷ lack of advocacy
- ▷ inappropriate line supervision i.e. by non-allied health professionals or non-clinical people
- ▷ lack of clinical and professional support (particularly in solo positions)
- ▷ difficulties in accessing professional development due to geographic isolation, cost, and lack of information technology access
- ▷ lack of orientation





- ▷ unrealistic expectations and pressure on allied health professionals for large caseloads including excessive travel
- ▷ failure to backfill or delay in recruiting vacant positions, lead to loss of esteem for the allied health positions and a backlog of work

And I think we can relate to all of them. It seems what people were asking for was to feel valued and respected, allowed and encouraged to develop in their career, and some sense of work/ life balance that didn't mean if they went away on leave etc that the work stopped and waited for when they came back.

So the model was designed to address these things, and the screen shows you what the key strategies were:

- ▷ line management by an experienced allied health professional with experience of rural and remote service delivery, personnel and service management.
- ▷ salary- equivalent to that paid to the Queensland Health outreach AHPs.
- ▷ realistic workloads and travel- based on the best information available at the time.
- ▷ attendance at a minimum two conferences per year with a budget of eventually \$5000 total. It costs a lot to get in and out of Mt Isa.
- ▷ cultural and contextual orientation to remote practice. This has largely been provided through the Graduate Certificate in Health (Remote Health Practice) offered through the Centre for Remote Health in Alice Springs, and local orientation to Indigenous culture.
- ▷ funded professional mentoring.
- ▷ six weeks annual leave
- ▷ annual airfare home.
- ▷ housing subsidy.
- ▷ relocation costs, with costs to be repaid on a pro-rata basis should the employee not complete their contract.
- ▷ assistance with spouse / partner employment
- ▷ childcare subsidy
- ▷ retention payments. To be paid after 2 years service, but with no amount specified either in the funding submission, or the staff contracts.

Staff were questioned at 3–6 months after first starting and this formed part of the early evaluation of the service by Kris Battye and Peter Stanley-Davies. It was identified that the structure of the recruitment and retention package and the obvious thought that had gone into its design was much more important than the individual benefits or overall financial package provided. Perhaps it was those feelings of value and respect that were generated that were the important part.

I had wanted this talk to be about our example of innovative models of service delivery and workforce practice. The story of the recruitment of the original team is important to us, and many of the original strategies we still apply today. More importantly we try and retain and build on the context in which they are applied and remember what the underlying values are.

We have a workplace that has strong team based and mentor based support networks, with team leaders/ managers who are allied health themselves and 'know what it is like'. As a young organisation we are behold to recreate a health bureaucracy. We have the benefits of flexibility, adaptability and breaking new boundaries. The rules are not there for rules sake, and sometimes protocols do not exist yet. So our workplace is for practitioners who are flexible, adaptable, team based, tolerant of diversity and sometimes like doing things just that little bit differently. (Oh and by the way, we are looking for an audiologist, psychologist, team leader and manager at the moment so if this sounds like you then see me or Kelly later! Couldn't resist that opportunity for a serious piece of advertising ...)





The evaluation conducted in 2003 by Kris Battye & Peter Stanley-Davies compared recruitment and selection process used by NWQPHC to international human resource management practices. I kinda liked this part. The evaluation identified some areas that had been found to be important for international assignments, and they sound familiar.

Cultural adaptability including cross-cultural fluidity, cultural sensitivity, tolerance of ambiguity, maturity, stability and ability to adapt behavioural style, identification of needs of the family, involving the spouse/ family in the selection process from the start, and last but not least technical ability. All things that we look for amongst our staff.

Back to the story.

NWQPHC has since experienced rapid growth and now employs over 35 staff in the Mt Isa office, of which 21 are allied health, and over 90 staff organisation wide of which a little under 60 are health service staff. Much of this was obtained in 2004/5 from OATSIH to strengthen our outreach health services, and even more importantly for us, to provide services for and with Aboriginal and Torres Strait Islanders clients in the community of Mt Isa itself where we are based. This had not previously been possible before under the RHS funding we received. We were able to strive on in some important directions from this, mostly directed and shaped by our community panel members who helped us to shape a plan for future growth. We:

- ▷ provided services to more communities
- ▷ provided more frequent services of some disciplines to some communities.
- ▷ put in place a more realistic workload demand for our staff to allow PD, leave and the model of work we supported. This is now 13 days travel in a 6 week (30 work days) cycle.
- ▷ employed a broader range of staff including HPOs, AHW, PHC nurses, endocrinology, audiology
- ▷ no solo practitioner disciplines- most have now two or three per discipline.
- ▷ introduced senior practitioner positions to put in place formal pathways of career progression
- ▷ strengthened the administration and management components of the model
- ▷ are starting a new mini- hub in Normanton in collaboration with the local GP to start a new concept in community based health services centred around the GP as a member of the PHC team. This is designed to build capacity locally and could be a topic for a whole different presentation. I am quite excited about the possibilities for this.
- ▷ completing some capital works programs in Mt Isa and Normanton to house all these new staff. This is no mean feat in remote areas in the middle of a resources boom.
- ▷ have employed a new Research and Evaluation Officer whose first job it is to progress the work formally birthed in Alice Springs last year to develop outcomes measurements for remote outreach allied health teams. Although Torres couldn't be with us this week, his able stablemate Tilley has workshopped some of that stuff with some of you yesterday and will present to you some initial findings tomorrow
- ▷ have embarked on a new information management system which will be able to achieve the multi-functions we need of it to capture statistical information and electronic health records for clients of the health professionals, but also cater for remote health clinic needs and GP practices.
- ▷ progress our CBW program across the region. This is the topic for another presentation by Katherine G and Karen O tomorrow.
- ▷ this is all Mt Isa based stuff. There are many other major milestones we have achieved across the whole division including the management of three remote primary health care clinics in Birdsville, Bedourie and McKinlay.

What have been some of the interesting issues for us?

When you look at this graph it is apparent how quickly we have grown and how much. From an on the ground perspective there were great opportunities that occurred with this, but there have also been challenges. Most of this





growth would have been almost impossible to predict and so when we have planned ahead for change, what has actually eventuated has been quite different! In our efforts to move on, take the opportunities given to us and get services out, an organisation of 10 or so people has had to reinvent itself a number of times. We have restructured several times out of necessity and had some periods of time where the struts of the model which are so important have not always been rigorously applied. We are in the process of conducting a review in our Mt Isa office, and hear staff viewpoints of inadequate orientation and IT nightmares.

For me the consolation is this. NWQPHC is an organisation that has proved itself able to listen, learn, and reinvent itself. It is not necessarily a shame to do things not as well as you pride yourself and would like to have done. The crime is to not do anything about it, and destroy the beauty of what you had.

So we are doing many things. We have undergone a financial system review last year to enable us to keep up with accountability requirements. An organisation of budget 100,000 working on MYOB struggled more than a bit when the budget started pushing \$9 mill. So now we have a financial software package 'Navision' which is bells and whistles and some.

We are now undergoing a review of our ICT and IM requirements as this part of our organisation has also struggled a bit to keep up with the demands of gazillions of outreach staff and their technological needs, our GP practice needs and the IM needs that a new health service model brings. I have no doubt that the review will show us ways of improving what we have, of relieving the pressure on our IT team and improving the services that we need for our staff and members.

We have realised that an undersung foundation of the contextual, cultural orientation and problem solving for our staff has been the addition of Kerry and later Liz to our team in the role of AHW and HPO respectively. It is these guys who can sit with team members and listen to their complex cross cultural issues which don't make sense to someone from my culture but which Kerry and Liz can help us sort through and mentor us through the cultural differences that exist. For us to really strengthen this aspect of our work in a team that is getting so big, we need to employ directly more Aboriginal staff. This is something that we are moving on as we speak.

Recognition of innovative ways of operating in remote outback Australia are essential if we are to have real impact on social, emotional and physical health of our communities. In Mt Isa now we have birds and planes and allied health professionals. We have new goals and dreams that go beyond people on the ground and into the measurement of real differences for people out there in communities.

I have been proud to be part of the journey. Its been a windy new path- but the view at the top I have heard is the best.

