DOCUMENT REVISION HISTORY

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<td>1.0</td>
<td>04/10/2017</td>
<td>Initial Document (Version 1.0, October 2017)</td>
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Executive Summary

More than 650 Allied Health professionals (447 FTE) work across the Southern Adelaide Local Health Network (SALHN) providing services across all levels and environments of a patient’s care journey – in home, intermediate, acute and sub-acute settings, providing inpatient, outpatient, ambulatory and community-based care. Allied Health professionals provide expert care from the fields of audiology, dietetics, exercise physiology, occupational therapy, orthotics and prosthetics, physiotherapy, podiatry, psychology, social work, speech pathology, ‘arts in health’ and spiritual care.

SALHN Allied Health and Intermediate Care provides care, treatment and support for children, adults and their families who live in the catchment areas of the SALHN network and services, as primary practitioners and as members of broader health care teams.

This paper outlines a proposed new workforce model and structure for SALHN Allied Health and Intermediate Care to support the achievement of:

- SALHN’s commitment to ‘provide the standard of care we desire for our own families and friends’
- SALHN Allied Health’s vision ‘to become a national leader in Allied Health care, blending the best of collaborative clinical practice, leadership and research, with optimal efficiency, effectiveness and positive health impact, for the people of the southern suburbs of Adelaide.’
  
  ‘One SALHN. One Allied Health. Striving for excellence in collaborative patient care.’
- SAHLN Allied Health’s values, goals and improvement measures as documented in the SALHN Allied Health Strategic Business Plan 2017-18.
- SALHN’s 2017 endorsed role for Intermediate Care being to:
  ‘Provide care to complex patients, often but not always older people who are frequently admitted to hospital or present at an emergency department and who could be more effectively managed in the community with appropriate specialist support. Intermediate Care at SALHN is time limited and multidisciplinary in nature, and aims to keep patients out of hospital, providing a ‘service bridge’ for patients with complex health needs from acute/sub-acute services to primary health care.’

The proposed model and structure has referenced principles applied within contemporary approaches to health-service workforce modelling, workforce renewal and organisational structure development. A selection are highlighted below, and detailed further within the paper:

- Maximising roles with responsibilities for clinical care and service delivery
- Partnering with Clinical Divisions to enable the delivery of excellence in patient-centred, collaborative, multi/interdisciplinary team based care (refer Diagram 2)
- Allied Health staff allocation within an interdisciplinary team structure
- Team management based on specific patient cohorts who benefit from Allied Health and/or Intermediate care
- Development of current and future clinical competencies specific to Allied Health
- Consistent expectation of roles, responsibilities and performance of staff for each classification level within teams, sites, services and locations across SALHN
- Development of a workforce that is responsive to fluctuations in demand, irrespective of periods of staff leave and day of week
- Eliminating role and service duplication

Note: the following groups of staff are not in scope for the proposed new model and structure: clinical epidemiologist; perfusionists, orthoptists, Pharmacists who are not part of the Drug and Therapeutics Information Service (DATIS); cardiac interventionist/physiologist/sonographers; radiographers.
• Developing career pathways for staff in the areas of clinical practice, management, leadership and research

This paper outlines a proposed model (refer Diagram 1 below) that aims to provide an innovative leadership and management structure to support staff in providing high quality clinical services across SALHN. The model recognises the need to provide strong Allied Health and Intermediate Care management to multidisciplinary teams and services that work in partnership with Allied Health profession-specific roles and career pathways. The proposed workforce model focuses on management and leadership positions across SALHN AH & IC. Positions with a predominantly clinical focus are out of scope for this stage of the workforce restructure and will be considered through a subsequent process of reform. Proposed positions central to the model are outlined below:

Executive Director Allied Health and Intermediate Care:

Allied Health and Intermediate Care staff will be led by the role currently titled Executive Director Allied Health. The proposed new title of Executive Director, Allied Health and Intermediate Care, is a more accurate description of the role with both Allied Health and the multidisciplinary staff of Intermediate Care Services (ICS) now reporting through to this position.

Allied Health and Intermediate Care (AH & IC) Directors:

Directors of key Allied Health and Intermediate Care clinical areas are proposed to work in a Business Partnership model with SALHN’s Clinical Divisions (Medicine, Critical and Cardiac Care; Surgery; Mental Health; Rehabilitation, Aged and Palliative Care; and Women’s and Children’s) and manage teams led by Service Managers/Team Leaders. The Directors will provide strategic and operational governance of Allied Health and Intermediate Care clinical teams providing care across the continuum of inpatient, outpatient and community. This will achieve consistency across SALHN in supporting high quality multidisciplinary collaborative decision-making, service and staff management for each Clinical Division, embracing the unique attributes, knowledge and skill sets provided by Medical, Nursing and Allied Health clinical leaders. Service Managers/Team Leaders will have responsibility for managing staff to provide quality and efficient patient-centred care within an interdisciplinary team context.

Lead Clinicians:

SALHN’s Allied Health professions will be led by Lead Clinicians whose newly defined scope will focus on profession-specific clinical competency development/assurance. Role responsibilities will include supporting the growth of student placements, building new graduate programs spanning SALHN-wide clinical experiences for staff; and human resource management of new and recently graduated staff. A partnership model will exist between Service Managers and Lead Clinicians to support flexible clinical staff allocation to ensure equitable patient access to high quality care across services and Clinical Divisions.

In summary, staff will be supported both through profession-based and service management structures with clearly defined lines of accountability and reporting.

The benefits of the proposed model are anticipated to include:

• Effective operational management & support provision of quality multidisciplinary care for relevant Allied Health/Intermediate Care service teams across the care continuum
• Improved contribution of Allied Health to service and clinical decision making across Clinical Divisions
• Development of an integrated Allied Health and Intermediate Care workforce across SALHN, underpinned by consistent SALHN-wide approaches to clinical governance, driving a continuously improving approach to safety and quality of Allied Health and Intermediate Care
• Greater equity of access for patients to high quality care
• Increased flexibility and adaptability of the AH & IC workforce to respond to patient and service needs to ensure staff are where they are needed most and can deliver maximal impact
• Increased access to clinical and administrative support positions (Project & Research Officer, Data Analyst, Recruitment Coordinator) supporting enhanced monitoring of clinical outcomes, team and profession-based performance measures, whilst allowing clinical staff to focus their time on clinical related activities
• Staff and system organisation to drive the achievement of the SALHN Allied Health vision, developed by staff:
  • ‘One SALHN. One Allied Health. Striving for excellence in collaborative patient care.’
  • Reinvestment of savings identified from the restructure of current management positions and roles, to fund new Allied Health clinical positions in support of endorsed Transforming Health models of care. As a result, the proposed new model results in no loss of FTE, with a marginal increase.

**Diagram 1: Proposed Organisation Structure – SALHN Allied Health**
Diagram 2: Business Partnership model: Allied Health with Clinical Division
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1. Preamble

‘Organisational structure is a term used to define a hierarchy within an organisation. It identifies each job/role, its function and where it reports to within the organisation. The structure is designed to establish how an organisation operates and assists an organisation in achieving its goals to allow for future growth and development. The structure is illustrated using an organisational chart.’

In February 2017, an inaugural ‘whole of SALHN Allied Health’ strategic planning workshop was held. One outcome from this workshop was the construction of SALHN Allied Health’s Strategic Business Plan (‘the Plan’ refer Appendix 1). The purpose of the Plan is to be a roadmap to guide SALHN Allied Health service delivery, operational management and decision-making into the future, positioning SALHN Allied Health for success. Two goals were identified by SALHN Allied Health staff at the workshop which relate to the Allied Health organisation structure.

Goal 2 as documented in the Plan is:

‘Define in detail and implement the next phase of the Allied Health restructure, based on ‘one SALHN-wide Allied Health, led by Allied Health’.

Goal 3 as documented in the Plan is:

‘Build a SALHN Allied Health culture – across professions, across teams, across services, across sites, across staff levels’.

These goals illustrate a concurrent aspiration of SALHN Allied Health staff to function with cohesion, both within an Allied Health workforce model and within broader clinical teams across SALHN’s clinical divisions and across the full geographic and service footprint of the network.

In addition, in April-May 2017, a consultant, Professor Justin Beilby, was engaged to:

- Identify opportunities for improvement in Intermediate Care Services (ICS) and SALHN Clinical Division service integration, to enable improved patient flow, continuum of care experience for patients, and outcomes
- Recommend where ICS should sit within SALHN’s overall organisational structure.

One recommendation documented in Professor Beilby’s report was for ICS ‘core services’, which have a number of Allied Health staff, to report through to the Executive Director Allied Health. As such, the multidisciplinary staff of ICS ‘core services’ are included within the scope of the new Allied Health and Intermediate Care workforce model and structure proposed within this paper.

This paper outlines a proposed new workforce model and structure for SALHN Allied Health and Intermediate Care to support the achievement of:

- SALHN’s commitment to ‘provide the standard of care we desire for our own families and friends’
- SALHN Allied Health’s vision ‘to become a national leader in Allied Health care, blending the best of collaborative clinical practice, leadership and research; with optimal efficiency, effectiveness and positive health impact, for the people of the southern suburbs of Adelaide.’
  ‘One SALHN. One Allied Health. Striving for excellence in collaborative patient care.’
- SAHLN Allied Health’s values, goals and improvement measures as documented in the Plan
- SALHN’s 2017 endorsed role for Intermediate Care being to:
  ‘Provide care to complex patients, often but not always older people who are frequently admitted to hospital or present at an emergency department and who could be more effectively managed in the community with appropriate specialist support. Intermediate Care at SALHN is time limited and multidisciplinary in nature, and aims to keep patients out of hospital, providing a ‘service bridge’ for patients with complex health needs from acute/sub-acute services to primary health care.’

2 www.smallbusiness.chon.com
2. Organisational structures and Accountability frameworks

Several types of organisational structure are described in business and health care management literature to underpin the varying decision making, clinical and corporate governance needs of organisations. These structures include divisional, functional, geographical and matrix. A divisional structure is suitable for organisations with distinct business units. A functional structure is based on the tasks or roles of each job. A matrix structure frequently includes each role reporting to two or more supervisors. Matrix structures are often the most complex but may be necessary for large organisations with many locations and functional areas.

SALHN’s organisational structure has features of all four structural elements, reflective of the many complexities typical of health care organisations which span multiple catchment areas/geographies, patient cohorts and associated health care specialties, and ‘levels’ of care including acute, sub-acute, intermediate, primary, community-based including home-based care.

Organisational structures are typically illustrated using organisational charts, in a top-down representation of reporting hierarchy. Appendix 2 includes a series of organisational charts illustrating the current varied reporting hierarchies that exist for Allied Health professionals across SALHN.

On the basis that one of the intents of organisational structures is to underpin and support desired behaviours and motivators of staff towards the achievement of organisational goals, an emerging trend in organisational development literature is the potential benefit of illustrating staff’s priority accountabilities. SALHN expresses its primary commitment being to patients as articulated by the statement: ‘we believe in the standard of care that we desire for our families and friends’. Thus, SALHN patients hold the primary position of focus in a SALHN accountability framework.

In addition, in the context of SALHN Allied Health, Allied health staff have clearly articulated a series of behaviours and principles of practice of importance to them (please refer below and to Appendix 1, page 6):

- **Respect** for our patients and the unique, diverse and valued contributions to excellent collaborative health care from the professions of audiology, dietetics, occupational therapy, orthotics and prosthetics, physiotherapy, podiatry, psychology, social work, speech pathology, arts therapy and spiritual care.

- **Clinical leadership** in highly performing teams, collaborating with patients and carers, our medical, nursing and health professional colleagues within SALHN, with GPs and with community service providers.

- **‘Enablement’** is our focus, using a proactive holistic approach to promote improvement in a patient’s quality of life.

- **Impact** across the patient’s care journey - in a patient’s home, and in intermediate, acute, sub-acute, outpatient/ambulatory, telehealth and community-based service environments.

- **Evidence-informed** approaches in clinical practice and supervision.

- **Criterion-based decision making** that references SALHN strategic priorities, SALHN Allied Health’s operational goals, financial imperatives, data analysis, benchmarks/key performance indicators, quality and safety standards.

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Recognition that excellence acknowledges **accountability** for clinical outcome achievement, cost-effectiveness and efficiency, embracing aims of no/least duplication of services, processes and management, and evaluation of performance.

SALHN-wide, **innovative strong leadership** that is a driving force at SALHN Executive, in planning and service delivery, irrespective of SALHN site, location and service.

Genuine **patient-centred** practice, where the patient and family are empowered to make their own health care decisions.

**Supported staff** who feel engaged and empowered to try new approaches, using data analysis, evidence and consumer input to develop, implement and evaluate practice change.

Effective and transparent **communication** within clinical teams and across and within all levels of SALHN.

Based on these values, the following Allied Health and Intermediate Care accountability framework or ‘inverted pyramid’ is proposed:

![Diagram 3: SALHN Allied Health accountability framework](http://smallbusiness.chron.com/organizational-structure-hospitals-3811.html)

Diagram 3 represents the primary focus of accountability of Allied Health and Intermediate Care clinicians in their day-to-day work. The primary focus of each clinician is on each patient and their family/carer and the staff member’s provision of the highest standard of care in the time allocated for care to each patient in their work day. The second focus is on working with, for and in support of, their health care team colleagues, such that the team can deliver first class, collaborative and coordinated care. The team incorporates elements of transdisciplinary practice as well as features of interdisciplinary and multidisciplinary care. Inherent within quality collaborative care are the profession-specific skills of each staff member, and the responsibility of each staff member to provide a quality of care that meets/exceeds profession-specific care standards.

Each staff member is also accountable to, but will have less frequent interface with:

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4 http://smallbusiness.chron.com/organizational-structure-hospitals-3811.html
• their respective Allied Health/Intermediate Care Director and the Clinical Director(s) and/or co-Directors of the relevant Clinical Division
• Executive Director Allied Health & Intermediate Care
• Chief Executive Officer

This accountability will be in relation to:

• the quality, safety, quantity and efficiency of care delivered to patients across SALHN
• supporting the achievement of strategic goals of Allied Health & Intermediate Care, Clinical Divisions & SALHN
• supporting the achievement of SA Health’s strategic imperatives, and specifically those of SA Health’s Allied and Scientific Health Office

New SALHN Allied Health & Intermediate Care (AH & IC) organisational structures need to support the achievement of the above accountability framework and SALHN Allied Health vision, mission and values (refer Appendix 1).
3. History of SALHN Allied Health

3.1 Context

More than 650 Allied Health professionals (447 FTE) work across SALHN providing services across all levels and environments of a patient’s care journey – in home, intermediate, acute hospital, subacute including (p)rehabilitation, and community-based care. Allied Health professionals provide expert care from the fields of audiology, dietetics, exercise physiology, occupational therapy, orthotics and prosthetics, physiotherapy, podiatry, psychology, social work, speech pathology, ‘arts in health’ and spiritual care.

SALHN Allied Health and Intermediate Care provides care, treatment and support for children, adults and their families who live in the catchment areas of the SALHN network and services, as primary practitioners and as members of broader health care teams.

3.2 Corporate and clinical governance

SALHN Allied Health staff operate predominantly in site based and/or clinical service-based departments. Reporting lines from a human resource, financial management and clinical governance perspective vary depending on site and clinical service. Profession-specific accountability lacks consistency across SALHN. Clinical service accountability for Allied Health/Intermediate care staff contributing to patient and service outcomes also varies across SALHN. The creation of the role of Executive Director Allied Health (EDAH) was partially in response to the recognition of the risks created by the disparate nature of both clinical and corporate governance of Allied Health across SALHN. The role of the EDAH has objectives including, but not limited to,

- strategic, operational, professional and corporate governance of Allied Health across SALHN recognising the key and unique role that Allied Health plays in the health care system
- Allied Health clinical governance including continuous improvement in relation to quality, safety and risk management of Allied Health patient care across SALHN,
- implementation of accurate, holistic approaches to workforce modelling, design and implementation across SALHN
- application of a consistent and efficient performance framework in the areas of Allied Health human resource, financial, profession-specific and multi/interdisciplinary models of care, quality
- strategic leadership and management of a large staff cohort, with unique skill sets borne from such staff having similar professional backgrounds, but with distinct differences from the professions of medicine and nursing.

The journey to the creation of the EDAH has reportedly spanned in excess of 7 years. At the time of the endorsement process for the creation of the EDAH in 2016, the following high-level proposed organisational structure for Allied Health was also published (Diagram 3):
4. History of SALHN Allied Health (cont.)

Diagram 3: SALHN Allied Health structure as endorsed April 2016

Source: Allied Health Structures Feedback, April 2016

There was minimal detail documented on the role and function of the Allied Health Operational Managers and Heads of Disciplines illustrated above.

The workforce model and organisational structure described in this paper provides the proposed details of these and other roles identified in order to drive the achievement of SALHN’s commitment ‘to provide the standard of care we desire for our families and friends’ and the vision, mission, goals and values as described in SALHN’s Allied Health strategic business plan 2017-18 (refer Appendix 1).
5. Current state SALHN Allied Health and Intermediate Care

There are currently a variety of reporting hierarchies that exist for Allied Health professionals across SALHN. These hierarchies are illustrated through a series of organisational charts in Appendix 2. The charts provide evidence of the wide-spread variation across the network in reporting lines, variation in roles, job and person specification content, clinical governance arrangements including credentialing processes, productivity expectations and approaches to human resource allocation and workforce modelling. Analysis of these charts, role classifications and job and person specifications, has identified the following:

- there is duplication of roles and functions
- opportunities exist to achieve efficiencies in practice, to realise clinical service delivery capacity through a ‘one SALHN Allied Health’ approach to leadership and management, leveraging greater economies of scale and achievement of critical mass in the case of smaller Allied Health discipline staff cohorts
- opportunities exist to improve clinical, financial, work health and safety risk management within a ‘one SALHN Allied Health, led by Allied Health’ approach
- opportunities exist to achieve enhanced standardisation of the leadership and management approach of SALHN’s current Allied Health and Intermediate Care workforce while also supporting the development of SALHN’s future Allied Health and Intermediate Care clinicians, researchers, educators, managers and leaders
- opportunities exist to enhance consistency in approach and standard of clinical competency development and assurance, including improved rigour in application of SA Health’s clinical supervision framework for Allied Health professionals
- opportunities exist to enhance the multidisciplinary team approach and integration to service planning and implementation, through stronger integration of Allied Health leadership within Clinical Division leadership.

4.1 Workforce profile

The role and function of management and leadership positions in the proposed new organisational structure and workforce model have been developed with reference to the current Allied Health professional workforce that exists across SALHN. The graphs below illustrate the composition of the SALHN workforce according to Allied Health professions.

(Please note the workforce profiling has excluded the following positions: SA pharmacists, radiographers, orthoptists, cardiac intervention/physiologists, perfusionists, and epidemiologists. These professions are out of scope for the Allied Health proposed workforce model and organisational re-structure.)
4.1 Workforce profile (cont.)

**Graph 1: Composition of the SALHN Allied Health workforce by Allied Health profession**

Graphs 1 and 2 illustrate the profile of the SALHN Allied Health workforce by profession.

Please refer to Appendix 3 for additional graphs and analysis of workforce data for Allied Health and Intermediate Care across SALHN. The graphs illustrate the composition of the SALHN Allied Health workforce according to the following parameters:

- Full-time vs part-time vs casual status of employment
- Age and gender
- Tenure with SALHN
- Number of staff who identify as being Aboriginal or Torres Strait Islander
4.1 Workforce profile (cont.)

- Number of staff per SALHN clinical division or service
- Number of staff per classification level
- Number of students/clinical placements supported
- Number of Allied Health staff in formalised research positions.

Connection between analysis and proposed roles and functions of SALHN Allied Health and Intermediate Care leadership and management positions is further described in Appendix 3.
6. Future state SALHN Allied Health and Intermediate Care workforce model and organisational structure

The proposed future state SALHN Allied Health and Intermediate Care workforce model and organisational structure is illustrated in this Section. The proposed roles, responsibilities, and associated reporting lines for clinical/service accountability, operational management and profession-specific clinical standard achievement for Allied Health & Intermediate Care are documented. The paper describes senior leadership, service and team management, and profession-specific clinical lead positions only. Detailed proposed descriptions of roles and functions of clinicians, their alignment to teams, and further delineation of supporting staff roles will occur via a subsequent phase of workforce design planning, consultation and implementation.

Allied Health professionals from the professions of pharmacy, radiography, orthoptics, cardiac intervention/physiology and perfusionists, and epidemiology are out of scope for the Allied Health proposed workforce model and organisational re-structure..

The proposed organisation structure has been illustrated in a series of organisational charts to assist in clarifying reporting lines and associated relationships associated with each role. They are:

- Organisational chart 1: Role of Executive Director Allied Health & Intermediate Care (EDAH&IC) and reporting relationships with SALHN Executive
- Organisational chart 2: Division of Allied Health & Intermediate Care Executive
- Business partnership model: Allied Health & Intermediate Care Director relationships with relevant Clinical Division Executive(s)
- Organisational chart 3: Division of Allied Health & Intermediate Care multidisciplinary service/team management structure
- Organisational chart 4: GP liaison hub including DATIS

Additional organisational charts are included for the purposes of providing a comprehensive picture of proposed reporting lines for staff who have previously been management under Intermediate Care Services.

- Organisational chart 5: Aboriginal Health services
- Organisational chart 6: Hospital @ Home; Metropolitan Referral Unit; Country Liaison
- Organisational chart 7: GP Plus site management
- Organisational chart 8: GP Plus site reception staff management

The proposed model, as illustrated by Organisational Charts 1-4 aims to provide an innovative leadership and management structure to support staff in providing high quality clinical services across SALHN. The model recognises the need to provide strong Allied Health and Intermediate Care leadership to multi-disciplinary teams that work in partnership with Allied Health profession specific roles and career pathways.

The benefits of the proposed model are anticipated to include:

- Effective operational management & support provision of quality multidisciplinary care for relevant Allied Health/Intermediate Care service teams across the care continuum
- Improved contribution of Allied Health to service and clinical decision making across Clinical Divisions
• Development of an integrated Allied Health and Intermediate Care workforce across SALHN, underpinned by consistent SALHN-wide approaches to clinical governance, driving a continuously improving approach to safety and quality of Allied Health and Intermediate Care

• Greater equity of access for patients to high quality care
• Increased flexibility and adaptability of the AH &IC workforce to respond to patient and service needs to ensure staff are where they are needed most and can deliver maximal impact
• Increased access to clinical and administrative support positions (Project & Research Officer, Data Analyst, Recruitment Coordinator) supporting enhanced monitoring of clinical outcomes, team and profession-based performance measures, whilst allowing clinical staff to focus their time on clinical related activities
• Staff and system organisation to drive the achievement of the SALHN Allied Health vision, developed by staff:
  • ‘One SALHN. One Allied Health. Striving for excellence in collaborative patient care’.
• Reinvestment of savings identified from the restructure of current management positions and roles, to fund new Allied Health clinical positions in support of endorsed Transforming Health models of care. As a result, the proposed new model results in no loss of FTE, with a marginal increase.

The proposed structure has been developed referencing the following guiding documents:

1. Directions of the Premier, including, but not limited to Flexibility for the Future (26/06/2017); Performance management and development (05/05/2016)

2. SA Health’s Aboriginal Workforce framework 2017-2022 (draft)


7. The endorsed SAHLN Allied Health organisational structure April 2016 (refer page 10).

The proposed structure has been developed referencing the following principles:

1. Strengthening the position of Allied Health and Intermediate Care clinicians across a broad scope of practice including as primary practitioners and in multidisciplinary/interdisciplinary collaborative team-based care roles.

2. The scope of practice of Allied Health and Intermediate Care clinicians is across the full SAHLN continuum of care spanning acute, subacute, intermediate, community and home-based care, and for all ages of patient cohorts.
3. The importance placed on the achievement of ‘one SALHN Allied Health, led by Allied Health’ as articulated by SALHN Allied Health staff and as outlined in the SALHN Allied Health strategic business plan 2017-18.

4. Values of importance as expressed by SALHN Allied Health professionals in 2017 as documented in the Plan (refer Appendix 1, page 6)

5. A model that will underpin the pursuit of the achievement of Allied Health vision, mission and goals, and Intermediate Care’s goals, within the context of SALHN’s strategic priorities.

6. Evidence based approaches to health-service workforce modelling, renewal and organisational structure development that promote the achievement of:

   - maximisation of roles with responsibilities for clinical care and service delivery
   - effective partnerships with each Clinical Division enabling the delivery of excellence in patient-centred, collaborative, team based care
   - multi/interdisciplinary team management
   - development of current and future clinical competencies specific to each SALHN Allied Health profession within consistent SALHN-wide frameworks that ensure safe and quality care across the care continuum and age span of the SALHN patient community. This will support SALHN Allied Health and Intermediate Care workforce renewal.
   - Allied Health staffing allocations based on:
     - Allied Health contribution to endorsed models of care,
     - Expectation of clinical care delivery capacity for staff at each classification level adapted to the respective clinical context
     - A SALHN-wide patient journey approach
   - consistency in expectation of roles, responsibilities and performance of staff across levels, teams, sites, services and locations across SALHN
   - adaptability of the workforce across a 7-day service cycle responding to fluctuations in demand, irrespective of periods of staff leave, through leveraging SALHN-wide approaches and staffing frameworks (currently under development)
   - elimination of duplication of roles
   - career pathways for staff in the areas of clinical practice; service and team management; quality and safety management; profession-specific and multi/interdisciplinary leadership and supervision; education and training; and senior leadership/management
   - effective partnership arrangements with Universities with undergraduate and postgraduate Allied Health profession student programs, that enhance the educational experiences of students. ‘SALHN workforce ready’ graduates will be supported with career opportunities through a coordinated SALHN-wide approach to ‘graduate’ Allied Health positions and rotation systems
   - increasing the number of Allied Health professionals within SALHN who identify as Aboriginal and/or Torres Strait Islander.

6. The recommendations of ‘the Beilby report’ into SALHN’s Intermediate Care services including:

   - ICS’ ‘core service streams’ reporting through to the EDAH
   - ICS’ ‘core service streams’ expanding connections and building stronger relationships with SALHN’s acute and subacute services, and the General Practitioner and Primary Care sector
   - Services currently managed under the ICS framework but not intermediate care in nature, be managed under other more suitable frameworks elsewhere in SALHN.
Organisational chart 1: SALHN Executive illustrating the reporting relationships of the Executive Director Allied Health & Intermediate Care (EDAHC)

*Please refer to Organisational Chart 5 for further details of this position, which is subject to a parallel business development process.
6.1 Role & relationships: Executive Director Allied Health & Intermediate Care (EDAHC)

This role is an evolution of the role of Executive Director Allied Health as per the endorsed Allied Health organisational structure April 2016, and reflects the expanded responsibility inclusive of Intermediate Care.

- Reports to the CEO
- Accountable to the CEO for strategic leadership, professional and operational performance of staff and services of SALHN Allied Health & Intermediate Care, across all services, relevant patient cohorts, locations and geographies of the network
- Accountable to the CEO for the evolution of the Allied Health and Intermediate Care workforce overtime, adapting to changes in patient demand, models of care, productivity expectations, clinical care standards and enterprise bargaining agreement requirements, within the SALHN and SA Health strategic priorities (refer Section 4 and Appendix 3)
- Accountable to the CEO, COO and Executive peers for oversight of effective clinical governance for the Allied Health professions of audiology, dietetics, exercise physiology, occupational therapy, orthotics and prosthetics, physiotherapy, podiatry, psychology, social work, and speech pathology, ‘arts in health’ and spiritual care. This includes responsibility for oversight of implementation of equitable frameworks across SALHN, adapted where relevant to the nuances of each Allied Health profession and/or team in the areas of:
  - education and training;
  - clinical audit;
  - clinical effectiveness;
  - clinical efficiency and staff productivity;
  - research and service development;
  - risk management;
  - profession and multidisciplinary/interdisciplinary team skill competencies;
  - consumer engagement.
- Works in partnership with Executive Director of Nursing & Midwifery (or delegate) in relation to clinical competency and assurance for nursing staff working within Intermediate Care teams
- Accountable to the CEO for the effective leadership of relevant SALHN-wide strategic projects, and designated projects driven from the Department of Health and Ageing.
- Accountable to SA Health’s Allied and Scientific Health Office in relation to implementation of state-wide Allied Health and Intermediate Care workforce frameworks, models of care, credentialing processes, professional development and under and post-graduate education approaches in partnership with SA’s three universities.
- As a member of SALHN Executive, contribute to the setting of SALHN strategic priorities and take a leading role in developing and implementing initiatives to achieve objectives.
Organisational chart 2: Division of Allied Health & Intermediate Care Executive

- EDAH&IC
- Executive Assistant
- Business Managers: AH & IC
- Director of Acute Allied Health and Intermediate Care Services
- Director of Sub-acute Allied Health and Intermediate Care Services
- Director of Allied Health Women’s & Children’s Services
- Director of Allied Health Mental Health Services
- Director of AH & IC Clinical Governance
- GP Liaison Hub and DATIS

Allied Health & Intermediate Care Proposed Workforce Model and Organisational Structure
Diagram 4 illustrates the dual nature of accountabilities of the respective directors to the EDAHIC, and to the relevant Clinical Divisions’ executives. While it is proposed the Directors have a direct reporting line and operational and professional responsibility to the EDAHIC, accountability for AH & IC contribution to holistic collaborative team-based patient-centred care is proposed to be in partnership with each relevant Clinical Division.
5.2 Role & relationships: **Director: Allied Health Acute & Intermediate Care Services**

This role is an evolution of the role of Operations Manager: Allied Health Acute Services as per the endorsed Allied Health organisational structure April 2016.

- Reports to the EDAH &IC
- Accountable to the EDAH &IC and Divisional executive peers for operational (including human and financial resource) management and service development of SALHN Allied Health & Intermediate Care acute services’ multidisciplinary teams, staffing and services (inpatient, outpatient, community) including: ED/AMU/Community Rapid Response AH & IC; Medicine AH; Surgery AH; Neurosciences AH; Diabetes IC; Respiratory IC; Chronic Liver Disease IC;— within the context of access to Allied Health services over 7 days where appropriate.
- Contributes to the leadership and decision-making functions of the Executives of the Division of Medicine, Critical and Cardiac care; and the Division of Surgery and Perioperative Medicine including, but not limited to, contributing an AH & IC perspective to these processes.
- Accountable to the EDAHIC and Clinical Division executive peers for the delivery of safe and quality care to relevant patient cohorts by clinicians from the Allied Health professions of audiology, dietetics, exercise physiology, occupational therapy, orthotics and prosthetics, physiotherapy, podiatry, psychology, social work, and speech pathology; and in collaboration with the Nursing Director for Ambulatory Care Services, for intermediate care nursing.
- It is proposed that the quantum of care to be provided by each Allied Health discipline to each Clinical Division’s service will be negotiated on a periodic basis as part of the SALHN budget setting process and will be documented in service agreements between the Allied Health and Intermediate Care Division and the Division of Medicine, Critical and Cardiac care; and the Division of Surgery and Perioperative Medicine. Expectations will reference:
  - SALHN-wide frameworks in relation to clinical care ratios which reference national Allied Health benchmarks;
  - Target measures in relation to:
    - face-to-face patient care
    - non face-to-face patient-related work
    - clinical supervision
    - future workforce development (student supervision)
    - non-clinical work activities such as mandatory training
  - Contemporary, evidence-based clinical care practices
  - Flexible working arrangements across services and professions to adapt to fluctuations in staff availability and clinical demands
  - Contribution by the Clinical Divisions to Allied Health resourcing as a result of reductions in length of stay arising from Allied Health and/or Intermediate care service provision
- Accountable for the evolution of Allied Health Acute and Intermediate Care Services’ workforce profile (refer Section 4 and Appendix 3), with the objective of supporting, wherever possible, continuity of Allied Health care within an Acute Services context **in conjunction with** supporting, wherever possible, allocation of Allied Health and Intermediate Care staff in a ‘whole of SALHN’ approach that supports best patient flow and patient experience across the whole SALHN patient journey.

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5 Chronic Liver Disease service is comprised of nursing staff only, and as such does not meet the SALHN definition for an intermediate care service being multidisciplinary in nature. It is proposed that Chronic Liver Disease nursing staff will transition to the Surgical and Perioperative Medicine Division. Accordingly, the operational management of this staff group via the Director Allied Health Acute and Intermediate Care Services is proposed to be transitional in nature.
5.3 Role & relationships: **Director: Sub-Acute and Intermediate Care Services**

This role is an evolution of the role of Operations Manager: Allied Health Sub-Acute Services as per the endorsed Allied Health organisational structure April 2016.

- Reports to the EDAHIC
- Accountable to the EDAHIC and Divisional executive peers for operational (including human and financial resource) management and service development of SALHN Allied Health & Intermediate Care subacute services’ multidisciplinary teams, staffing and services (inpatient, outpatient, community) including: GEM; Allied Health Inpatient Rehab; Day Rehab*; Home, Outreach and Tele-rehabilitation*; Outpatient & Community Services; Weight management stream - within the context of access to Allied Health services over 7 days where appropriate.
- *Where service/program managers must operate with a ‘profession-neutral’ and/or global clinical team management mindset, inclusive of Medical, Nursing and Allied Health in their management responsibilities, it is proposed that these positions report directly to the Director of Rehabilitation and Co-Director, Division of Rehabilitation, Aged Care and Palliative Care. These service/program managers will lead and manage AH&IC staff working within their services in a partnership model with the Director: Sub-Acute and Intermediate Care Services and Lead Clinicians for each profession.
- Contributes to the leadership and decision-making functions of the Executive of the Division of Rehabilitation, Aged Care and Palliative Care including, but not limited to, contributing an AH&IC perspective to these processes.
- Accountable to the EDAHIC and Clinical Division executive peers and the Director of Rehabilitation for the delivery of safe and quality care to relevant patient cohorts by clinicians from the Allied Health professions of audiology, dietetics, exercise physiology, occupational therapy, orthotics and prosthetics, physiotherapy, podiatry, psychology, social work, and speech pathology, and in collaboration with the Nursing Director for Ambulatory Care Services, for intermediate care nursing.
- It is proposed that the quantum of care to be provided by each Allied Health discipline to each Rehabilitation, Aged and Palliative Care service will be negotiated on a periodic basis as part of the SALHN budget setting process and will be documented in service agreements between the Allied Health and Intermediate Care Division and the Division of Rehabilitation, Aged and Palliative Care. Expectations will reference:
  - SALHN-wide frameworks in relation to clinical care ratios which reference national Allied Health and Rehabilitation benchmarks;
  - target measures in relation to:
    - face-to-face patient care:
    - non face-to-face patient-related work
    - clinical supervision
    - future workforce development (student supervision)
    - non-clinical work activities such as mandatory training
  - contemporary, evidence-based clinical care practices
  - flexible working arrangements across services and professions to adapt to fluctuations in staff availability and clinical demands
  - contribution by the Rehabilitation, Aged and Palliative Care Division to future increases in Allied Health resourcing as a result of reductions in length of stay arising from Allied Health and/or Intermediate care service provision
- Accountable for the evolution of Allied Health Sub-acute and Intermediate Care Services’ workforce profile (refer Section 4 and Appendix 3), with the objective of supporting, wherever possible, continuity of Allied Health care within a Sub-acute Services context in conjunction with supporting, wherever possible, allocation of Allied Health and Intermediate Care staff in a ‘whole of SALHN’ approach that supports best patient flow and patient experience across the whole SALHN patient journey.
5.4 Role & relationships: **Director: Allied Health Women’s & Children’s Services**

This is a proposed new role. It has been conceptualised given that patients of the Women’s & Children’s Division comprise two core patient cohorts of SALHN, and that Allied Health expertise and resource management requires focused and specific attention to enable best utilisation of Allied Health resources, concurrent with ensuring clinical competency and quality assurance.

- Reports to the EDAHIC
- Accountable to the EDAHIC and Divisional executive peers for operational (including human and financial resource) management and service development of SALHN Allied Health services’ multidisciplinary teams, staffing and services (inpatient, outpatient, community) including: Women’s Health, Paediatrics (including Early Childhood and Family Services) - within the context of access to Allied Health services over 7 days where appropriate.
- Works in partnership with Director of Paediatrics in relation to the provision of Allied Health services to the Child Assessment Team and Neonatal Follow Up Unit.
- Accountable to the EDAHIC and Divisional executive peers for operational management and service development of SALHN’s ‘Arts In Health’ services and team; and spiritual care services
- Accountable to the EDAHIC and AH & IC Divisional executive peers for effective support of optimal W&C divisional operational management and service development of Paediatric intermediate care services in the areas of diabetes, asthma and eating disorders
- Contributes to the leadership and decision-making functions of the Executive of the Women’s & Children’s Division including, but not limited to, contributing an AH & IC perspective to these processes.
- Contributes an Allied Health perspective to the leadership and decision-making functions of the Executive of the Women’s & Children’s Division
- Accountable to the EDAHIC and Clinical Division executive peers for the delivery of safe and quality care to relevant patient cohorts by clinicians from the Allied Health professions of audiology, dietetics, exercise physiology, occupational therapy, orthotics and prosthetics, physiotherapy, podiatry, psychology, social work, and speech pathology
- **NOTE:** It is proposed that the quantum of care to be provided by each Allied Health discipline to each Women’s & Children’s Division service will be negotiated on a periodic basis as part of the SALHN budget setting process and will be documented in service agreements between the Allied Health and Intermediate Care Division and the Women’s & Children’s Division. Expectations will reference:
  - SALHN-wide frameworks in relation to clinical care ratios which reference national Allied Health benchmarks;
  - Target measures in relation to:
    - face-to-face patient care:
    - non-face-to-face patient-related work
    - clinical supervision
    - future workforce development (student supervision)
    - non-clinical work activities such as mandatory training
  - contemporary, evidence-based clinical care practices
  - flexible working arrangements across services and professions to adapt to fluctuations in staff availability and clinical demands
  - contribution by the Women’s & Children’s Division to future increases in Allied Health resourcing as a result of reductions in length of stay arising from Allied Health and/or Intermediate care service provision.
- Accountable for the evolution of Allied Health: Women’s & Children’s Services’ workforce profile (refer Section 4 and Appendix 3), with the objective of supporting, wherever possible, continuity of Allied Health care within a Women’s & Children’s Services context in conjunction with supporting, wherever possible, allocation of Allied Health and Intermediate Care staff in a ‘whole of SALHN’ approach that supports best patient flow and patient experience across the whole SALHN patient journey.
5.5 Role & relationships: Allied Health Director: Mental Health

This is a proposed new role. Mental Health Services within SALHN, and across other LHNs, are undergoing a number of reform processes. The description below may need to be adapted according to the evolution of vision, purpose, service models and associated workforce requirements to meet the needs of the specific consumer cohorts of SALHN Mental Health Services. It is proposed that the Allied Health Director: Mental Health contributes to the Mental Health Services’ Executive and various Mental Health reform project teams, drawing on the input of the SALHN Mental Health Allied Health ‘Principal Practitioners’ for profession-specific requirements as required.

- Reports to the EDAHIC
- Accountable to the Clinical and Co-Director/Director Operations Mental Health Services
- Accountable to the EDAHIC and Divisional Executive peers for operational management (including human and financial resource), achievement of quality and safety clinical standards of the respective Allied Health professions, and service development of SALHN Allied Health Mental Health services’ multidisciplinary teams, staffing and acute and non-acute services (inpatient, outpatient, community), spanning Youth Mental Health Services, FMC, Morier Ward, Margaret Tobin Centre, Trevor Parry Centre, Marion Community Team, Carramar Community Team, Outer South Teams A & B, Older Persons Mental Health Service, Veterans Mental Health Rehabilitation Unit (Jamie Larcombe Centre), Statewide Eating Disorder Service + 4GP, Inner South DBT Service, Statewide Gambling Therapy Service -within the context of access to Allied Health services over 7 days where appropriate.
- Contributes to the leadership and decision-making functions of the Executive of the Division of Mental Health Services including, but not limited to, contributing an AH perspective to these processes.
- Accountable to the EDAHIC and Clinical Division Executive peers for the delivery of safe and quality care to relevant patient cohorts by clinicians from the Allied Health professions of dietetics, exercise physiology, occupational therapy, physiotherapy, psychology, and social work
- It is proposed that the quantum of care to be provided by each Allied Health discipline to each Mental Health service will be negotiated on an annual basis as part of the SALHN budget setting process and will be documented in annual service agreements between the Allied Health and Intermediate Care Division and the Mental Health Services’ Division. Expectations will reference:
  - SALHN-wide frameworks in relation to clinical care ratios which reference national Allied Health and Mental Health benchmarks;
  - Target measures in relation to:
    - face-to-face patient care:
    - non face-to-face patient-related work
    - clinical supervision
    - future workforce development (student supervision)
    - non-clinical work activities such as mandatory training
  - contemporary, evidence-based clinical care practices
  - flexible working arrangements across services and professions to adapt to fluctuations in staff availability and clinical demands
  - contribution by the Mental Health Division to future increases in Allied Health resourcing as a result of reductions in length of stay arising from Allied Health service provision.
- Accountable for the evolution of Allied Health: Mental Health Services’ workforce profile (refer Section 4 and Appendix 3), with the objective of supporting, wherever possible, continuity of Allied Health care within a Mental Health Services context in conjunction with supporting, wherever possible, allocation of Allied Health and Intermediate Care staff in a ‘whole of SALHN’ approach that supports best patient flow and patient experience across the whole SALHN patient journey.
- It is proposed that the Mental Health Principal Practitioners: Occupational Therapy, Psychology, Social Work have dual accountabilities: Allied Health Director: Mental Health Services and the Director: AH & IC Clinical Governance
5.6 Role & relationships: **Director: AH & IC Clinical Governance**

This is a proposed new role. It has been conceptualised based on the recognition of the scale of variability in approaches that currently exist across SALHN in relation to Allied Health and intermediate care safety and quality management, clinical competency development and assurance, clinical supervision, clinical audit, undergraduate student placements, new graduate programs, research, and relationships with Universities that support Allied Health discipline under/postgraduate programs. SALHN–wide Allied Health and intermediate care clinical risk mitigation, workforce renewal for the Allied Health professions, clinical competency development and assurance for profession-specific and interdisciplinary professional practice are proposed expected outcomes of the position.

- Reports to the EDAHIC
- Accountable to the EDAHIC and AH & IC Divisional executive peers for effective leadership and management of SALHN’s ‘lead clinicians’ for the professions of dietetics and nutrition, occupational therapy, orthotics and prosthetics, physiotherapy and exercise physiology, podiatry, psychology, social work, and speech pathology and audiology
- Contributes a perspective centred on clinical competency assurance and scope of practice development for each Allied Health profession to the leadership and decision-making functions of the AH & IC Divisional Executive
- Accountable to the EDAH & IC and Divisional executive peers for development and implementation of consistent SALHN Allied Health frameworks in safety and quality management and improvement; profession-centric and multi/interdisciplinary clinical governance and performance, adapted where relevant to the nuances of each Allied Health profession, in the areas of:
  o education and training
  o clinical audit
  o clinical effectiveness
  o practice efficiency and productivity
  o research and service development
  o risk management
  o profession-specific skill competencies
  o contribution of these skills within multi/interdisciplinary care processes
  o consumer engagement
- Accountable to SALHN’s Clinical Governance Unit for AH & IC specific contributions to SALHN’s achievement of National Safety and Quality Health Service Standards
- Accountable for effective oversight of data collection, analysis, reporting and business intelligence systems, including but not limited to:
  o clinical data analysis
  o safety and quality management
  o performance reporting.
- Accountable to the EDAHIC for the development and enhancement of strategic partnerships with Universities with undergraduate and postgraduate student programs for SALHN Allied Health professions, and establishing a coordinated SALHN-wide new graduate program to assist in renewal of SALHN Allied Health workforce (refer Section 4).
- Accountable to the EDAHIC for the exploration (with relevant Universities) of opportunities for the creation of joint University/SALHN Allied Health positions to support and drive increase in Allied Health clinical research within SALHN.
Organisational chart 3: Division of Allied Health & Intermediate Care Multidisciplinary team management structure
5.7 Role & relationships: **AH & IC Acute Service Managers**

- Report to the Director: AH Acute & Intermediate Care Services
- Accountable to the Director: AH Acute & Intermediate Care Services for effective operational management (human resource and financial) and quality multidisciplinary care through effective human resource management across multiple professions and service development for their relevant team across the care continuum of inpatient, outpatient and community
- Accountable for recruitment and rostering of non-rotational AHP2, AHP3 and AHP4 staff within their relevant team including across fixed five day and seven day rosters to enable relevant patient cohorts to access Allied Health services over 7 days where relevant
- Accountable for AH & IC support and care delivery within endorsed models of care, within resource constraints
- Contributes an Allied Health and Intermediate Care perspective to clinical and service decision-making of relevant broader clinical teams
- Work in partnership with AH Lead clinicians in regards to recruitment, orientation, supervision, performance review & development to ensure current and future workforce deliver care which meet or exceeds minimum clinical competency standards, within endorsed scope of practice of staff
- Accountable to EDAH&IC, Director AH Acute & Intermediate Care Services and Clinical Divisional executives for effective workforce renewal planning such that
  - proportions of allied health professions within a team adapt over time according to changing SALHN patient cohort health care needs, changing models of care, and emerging evidence of effectiveness of relevant allied health interventions
  - re-profiling of positions occurs over time to ensure skill sets of the Allied Health team meet operational requirements. (Refer Section 4 and Appendix 3).

5.8 Role & relationships: **AH & IC Sub-acute Service Managers**

- Report to the Director: Sub-acute and Intermediate Care services (Program managers that operate with a ‘profession-neutral’ and/or global clinical team management mindset, inclusive of Medical, Nursing and Allied Health in their management responsibilities, are proposed to report directly to the Director of Rehabilitation and Co-Director, Division of Rehabilitation, Aged Care and Palliative Care.)
- Accountable to Director: Sub-acute and Intermediate Care services for effective operational management (human resource and financial) and quality multidisciplinary care including human resource management and service development for their relevant team across the care continuum of inpatient, outpatient and community
- Accountable for recruitment and rostering of non-rotational AHP2, AHP3 and AHP4 staff within their relevant team including across fixed five day and seven day rosters to enable relevant patient cohorts to access Allied Health services over 7 days
- Accountable to the RAP Division’s Heads of Units and broader clinical teams for effective AH & IC support and care delivery within endorsed models of care, within resource constraints
- Contributes an Allied Health and Intermediate care perspective to clinical and service decision-making of relevant broader clinical teams
- Work in partnership with Allied Health Lead Clinicians in regards to recruitment, orientation, supervision, performance review & development to ensure current and future workforce
deliver care which meet or exceed minimum clinical competency standards, within endorsed scope of practice of staff

- Work in partnership with AH Lead clinicians to access leave relief staff to ensure consistency of care across a 7 day service cycle, 52 weeks per year, for relevant patient cohorts
- Accountable to EDAH&IC, Director AH Sub - Acute & Intermediate Care Services and Clinical Divisional executives for effective workforce renewal planning such that
  - proportions of allied health professions within a team adapt over time according to changing SALHN patient cohort health care needs, changing models of care, and emerging evidence of effectiveness of relevant allied health interventions, and/or
  - re-profiling of positions occurs over time to ensure skill sets of the Allied Health team meet operational requirements. *(Refer Section 4 and Appendix 3).*

5.9 Role & relationships: **Allied Health Women’s & Children’s Service Managers**

- Report to the Director: Allied Health Women’s & Children’s Services
- Accountable to the Director: Allied Health Women’s & Children’s Services for effective operational management (human resource and financial) and quality multidisciplinary care including human resource management and service development for their relevant team across the care continuum of inpatient, outpatient and community
- Accountable for recruitment and rostering of non-rotational AHP2, AHP3 and AHP4 staff within their relevant team including across fixed five day and seven day rosters to enable relevant patient cohorts to access Allied Health services over 7 days
- Accountable to the W&C Division’s Heads of Units and broader clinical teams for effective AH & IC support and care delivery within endorsed models of care, within resource constraints
- Contributes an Allied Health perspective to clinical and service decision-making of relevant broader clinical teams
- Work in partnership with Allied Health lead clinicians in regards to recruitment, orientation, supervision, performance review & development to ensure current and future workforce deliver care which meet or exceed minimum clinical competency standards, within endorsed scope of practice of staff
- Accountable to EDAH&IC, Director AH Women’s & Children’s Services and Clinical Divisional executives for effective workforce renewal planning such that
  - proportions of allied health professions within a team adapt over time according to changing SALHN patient cohort health care needs, changing models of care, and emerging evidence of effectiveness of relevant allied health interventions, and/or
  - re-profiling of positions occurs over time to ensure skill sets of the Allied Health team meet operational requirements. *(Refer Section 4 and Appendix 3).*

5.10 Role & relationships: **Mental Health team managers where an Allied Health professional**

Mental Health Services within SALHN are undergoing change processes as part of a state-wide approach to Mental Health service reform. Roles, responsibilities and reporting lines will be determined according to these broader agendas.
5.11 Role & relationships: **Lead Clinicians:** Audiology, Dietetics & Nutrition, Occupational Therapy, Physiotherapy & Exercise Physiology, Podiatry, Psychology, Social work, Speech Pathology

These roles equate to the roles of “Heads of Discipline” as per the endorsed Allied Health organisational structure April 2016. The focus of these roles will be for the respective Allied Health discipline clinical competency development and assurance, clinical supervision, clinical audit, undergraduate student placements, new graduate programs, research, and relationships with Universities that support the respective Allied Health discipline under/postgraduate programs. Human resource management will focus on the new and recently graduated staff of the respective discipline (AHP 1 and rotational AHP2), weekend and relief staff rosters.

- **Report to the Director: AH & IC Clinical Governance**
- **Accountable to the EDAHIC, Director: AH & IC Clinical Governance, all AH & IC directors and service managers:** acute services; sub-acute services; women’s & children’s services and mental health services for assurance and development of profession-specific clinical competencies for their profession’s staff cohort across SALHN. Responsibilities are proposed to include education and training; clinical audit; monitoring of clinical effectiveness; identifying and leading profession specific and multi/inter-disciplinary research opportunities and service development; risk management; profession-specific skill competencies; credentialing and consumer engagement. Lead Clinicians will engage with and work closely with senior and extended scope clinicians within their relevant profession in the process of carrying out these responsibilities.

- **Accountable to the EDAH, Director: AH & IC Clinical Governance, all AH & IC directors and service managers:** acute services; sub-acute services; women’s & children’s services and mental health services for human resource management including recruitment, orientation, performance review & development, and:
  - Rostering of all rotational AHP1 and AHP2 positions
  - Maintenance of discipline casual pool and provision of access to or rostering of casual staff to realise 7 day Allied Health service access for relevant patient cohorts if required by service managers if staffing gaps exist between fixed 5 day and 7 day rostering systems
  - Ensuring consistency of clinical care for patients during times of staff leave for staff in their profession, within resource constraints

- **Accountable to the EDAHIC and Director: AH & IC Clinical Governance** for the strengthening of relationships with Universities with undergraduate and postgraduate student programs for relevant SALHN Allied Health professions, and establishing a coordinated SALHN-wide new graduate program for the discipline to assist in renewal of SALHN Allied Health workforce (refer Section 4 and Appendix 3).
- **Accountable to the EDAHIC and Director: AH & IC Clinical Governance** for the proactive coordination of undergraduate Allied Health student placements where student patient-care experiences are reflective of the reality of patient care provision of SA Health’s public health system
- **Accountable to Clinical Divisions and broader clinical teams** for safe, quality and effective relevant profession-specific care delivery within endorsed models of care, within resource constraints

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6 Mental Health Services within SALHN are undergoing large scale reform. The detail of roles and responsibilities of the Mental Health Allied Health Principal Practitioners for Social Work, Occupational Therapy and Psychology will emerge from these processes. It is proposed that these roles will assist the SALHN Lead Clinician for the respective profession to ensure quality clinical governance for each profession spans the full scope of SALHN patient cohorts that require Allied Health services.
• Contribute an Allied Health, Intermediate Care and profession-specific perspective to clinical and service decision-making of relevant broader clinical teams
• Work in partnership with AH & IC service managers in regards to recruitment, orientation, supervision, performance review & development, and position re-profiling to ensure current and future AH & IC workforce deliver care which meet or exceeds minimum clinical competency standards and team-based approaches, within endorsed scopes of practice of staff
• Draw on the skills, knowledge and expertise of experienced clinical staff within the relevant Allied Health discipline for specialist advice regarding contemporary practice as required
• Accountable to the SALHN Clinical Governance Unit for AH profession-specific contributions to SALHN’s achievement of National Safety and Quality Health Service Standards
• Accountable for maintaining a clinical caseload - the proportion of time to be determined relative to the number of FTE and student placements supported
• It is proposed that the Mental Health Principal Practitioners: occupational therapy, psychology, social work have dual accountabilities: Allied Health Director: Mental Health Services and the Director: AH & IC Clinical Governance

5.12 Role & relationships: AH & IC business support resource manager
• Reports to the EDAHIC
• Accountable to the AH & IC divisional executive for effective operational management (human resource and financial) of the following AH & IC staff:
  o Administrative officers
  o Project officers
• Contribute to workforce modelling and business analysis in relation to the above listed staff groups
• Work in partnership with AH & IC business management staff to compile performance reports in accordance with the AH & IC performance framework, and adhoc requirements as may be needed to respond to SALHN Executive and AH & IC divisional executive reporting requirements.

5.13 Role & relationships: GP Liaison hub including Drug and Therapeutics Information Service (DATIS)
• Please refer to Organisational Chart 4. The associated description of the functionality and roles of this unit are part of a separate Business Change request process. The organisational chart is included within this paper for completeness.
5.13 Role & relationships: GP liaison/DATIS manager

- Reports to EDAH&IC
- Accountable for the provision of operational management oversight of a new SALHN GP Liaison Hub inclusive of:
  - A SALHN GP Liaison unit modelled on the Women’s & Children’s Health network 2017 model
  - DATIS
  - Health Hub and its service contribution to SALHN’s Aboriginal Family Clinics.
- Purpose of the new SALHN GP liaison hub is to expand and strengthen working relationships between SALHN clinicians and the GP sector such that patients can be better supported to access an integrated continuum of care across community/acute/subacute/intermediate care.
- Accountable for the operational and professional leadership, management and service development of DATIS.

*Please note that the proposed new roles outlined in Organisation Chart 4 are the subject of a parallel Business Case*
*Please note that the new role of Executive Director Aboriginal Health Services is the subject of a parallel Business Case*
5.14 Role & relationships: Hospital at Home Manager; MRU Nursing Director; Country Liaison Officer

- Report to: Nursing Director: Patient Flow or Co-Director: SAPOM or Division of Medicine, Critical and Cardiac Care* to be determined
- Accountable for operational and professional management of respective services and functions

Note: MRU responsibilities span all LHNs
5.15 Roles and relationships: Project officer – GP Plus Outpatient reconfiguration

- The Intermediate Care Service’s Project Officer position has been dedicated to reconfiguring Marion GP Plus and Noarlunga GP Plus service. It has recently moved to Corporate Services management to enable improved coordination of all corporate service functions associated with infrastructure changes. The role includes responsibility for Aldinga GP Plus.

- Contract management for GP Plus site tenants, and reporting requirements to SA Health and the Commonwealth in relation to SALHN GP Plus site utilisation has been transferred to ensure a holistic and efficient approach across all SALHN facilities.

- Upon completion of all service moves associated with Transforming Health, Corporate services will evaluate staffing structures to enable best management of facilities across SALHN.

- An assessment of role and function of Intermediate Care administrative staff located at each GP Plus site is planned to identify relevant resources and positions to potentially transfer to Corporate Services.
5.16 Roles and relationships: Reception staff: Marion and Noarlunga GP Plus sites

- Upon completion of all outpatient service moves associated with Transforming Health, it is proposed that reception staff currently employed by Intermediate Care Services are transitioned to be under the operational leadership and management of the Outpatient Support Services Operational Manager.
- Report to: Administration Team Leader, Outpatient Support Services
- Accountable for premium customer-oriented reception services at Marion and Noarlunga GP Plus sites
- An assessment of role and function of Intermediate Care administrative staff located at each GP plus site, is to identify relevant resources and positions to potentially transfer to Corporate Services
7. Allied Health and intermediate care workforce contribution to new models of care

The Transforming Health (TH) program described six quality principles that outline the features of a quality health system. These features include services that are:

- Patient-centred
- Safe
- Effective
- Accessible
- Efficient
- Equitable

SALHN transformation is focused upon improving patient access and flow and ensuring there is an effective creation of capacity to deliver services across SALHN hospitals, outpatient and community services. TH has included initiatives focused upon improving the patient journey from first presentation through to discharge and the delivery of outpatient care, using evidence based ‘models of care’ for particular clinical conditions. Model of care evolution continues within SALHN.

Models of Care that are of particular significance to which Allied Health and/or Intermediate Care workforce include:

- Stroke
- Orthogeriatric
- Older Persons/ED/AMU
- Allied Health 7day service access
- Trauma
- Pain management
- GEM services
- Rehabilitation
- Acute Coronary syndrome
- Veteran’s mental health services.

The above models of care have documented the essential role that Allied Health professionals play in the delivery of quality, safe and evidence-informed practice to these patient cohorts. In all areas, a requirement for additional Allied health staff has been identified compared to historical models, concurrent with an emphasis on Allied Health intervention occurring as early as possible in a patient’s care journey, and over a 7 day cycle. Return on investment in terms of improved patient recovery, savings via length of stay reductions with a benefit-cost ratio of 2.52 have been cited (a Benefit Cost Ratio greater than 1 means the financial benefits outweigh the costs and the investment should be considered).

It is anticipated that the Workforce Model proposed in this paper for SALHN AH & IC provides a enhanced framework to support the implementation of these models of care. This paper also proposes that savings in FTE and costs identified through organisational structure redesign and as part of the 2017/18 budget setting process, be reallocated to ensure SALHN can meet the staffing imperatives of the new Transforming Health models of care.

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7 Transforming Health: Allied health 7 Day Services – Service Design Review June 2016
8. **Current and future state AH & IC workforce model comparison by FTE**

Table 2 documents current staffing levels in managerial (including project managerial) positions within Allied Health and Intermediate Care as at June 30, 2017. The table also documents the proposed future state management composition by FTE, and the net change indicated by the proposed changes.

<table>
<thead>
<tr>
<th>Current Staffing</th>
<th>Current state FTE</th>
<th>Classification</th>
<th>Future Staffing</th>
<th>Future state FTE</th>
<th>Indicative Classification – to be determined</th>
<th>Change in FTE</th>
</tr>
</thead>
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<tr>
<td>Executive Director</td>
<td>1.0</td>
<td>AHP6</td>
<td>Executive Director</td>
<td>1.0</td>
<td>AHP6</td>
<td>0.0</td>
</tr>
<tr>
<td>AH &amp; IC Manager</td>
<td>4.6</td>
<td>AHP5</td>
<td>AH &amp; IC Director</td>
<td>3.5</td>
<td>AHP5</td>
<td>-1.1</td>
</tr>
<tr>
<td>• AH Director FMC</td>
<td>1.0</td>
<td>AHP5</td>
<td>• Director: Acute AH &amp; IC Services</td>
<td>1.0</td>
<td>AHP5</td>
<td></td>
</tr>
<tr>
<td>• AH Director RGH</td>
<td>0.6</td>
<td>AHP5</td>
<td>• Director Sub-Acute AH &amp; IC Services</td>
<td>1.0</td>
<td>AHP5</td>
<td></td>
</tr>
<tr>
<td>• AH Director NH</td>
<td>1.0</td>
<td>AHP4</td>
<td>• Director AH W&amp;C Services</td>
<td>0.5</td>
<td>AHP5</td>
<td></td>
</tr>
<tr>
<td>• Manager – ICS &amp; Aboriginal Health</td>
<td>1.0</td>
<td>AHP5</td>
<td>• Director AH Mental Health</td>
<td>1.0</td>
<td>AHP5</td>
<td></td>
</tr>
<tr>
<td>• Manager ICS</td>
<td>1.0</td>
<td>RN5/ MAS3</td>
<td></td>
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<tr>
<td></td>
<td>0.0</td>
<td></td>
<td>AH &amp; IC Director Clinical Governance</td>
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<tr>
<td>Team Leaders/Managers</td>
<td>12.9</td>
<td>AHP3</td>
<td>Service/Team Managers</td>
<td>14.6</td>
<td>AHP4</td>
<td>+1.7</td>
</tr>
<tr>
<td>• FMC Stroke Team Leader</td>
<td>0.3</td>
<td>AHP3</td>
<td>• AH Acute Service Manager - Medicine</td>
<td>1.0</td>
<td>AHP4</td>
<td></td>
</tr>
<tr>
<td>• FMC Neurosurgery Team Leader</td>
<td>0.3</td>
<td>AHP3</td>
<td>• AH Acute Service Manager - Surgery</td>
<td>1.0</td>
<td>AHP4</td>
<td></td>
</tr>
<tr>
<td>• FMC ED/AMU Team Leader</td>
<td>2.7</td>
<td>AHP4</td>
<td>• AH Acute Service Manager - Neurosciences</td>
<td>0.8</td>
<td>AHP4</td>
<td></td>
</tr>
<tr>
<td>• RGH Inpatient Rehab Services Manager</td>
<td>0.8</td>
<td>AHP4</td>
<td>• AH Acute Service Manager – ED/AMU/Community Rapid Resp</td>
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<td></td>
</tr>
<tr>
<td>• RGH GEM Team Leader</td>
<td>0.8</td>
<td>AHP3</td>
<td>o (ED/AMU Senior Clinician)</td>
<td>1.7</td>
<td>AHP3</td>
<td></td>
</tr>
<tr>
<td>• RGH OPSA Manager</td>
<td>1.0</td>
<td>AHP4</td>
<td>• Advanced CPC – Respiratory</td>
<td>1.0</td>
<td>RN4</td>
<td></td>
</tr>
<tr>
<td>• Advanced CPC – Respiratory</td>
<td>1.0</td>
<td>RN4</td>
<td>• Advanced CPC – Diabetes</td>
<td>1.0</td>
<td>RN4</td>
<td></td>
</tr>
<tr>
<td>• Advanced CPC – Diabetes</td>
<td>1.0</td>
<td>RN4</td>
<td>• CPC – Weight Management</td>
<td>1.0</td>
<td>RN3</td>
<td></td>
</tr>
<tr>
<td>• CPC – Weight Management</td>
<td>1.0</td>
<td>RN3</td>
<td>• AH Sub-acute Service Manager – Inpatient Rehab</td>
<td>0.8</td>
<td>AHP4</td>
<td></td>
</tr>
<tr>
<td>• AH&amp;IC Team Manager – Hospital Avoidance, Support DC and Comm Services</td>
<td>1.0</td>
<td>RN4/</td>
<td>• AH Sub-acute Service Manager – GEM</td>
<td>0.8</td>
<td>AHP4</td>
<td></td>
</tr>
<tr>
<td>• IC Multidisciplinary team leader</td>
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<td>• AH Sub-acute Service Manager – OPSA</td>
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<td>AHP4</td>
<td></td>
</tr>
<tr>
<td>• Director CPS</td>
<td>1.0</td>
<td>AHP4</td>
<td>• AH Sub-acute Team Leader – Palliative Care</td>
<td>0.2</td>
<td>AHP3</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• AH &amp; IC Service Manager - Outpatient &amp; Community Services</td>
<td>1.0</td>
<td>AHP4</td>
<td></td>
</tr>
<tr>
<td>Current Staffing</td>
<td>Current state FTE</td>
<td>Classification</td>
<td>Future Staffing</td>
<td>Future state FTE</td>
<td>Indicative Classification – to be determined</td>
<td>Change in FTE</td>
</tr>
<tr>
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<td>--------------------------------------------------------------------------------</td>
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<tr>
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<td>• AH W&amp;C Service Manager – Paediatrics</td>
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<td></td>
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<td></td>
<td>• AH W&amp;C Team Leader – Women’s Health</td>
<td>0.3</td>
<td>AHP3</td>
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</tr>
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<td></td>
<td></td>
<td>• Director CPS</td>
<td>1.0</td>
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<td></td>
</tr>
<tr>
<td>GP Liaison/DATIS manager</td>
<td>1.0</td>
<td>AHP5</td>
<td>GP Liaison/DATIS Manager</td>
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<td>Allied Health &amp; IC Project/Research Officers</td>
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<td>AHP5</td>
<td>• Allied Health Research &amp; Project Officer</td>
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<td>ASO7</td>
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<tr>
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<td>Improvement</td>
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<tr>
<td>Heads of Disciplines/Profession Managers/Directors</td>
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<td>AHP4</td>
<td>-7.2</td>
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<tr>
<td>• Audiology</td>
<td></td>
<td></td>
<td>assurance responsibilities and clinical care</td>
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<td></td>
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</tr>
<tr>
<td>o FMC</td>
<td>0.6</td>
<td>AHP3</td>
<td>responsibilities combined</td>
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<tr>
<td>• Dietetics</td>
<td></td>
<td></td>
<td>• Audiology</td>
<td>0.6</td>
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</tr>
<tr>
<td>o RGH &amp; FMC</td>
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<td>• Dietetics</td>
<td>1.0</td>
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<td></td>
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<tr>
<td>o NH</td>
<td>0.5</td>
<td>AHP3</td>
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<td>1.0</td>
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<tr>
<td>• Occupational Therapy</td>
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<td></td>
<td>• Physiotherapy (including Exercise Physiology)</td>
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</tr>
<tr>
<td>o RGH &amp; FMC</td>
<td>2.0</td>
<td>AHP4</td>
<td>• Podiatry</td>
<td>1.0</td>
<td>AHP4</td>
<td></td>
</tr>
<tr>
<td>o NH</td>
<td>0.5</td>
<td>AHP3</td>
<td>• Psychology</td>
<td>1.0</td>
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</tr>
<tr>
<td>• Physiotherapy</td>
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<td></td>
<td>• Social Work</td>
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<td></td>
</tr>
<tr>
<td>o RGH</td>
<td>1.0</td>
<td>AHP5</td>
<td>• Speech Pathology</td>
<td>1.0</td>
<td>AHP4</td>
<td></td>
</tr>
<tr>
<td>o FMC</td>
<td>1.0</td>
<td>AHP4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Podiatry</td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>o FMC</td>
<td>1.0</td>
<td>AHP4</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o RGH &amp; NH</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>• Social Work</td>
<td></td>
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<tr>
<td>o RGH &amp; FMC</td>
<td>2.0</td>
<td>AHP4</td>
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<tr>
<td>Current Staffing</td>
<td>Current state FTE</td>
<td>Classification</td>
<td>Future Staffing</td>
<td>Future state FTE</td>
<td>Indicative Classification – to be determined</td>
<td>Change in FTE</td>
</tr>
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<tr>
<td>o NH</td>
<td>0.5</td>
<td>AHP3</td>
<td>AH&amp;IC Safety and Quality Manager</td>
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<td>AHP4/ASO7</td>
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<tr>
<td>• Speech Pathology</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>o RGH &amp; FMC</td>
<td>1.5</td>
<td>AHP4</td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>o NH</td>
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<td>AHP3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Safety &amp; Quality/Performance Evaluation Manager</td>
<td>3.6</td>
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<td>AH&amp;IC Safety and Quality Manager</td>
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<td>-2.6</td>
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<tr>
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<td>0.8</td>
<td>AHP3</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• ICS Manager, Performance &amp; Strategy</td>
<td>1.0</td>
<td>ASO7</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>• ICS Project Officer, Performance &amp; Strategy</td>
<td>1.0</td>
<td>ASO6</td>
<td></td>
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<td>• ICS Project Officer Quality</td>
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<td></td>
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<tr>
<td>(Project Officer IC)</td>
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<td>(ASO7)</td>
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<td>Advanced Clinical Practice Consultant</td>
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<td>RN4</td>
<td>Clinical data analyst &amp; performance evaluation AH&amp;IC</td>
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<td>AHP3/RN3</td>
<td>0.0</td>
</tr>
<tr>
<td>ICS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Business support/resource manager</td>
<td>1.0</td>
<td>ASO7</td>
<td>Business support/resource manager</td>
<td>1.0</td>
<td>ASO7</td>
<td>0.0</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>AH&amp;IC Recruitment Coordinator</td>
<td>1.0</td>
<td>ASO5</td>
<td>+1.0</td>
</tr>
<tr>
<td>System Administrator (ICS)</td>
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<td>ASO5</td>
<td></td>
<td></td>
<td></td>
<td>-1.0</td>
</tr>
<tr>
<td>Senior Tech Support Officer (ICS)</td>
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<td>Senior Tech Support Officer</td>
<td>1.0</td>
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<td>0.0</td>
</tr>
<tr>
<td>Project Manager Primary Health Clinical Information Systems</td>
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<td>ASO7</td>
<td></td>
<td></td>
<td></td>
<td>-1.0</td>
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<tr>
<td>Facilities Manager – ICS</td>
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<td>ASO8</td>
<td></td>
<td></td>
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<tr>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>-11.0</td>
</tr>
</tbody>
</table>
9. Reinvestment into clinical positions arising from FTE ‘savings’ from new management structure and model

The change in FTE identified in Table 2 supports the achievement of required 2017-2018 financial savings targets for Allied Health and Intermediate Care. It is proposed however, that in keeping with the principles articulated in Section 5, these savings are reinvested to support SALHN’s achievement of Transforming Health-endorsed models of care and/or other state-wide reforms. The positions proposed are documented in Table 3 below. The reinvestment of savings allows Allied Health and Intermediate Care to fund approximately 85% of the FTE required to support the implementation of the Transforming Health Models of Care in the areas of Ortho-geriatrics and Stroke. It is proposed that the savings to the health systems that have been forecasted by adopting these Models of Care would allow the Clinical Divisions to support the funding of the additional required FTE. Owing to the relative lower classifications of the clinical positions proposed in the future state compared to the relatively higher classifications and associated salaries and wages of management positions of the current state, an increase of 1 FTE is proposed.

Table 3: Proposed positions to be funded from organisational redesign

<table>
<thead>
<tr>
<th>POSITION TITLE</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dietitian – Orthogeriatrics</td>
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</tr>
<tr>
<td>Occupational Therapist - Orthogeriatrics</td>
<td>1.50</td>
</tr>
<tr>
<td>Physiotherapist - Orthogeriatrics</td>
<td>1.00</td>
</tr>
<tr>
<td>Podiatrist - Orthogeriatrics</td>
<td>0.20</td>
</tr>
<tr>
<td>Social Worker - Orthogeriatrics</td>
<td>0.60</td>
</tr>
<tr>
<td>Speech Pathologist - Orthogeriatrics</td>
<td>0.10</td>
</tr>
<tr>
<td>Allied Health Assistant - Orthogeriatrics</td>
<td>0.30</td>
</tr>
<tr>
<td>Psychology - Orthogeriatrics</td>
<td>0.20</td>
</tr>
<tr>
<td>Dietitian - Stroke</td>
<td>0.20</td>
</tr>
<tr>
<td>Occupational Therapist - Stroke</td>
<td>0.70</td>
</tr>
<tr>
<td>Physiotherapist - Stroke</td>
<td>0.70</td>
</tr>
<tr>
<td>Psychologist - Stroke</td>
<td>0.70</td>
</tr>
<tr>
<td>Neuro-psychologist - Stroke</td>
<td>0.30</td>
</tr>
<tr>
<td>Social Worker - Stroke</td>
<td>0.70</td>
</tr>
<tr>
<td>Speech Pathologist - Stroke</td>
<td>1.00</td>
</tr>
<tr>
<td>Allied Health Assistant - Stroke</td>
<td>0.40</td>
</tr>
<tr>
<td>GEM Allied Health</td>
<td>2.30</td>
</tr>
<tr>
<td>Mental Health: Jamie Larcombe Centre</td>
<td>1.20</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>12.55</strong></td>
</tr>
</tbody>
</table>
10. Aboriginal impact statement

Given the elevation of Aboriginal Health Services leadership to have a direct presence and voice within SALHN’s executive team, and accountability of each managerial role within the Allied Health and Intermediate Care division to promote the attraction and retention of Aboriginal and Torres Strait Islander people to the workforce, it is anticipated that positive impact to Aboriginal and Torres Strait Islander communities will result.

SALHN Allied Health and Intermediate care is committed to investing in realising SALHN and SA Health’s target of increasing participation of Aboriginal and Torres Strait Islander people across all SALHN Allied Health and Intermediate Care professions and classifications. The proposed role of each profession’s Lead Clinician with Universities with undergraduate student Allied Health programs will be key to influencing increasing the number of Aboriginal and Torres Strait islander students in these programs and providing a culturally safe environment for Aboriginal and Torres Strait Islander Allied Health students and patients.

11. Implementation Process

The following staff will be in-scope for the organisational restructure:

- Allied Health professionals of all Divisions excluding perfusionists, pharmacists of SA Pharmacy, radiographers, cardiac interventionists, cardiac physiologists, orthoptists, epidemiologists.
- All staff of Intermediate Care services.

Transforming Health Principles – WPEA: Salaried Transforming Health HR Principles and underpinning industrial instruments will be applied for SA Public Sector Wages Parity Enterprise Agreement: Salaried 2014 (WPEA: Salaried) staff (ASO, AHP, OPS, PO, TGO, MeS, GFSC).

The SA Health HR Principles – Nursing and Midwifery and underpinning industrial instruments will be applied for all affected Nursing and Midwifery staff.

It is proposed that structure and workforce model finalisation will take place following the receipt of feedback. Implementation will commence with selection processes based on the above mentioned HR Principles in the following sequence:

Phase 1 (February 2018 *indicative time frame only):
- Director: Allied Health Acute and Intermediate Care Services
- Director: Allied Health Sub-Acute and Intermediate Care Services
- Director: Allied Health Women’s & Children’s Services
- Director: Allied Health Mental Health Services
- Director: Allied Health and Intermediate Care Clinical Governance

Phase 2 (March – April 2018 *indicative time frame only):
- Service Managers
- Lead Clinicians
Phase 3 (May – June 2018 *indicative time frame only)

- Safety & Quality Manager
- Clinical Data Analyst
- Recruitment Coordinator
- Project/Research Officer

Phase 4 (July 2018 *indicative time frame only)

- Remaining positions in the new model

12. Communication Plan

It is anticipated that communication with in-scope staff regarding the consultation process, model finalisation pending feedback and progress regarding implementation will occur via:

- Staff forums across SALHN sites
- Allied Health and Intermediate Care organisational structure updates/’newsletters’ to Allied Health and Intermediate Care staff via email
- The creation of an Allied Health and Intermediate Care organisation structure page on the SALHN intranet
- Communication via regular staff meetings between Allied Health and ICS directors with staff
- Updates for unions at SALHN Industrial Liaison Forums

13. Next steps

The proposed new workforce model and organisational structure for SALHN Allied Health and Intermediate Care is being released with the aims of seeking feedback from:

- Allied Health and Intermediate Care staff
- Clinical Division executive staff
- SALHN Executive
- SA Health’s Allied Health and Scientific Office staff
- Unions

Input and feedback can be provided via:

- Staff forums within Allied Health and Intermediate care
- Via email at HealthSALHNAHICFeedback@sa.gov.au
- Directly to Allied Health and Intermediate Care executive
- Directly to unions

Closing date for all feedback is COB Monday 11 December 2017.
All questions and feedback will be communicated to the Project Manager - Allied Health Restructure. Following the collation of, and consideration of feedback, the proposed model will be refined and formalised and a detailed implementation plan developed.
APPENDIX 1: SALHN ALLIED HEALTH STRATEGIC BUSINESS PLAN 2017-18
SOUTHERN ADELAIDE LOCAL HEALTH NETWORK (SALHN)

ALLIED HEALTH

STRATEGIC BUSINESS PLAN

2017/18
Executive Summary

SALHN ALLIED HEALTH

- Invest in staff wellbeing to ensure engagement, enthusiasm and quality patient care throughout the next 18 months
- Define in detail and implement the next phase of the Allied Health restructuring, based on ‘one SALHN-wide Allied Health’ led by Allied Health
- Build a ‘SALHN Allied Health’ culture across professions, across teams, across services, across sites, across staff levels
- Maintain and measure clinical excellence and patient-centred care throughout this time of change
- Develop a new model of care models in ITU/AUI, outpatients and intermediate care with Allied Health leaders at every level of care delivery and management

Goals

2017-2018

Vision

‘One SALHN. One Allied Health. Striving for excellence in collaborative patient care.’

Values

‘We believe in providing the standard of care that we desire for our families and friends’

Mission

Audiology, dietetics, exercise physiology, occupational therapy, orthotics & prosthetics, physiotherapy, podiatry, psychology, social work, speech pathology, art therapy & spiritual care

- We aim to become a national leader in Allied Health care, blending the best of collaborative clinical practice, leadership and research with optimal efficiency, effectiveness and positive health impact for the people of the southern suburbs of Adelaide.

- In Allied Health we demonstrate this through:
  - respect
  - clinical leadership
  - enablement
  - positive impact
  - evidence-informed practice
  - evidence-based decision making
  - accountability
  - SALHN wide mindset
  - patient centred
  - supported staff
  - transparent communication
  - collaborative team-based patient care

- Optimise a patient’s health and function,
- Minimise and prevent deterioration
- Enable a person to independently manage their own health
- Maximise a patient’s capacity/potential for participating fully in their community, work and/or family life
SALHN ALLIED HEALTH STRATEGIC BUSINESS PLAN

Section 1: Background

A strategic business plan is a roadmap to build and position an organisation for future success. The process of strategic planning can be more important than the Plan itself\(^8\). This Plan was developed referencing three primary sources:

(1) SALHN Allied Health staff whose views were harnessed at a ‘whole of SALHN Allied Health’ strategic planning workshop held on February 22, 2017. The workshop was held with the following goals:

- To create an opportunity for Allied Health professionals and support staff across all SALHN sites to meet one another, in many cases for the first time
- To develop a shared vision for SALHN Allied Health
- To provide an avenue for staff to provide their insights into principles of clinical practice and management decision making
- For staff to identify what should be the top five priorities for SALHN Allied Health for the next 12-18 months
- To construct a strategic business plan to Allied Health be used as tool to guide service delivery development, operational management and decision making into the future.

Thematic analysis was conducted on the rich and extensive input received from more than 310 staff who participated at the workshop. The themes have been incorporated into this Plan.

(2) Insights of members of SALHN’s Executive team and consumers regarding:

- Allied Health’s role, function and essential contribution to patient care at SALHN.
- Priorities for Allied Health given the external environmental context within which SALHN operates, with a particular emphasis on SA Health’s and SALHN’s Transforming Health strategic agenda, and financial constraints.

(3) SA Health’s and SALHN’s key priorities including Transforming Health, decommissioning of the Repatriation General Hospital, development and launch of new models of care, improving patient-centred care, research, and activity and financial key performance indicators.

\(^8\) Strategic Plans are less important than strategic planning. Kenny, G at hbr.org/2016/06/strategic-plans-are-less-important-than-strategic-planning
Section 2: Environmental Analysis

The South Australian health sector is undergoing unprecedented change. SA Health is committed to delivering on its Transforming Health agenda. For SALHN, a pivotal impact is the closure of the Repatriation General Hospital at the end of 2017. Investment in new infrastructure including the new Rehabilitation centre, car parks, minor and capital works is occurring to enable inpatient and outpatient reconfiguration in alignment with SA Health and SALHN priorities. This is occurring concurrent with need to find efficiencies in financial and activity performance with an expectation of urgent correction of current over-budget performance.

Section 3: Allied Health at SALHN (who we are)

More than 450 Allied Health professionals work across SALHN providing services across all levels and environments of a patient’s care journey – in home, ‘intermediate’, acute hospital, subacute including (p)rehabilitation, outpatient, ambulatory and community-based care. Allied Health professionals provide expert care from the fields of audiology, dietetics, occupational therapy, orthotics and prosthetics, physiotherapy, podiatry, psychology, social work, speech pathology, art therapy and spiritual care.

SALHN Allied Health provides care, treatment and support for children, adults and their families who live in the southern suburbs of Adelaide, as primary practitioners and as members of broader health care teams.

Demand

The southern suburbs have been identified in population health data as growth suburbs for children and families, with areas of high levels of socio-disadvantage linked to poorer health status, proportionally higher numbers of Aboriginal and Torres Strait Islander families with complex health and social issues, and an ageing population. This provides a projection for the future of escalating demand for SALHN Allied Health care.

The emergence in recent years of increasing health economics evaluations citing the financial benefits of earlier, intensive and broader scope of Allied Health service provision in a patient’s care journey amplifies the projection of potential increasing demand for Allied Health care into the future.

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10 Transforming Health: Allied Health 7 Day Services (2016) SA Health
Supply

Patient-need or ‘stream’ foci of SALHN Allied Health include, but are not limited to those clinical areas listed below:

- Emergency Department
- Acute medical and surgical
- Geriatric Evaluation & Management
- Rehabilitation (inpatient, day, in-home, telehealth, and ‘prehabilitation’)
- Community and hospital substitution
- Older Persons’ (‘frailty’)
- Pain management
- Neonatal
- Paediatrics, child development
- Child Protection
- Women’s Health
- Mental Health
- Chronic disease
- Neurological disorders
- Musculoskeletal disorders
- Pre and post-surgical
- Sensory impairments
Section 4: A vision for SALHN Allied Health (our desired future)

We aim to become a national leader in Allied Health care, blending the best of collaborative clinical practice, leadership and research; with optimal efficiency, effectiveness and positive health impact, for the people of the southern suburbs of Adelaide.

‘One SALHN. One Allied Health. Striving for excellence in collaborative patient care.’

Section 5: Mission Statement (our purpose and what we do, today)

SALHN Allied Health provides assessments, diagnosis, education and advocacy, early intervention, therapy/treatment, and case coordination. Our unique contribution to health outcomes comes from our expertise in the fields of audiology, dietetics, exercise physiology, occupational therapy, orthotics and prosthetics, physiotherapy, podiatry, psychology, social work, and speech pathology, and ‘arts in health’. We use a strengths-based collaborative approach, partnering with patients and SALHN’s broader clinical teams and other service sectors, to:

- optimise a patient’s health and function,
- minimise/prevent deterioration,
- enable a person to independently manage their own health
- maximise a patient’s capacity/potential for participating fully in their community, work and/or family life.

We provide high quality care across all phases and patient care environments including in a patient’s home and in acute, sub-acute, intermediate, outpatient/ambulatory and/or community-based services. We support the development of the future Allied Health workforce through providing clinical placement opportunities for health and social sciences’ university students.

Section 6: Our Values

SALHN has a primary commitment statement which recognises the core value of all staff in providing the standard of patient care that we desire for our own families and friends. SALHN Allied Health have further defined these values in terms of principles of practice of priority importance to them values that are important to Allied Health.

✓ **Respect** for our patients and the unique, diverse and valued contributions to excellent collaborative health care from the professions of audiology, dietetics, occupational therapy, orthotics and prosthetics, physiotherapy, podiatry, psychology, social work, speech pathology, arts therapy and spiritual care.
✓ *Clinical leadership* in highly performing teams, collaborating with patients and carers, our medical, nursing and health professional colleagues within SALHN, with GPs and with community service providers.

✓ ‘Enablement’ is our focus, using a proactive holistic approach to promote improvement in a patient’s quality of life.

✓ *Impact* across the patient’s care journey - in a patient’s home, and in intermediate, acute, sub-acute, outpatient/ambulatory, telehealth and community-based service environments.

✓ *Evidence-informed* approaches in clinical practice and supervision.

✓ *Criterion-based decision making* that references SALHN strategic priorities, SALHN Allied Health’s operational goals, financial imperatives, data analysis, benchmarks/key performance indicators, quality and safety standards.

✓ Recognition that excellence acknowledges *accountability* for clinical outcome achievement, cost-effectiveness and efficiency, embracing aims of no/least duplication of services, processes and management, and evaluation of performance.

✓ *SALHN-wide*, innovative strong leadership that is a driving force at SALHN Executive, in planning and service delivery, irrespective of SALHN site, location and service.

✓ Genuine *patient-centred* practice, where the patient and family are empowered to make their own health care decisions.

✓ *Supported staff* who feel engaged and empowered to try new approaches, using data analysis, evidence and consumer input to develop, implement and evaluate practice change.

✓ Effective and transparent *communication* within clinical teams and across and within all levels of SALHN.
Section 7: SWOT

Analysis of a health care service’s Strengths, Weaknesses, Opportunities and Threats (SWOT) assists in the determination of the best opportunities to pursue to achieve goals. A SWOT analysis can focus an organisation on building on its strengths to improve performance in quality, quantity and outcomes of clinical care within an environment of constrained resources.11

A SWOT analysis was conducted using the input from all resources as outlined in Section 1.

Table 1: SWOT analysis: SALHN Allied Health

<table>
<thead>
<tr>
<th>Strengths</th>
<th>Weaknesses</th>
</tr>
</thead>
<tbody>
<tr>
<td>• focus on and with patient on health, function and quality of life outside of hospital</td>
<td>• current staffing not matched to need across 7 days, and span of hours per day required and reflective of a ‘historical’ approach to resource allocation</td>
</tr>
<tr>
<td>• commitment and skill in multi-D team leadership and service planning and delivery across acute/subacute/intermediate/community care</td>
<td>• variation across SALHN sites in intake/discharge criteria, performance expectations and productivity</td>
</tr>
<tr>
<td>• recognition of benefits and motivation to form ‘one SALHN Allied Health’ to maximise efficiency, care responsive and clinical learning opportunities</td>
<td>• minimal current exposure to AH staff across SALHN sites, leading to site-centricity and independent cultures</td>
</tr>
<tr>
<td>• value of AH by medical and nursing colleagues in clinical divisions, and SALHN Executive</td>
<td>• AH staff distributed across SALHN in a mix of AH-led and non-AH led management structures resulting in management inefficiency, variation in performance, and perception amongst AH staff of a lack of identity and influence within decision-making at all levels of organisation</td>
</tr>
<tr>
<td>• evidence of commitment to quality &amp; safety via achievements in credentialling, PR &amp; D, service improvement</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Opportunities</th>
<th>Threats</th>
</tr>
</thead>
<tbody>
<tr>
<td>• expansion of evidence of benefit of intensive AH care and advanced scope of practice AH care upfront in a patient’s care journey, across 7 days and expanded hours</td>
<td>• scale of unprecedented number and range of transformational change processes leading to ‘change fatigue’ and erosion of AH impact</td>
</tr>
<tr>
<td>• explicit recognition of AH in Models of Care</td>
<td>• attracting/retaining staff given opportunities elsewhere in Health, Ageing and Human Services’ sectors</td>
</tr>
<tr>
<td>• SALHN inpatient/outpatient reconfiguration to optimise cost effectiveness of AH service delivery, in least duplicated model for patients</td>
<td>• savings strategies imposed referencing conceptual framework not compatible with contemporary approaches to AH management and performance frameworks</td>
</tr>
<tr>
<td>• endorsement of AH restructure by SALHN executive</td>
<td>• site-based cultures will transfer to new buildings without individual accountability to drive forging of and maintaining of new culture</td>
</tr>
<tr>
<td>• National Disability Insurance Scheme as a vehicle to provide expanded AH, with new income streams</td>
<td></td>
</tr>
<tr>
<td>• current &amp; future AH workforce development through coordinated SALHN-wide approaches to student placements, staff rotations, supervision, professional development, information sharing</td>
<td></td>
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</tbody>
</table>

11 https://www.forbes.com/sites/davelavinsky/2013/10/18/
Section 8: Goals

Setting and achieving goals is the hallmark of successful organisations\textsuperscript{12}. SALHN Allied Health staff were expressly asked to describe and prioritise their goals for SALHN Allied Health over 2017 - 2018. These goals are described below:

1. Invest in staff well-being to enable resilience, enthusiasm and quality patient care throughout the next ~18 months

2. Define in detail and implement the next phase of the Allied Health restructure, based on ‘one SALHN-wide Allied Health, led by Allied Health’

3. Build a SALHN Allied Health culture – across professions, across teams, across services, across sites, across staff levels

4. Maintain clinical excellence and patient care throughout this time of change

5. Develop Allied Health led care models in ED/AMU, outpatients and intermediate care, and with AH leaders at every level of care delivery and management

\textsuperscript{12} https://www.forbes.com/sites/davelavinsky/2013/10/18/
Section 9: Improvement measures

Great health care services understand their metrics and KPIs. By tracking our KPIs, we will know exactly how we are performing and can adjust as needed. Our KPI’s will be set within a ‘balanced scorecard’ framework that is inclusive of metrics that relate to our goals as well as broader SALHN priorities. The Allied Health performance framework for 2017-2018 is outlined below:

<table>
<thead>
<tr>
<th>Patient care activity</th>
<th>Financial</th>
<th>Staff</th>
<th>Quality</th>
<th>Impact/outcome</th>
<th>Consumer engagement</th>
</tr>
</thead>
</table>
| Targets set and performance compared against targets in Inpatient/Outpatient/Intermediate care contexts – per team, per professional, per model of care | 4+/- variance against budget | next phase structure design & implementation on progress | Falls rate target established with nursing colleagues using suitable benchmarks if available | # complaints and compliments
| # AH led triage outpatient processes in development and in place | average AH $ expended per model of care per patient and per care episode | staff rotational system in place | % AH reps in place for all NSQIC areas | 2 service improvement projects with consumer involvement in planning and evaluation
| Increased AH resource per clinical division | # of hospital admissions and outpatient sessions/waiting list additions as a result of AH led triage models and/or AH-led hospital avoidance interventions | # resignations as % of total AH staff | Incident rates monitored and below target/benchmark | (i) Aboriginal and Torres Strait Islander cultural awareness training and use of culturally appropriate resources - # of staff who complete module
| NWAUs & OOS against targets | leave liability | # new staff induction as % of total staff | access - set target response times/wait lists thresholds & performance measured against targets | (ii) Disability Access and Inclusion priority project with consumers
| Clinical care ratios devised and monitored for clinical areas/settings | # AH led triage | # workcover claims as % total FTE | # service improvement projects within clinical divisions | # patients receiving AH care
| # of advanced scope of practice/extensive scope of practice roles in place | hospital admissions and outpatient sessions/waiting list | PR & D target achievement | equity - % patients in clinical streams relevant to AH that receive AH | Outcome indicators in place, and baseline performance
| | | 100% credentialled achieved | compliance with National standards framework: swallow screen, physio assessment time frames, post stroke; MUST nutrition scores |
| | | mandatory training completion | | response time per priority level of patient |
| | | # staff in resilience/leadership and disability/access training | | establish new review ratios and develop KPIs for each patient group |
| | | net promoter score | | LOS changes post 7 day & expanded hours |
| | | sick leave | | key broader health care team outcomes eg AROC |
| | | # staff engaged in post grad education and/or research | | clinical outcome by DRG per % of presentations compared with benchmarks of Health Roundtable |
| | | # staff accessing supervision as per SA Health’s frameworks | | |
| | | $ accessed from ASHO PD fund as measure of support for PD attendance/skill development | | |

13 [www.slideshare.net/alberpaules/strategic-planning-for-healthcare-services](http://www.slideshare.net/alberpaules/strategic-planning-for-healthcare-services)
**Section 10: Operations Plan**

In this section, key large scale Allied Health initiatives that span SALHN and address the key goals outlined in section 8 are documented. The projects are, or will be, mapped in Gantt charts, to identify indicative start and completion dates and who will lead them.

**Goal 1:** *Invest in staff well-being to enable resilience, enthusiasm and quality patient care throughout the next ~18 months.*

Project leadership: **Allied Health Directors**

Gantt chart to be developed.

**Goal 2:** *Define in detail and implement the next phase of the Allied Health restructure, based on ‘one SALHN-wide Allied Health, led by Allied Health’*

Project leadership: **Executive Director Allied Health**

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**Gantt chart: Next phase Allied Health restructure**

<table>
<thead>
<tr>
<th>Phase &amp; target time frame</th>
<th>Apr</th>
<th>May</th>
<th>Jun</th>
<th>Jul</th>
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<th>Sep</th>
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<td>Implementation preparation e.g J &amp; P, position creation</td>
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<td>Consultation re recruitment process with staff &amp; unions</td>
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<td>Recruitment &amp; appointment</td>
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Allied Health & Intermediate Care Proposed Workforce Model and Organisational Structure
Goal 3:  *Build a SALHN Allied Health culture – across professions, across teams, across services, across sites, across staff levels*

Project leadership:  Allied Health Directors & Profession Leads

Gantt chart to be developed.

Goal 4:  *Maintain clinical excellence and patient care throughout this time of change*

Leadership:  Allied Health Directors; Profession Leads; Team Leaders; Clinical Supervisors; Allied Health Safety & Quality Manager

1. Goal 5:  *Develop Allied Health led care models in ED/AMU, outpatients and intermediate care, and with AH leaders at every level of care delivery and management*

Project leadership:  Allied Health Directors in collaboration with other divisions

Gantt chart to be developed.

This strategic business plan will be utilised by Allied Health business units as an overarching framework in the development of local operations plans.

Section 11: Financial Projections

At present, with the exception of Orthotics Prosthetics SA (OPSA), SALHN Allied Health financial resources are entirely dependent on SALHN’s internal allocation process of SA Health’s budget setting process. The use of activity-based funding tied to divisional budgets and performance analysis is in its infancy in SALHN with variation in its application across the network. Typically, Allied Health budgets, where they exist and assigned to an Allied Health manager/director, have been established using historical, annual ‘roll-over’ methodologies, with only partial synergy to changes in patient demand, productivity/practice change expectations for and with staff.

This section will incorporate, SALHN Allied Health’s divisional budget for 2017 – 18 budget when finalised.
APPENDIX 2: CURRENT ORGANISATIONAL CHARTS OF

ALLIED HEALTH AND INTERMEDIATE CARE STAFF

ACROSS SALHN
Allied Health & Intermediate Care Proposed Workforce Model and Organisational Structure
FMC Physiotherapy Organisation Chart

Director FMC Allied Health
AHP5

Manager Physiotherapy FMC
AHP4

Advanced Physiotherapist ED
AHP4

Research Physiotherapist
AHP4

Administrative Coordinator
AS03

Clerical Officer
AS02
Appliance Clerk
AS01

Senior Physiotherapist - Aged Care & General Medicine
AHP3

Senior Physiotherapist - ICCU
AHP3

Senior Cardiorespiratory Physiotherapist
AHP3

Senior Physiotherapist Orthopaedics & Vascular Surgery
AHP3

Senior Physiotherapist Neurosciences
AHP3

Senior Physiotherapist Musculoskeletal
AHP3

Senior Physiotherapist Paediatrics
AHP3

Senior Physiotherapist Women’s Health
AHP3

Senior Aquatic Physiotherapist
AHP3

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapist Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapist Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapist Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapist Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapist Attendant
OPS1/2

Advanced Physiotherapist ED
AHP4

Research Physiotherapist
AHP4

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapy Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapy Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapy Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapy Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapy Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapy Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapy Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapy Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapy Attendant
OPS1/2

Physiotherapist
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Physiotherapist
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Physiotherapy Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapy Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapy Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapy Attendant
OPS1/2

Physiotherapist
AHP2

Physiotherapist
AHP1

Physiotherapy Attendant
OPS1/2
FMC Psychology Organisation Charts

Mental Health/Paediatrics
- Advanced Clinician Psychologist
  - AHP4

Pain Management Unit
- Senior Psychologist
  - AHP3
- Senior Psychologist
  - AHP3

Mental Health
- Senior Neuro-Psychologist
  - AHP4

Oncology
- Psychologist
  - AHP2

Paediatrics - Child Assessment Team
- Senior Psychologist/CAT Coordinator
  - AHP3
- Senior Psychologist
  - AHP3
- Psychologist
  - AHP2

Neonatal Follow Up
- Psychologist
  - AHP2
Repatriation General Hospital (RGH)

RGH Allied Health Management Organisation Chart
RGH Nutrition and Dietetics Organisation Chart

Director Allied Health RGH
AHP5

Director Nutrition & Dietetics RGH
AHP4

Senior Dietitian Food Services
AHP3

Senior Clinical Dietitian
GEM/Aged Care
AHP3

Senior Clinical Dietitian Rehab
AHP3

Senior Clinical Dietitian Acute/Pall Care/Outpatient
AHP3

Dietitian TCP
AHP2

Dietitian GEM
AHP2

Dietitian Rehab Ambulatory Services
AHP2

Dietitian
AHP1

Dietitian Rehab
AHP1

Please note that clinical AHP staff at RGH may have dual reporting relationships – professionally to discipline managers and operationally to program/service managers or team leaders.
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RGH Speech Pathology Organisation Chart

Please note that clinical AHP staff at RGH may have dual reporting relationships – professionally to discipline managers and operationally to program/service managers or team leaders.
RGH Transitional Care Program Liaison Organisation Chart

Co-Director Rehabilitation, Aged Care & Palliative Services

Manager, Transition Services
AHP4

Transitional Care Program Liaison
AHP2

VITA TCP Clinical Staff
AHP1/2
RGH ACAT Allied Health Organisation Chart

- Co-Director Rehabilitation, Aged Care & Palliative Services
- ACAT Manager RN4
- ACAT Assessor AHP2
*Other Allied Health services (PT, OT, DN, SP) are provided on referral basis from RGH Allied Health discipline teams
Child Protection Services

Child Protection Services Organisation Chart

Director Child Protection Services
AHP5

Office Manager
ASO3

Administrative Officers
ASO2

Clinical Services Coordinator
AHP4

Senior Clinical Practitioner
AHP3

Senior Clinical Practitioner
AHP3

Senior Social Worker/Clinical Psychologist - Early Links
AHP2

Senior Social Workers/Clinical Psychologists
AHP2

Allied Health & Intermediate Care Proposed Workforce Model and Organisational Structure
Intermediate Care Services

Intermediate Care Services Organisation Chart

- SALHN EXECUTIVE MANAGEMENT
- SALHN CLINICAL COUNCIL
- SALHN DIVISIONAL PERFORMANCE
- ICS Clinical Governance Committee
- Executive Director Allied Health
- Director Intermediate Care Services

- GP Plus Sites
  - Marion | Noarlunga | Aldinga
- Community Services

- Multi-Disciplinary Team
- Performance & Strategy
- Facilities Management | Support Services

- Drug & Therapeutic Information Service
- Aboriginal Health Service
- Diabetes Care Stream
- Respiratory Care Stream
- Bariatric Management Stream
- Hospital Avoidance and Supported Discharge Care Stream

Aboriginal Health Service
Hospital Avoidance and Supported Discharge Care Stream
Drug & Therapeutic Information Service
Multi-Disciplinary Team
Performance & Strategy
Facilities Management | Support Services

ICS Clinical Governance Committee
Executive Director Allied Health
Director Intermediate Care Services
GP Plus Sites
Marion | Noarlunga | Aldinga
Community Services

Drug & Therapeutic Information Service
Aboriginal Health Service
Diabetes Care Stream
Respiratory Care Stream
Bariatric Management Stream
Hospital Avoidance and Supported Discharge Care Stream
Multi-Disciplinary Team
Performance & Strategy
Facilities Management | Support Services
Intermediate Care Organisational Chart

Director Intermediate Care Services

Resource Manager

ICS CSC Diabetes

ICS CSC Respiratory

ICS CSC Weight Management

ICS CSC Hospital Avoidance & Supported Discharge

ICS Intake Coordinator

Admin Coordinator

Admin

Multi Disciplinary Team Leader (Clinical Services Co-ordinator)

MULTI DISCIPLINARY TEAM

LEGEND

Care Pathways

Site & Clinical Administration Services
Intermediate Care Organisation Chart – Administrative Officer Staff

- Director ICS & Aboriginal Health
- Manager ICS RN5/MAS3
- Executive Assistant ASO3
- Facilities Manager ASO8
- Project Manager Primary Health Clinical Information Systems ASO7
- Resource Manager ASO7
- Senior Project Officer - Strategic Projects ASO7
- Project Officer ASO6
- Project Officer Performance & Strategy ASO6
- Senior Tech Support Officer ASO6
- Project Officer Quality ASO6
- System Administrator ASO5
- Administration Coordinator ASO4
- Senior Administration Officer ASO3
- Administration Officer - Executive Secretary ASO2
- Administration Officer ASO2
Intermediate Care Organisation Chart – Early Childhood Team

- Director ICS & Aboriginal Health
  - AHP5
- Team Leader Early Childhood Team
  - AHP4
  - Senior Clinical Psychologist
    - AHP3
    - Child & Family Psychologist
      - AHP2
  - Chief Occupational Therapist
    - AHP3
  - Occupational Therapist
    - AHP2
  - Speech Pathologist
    - AHP2
  - Regional Creche Service Manager
    - OPS4
  - Therapy assistant Creche Coordinator
    - OPS2
  - Therapy Assistant
    - OPS1
  - Casual Creche Workers
    - WHA3
APPENDIX 3: SALHN ALLIED HEALTH AND INTERMEDIATE CARE WORKFORCE ANALYSIS
Analysis of the SALHN Allied Health professional workforce illustrated in Graph 1 indicates that 40% of the workforce is employed on a full-time basis; 47% on a part-time basis; and more than 12% on a casual basis. This composition would appear to meet the Premier’s direction of June 2016 in relation to supporting flexibility in workforce arrangements via the availability of part-time roles. The cost burden in terms of financial outlay, coupled with costs associated with time required for casual staff to complete mandatory training relative to the time spent in clinical care delivery, creates an opportunity to achieve improvements and efficiency in resource allocation. It is proposed that the future state for the SALHN Allied Health professional workforce leverages the size of the total SALHN Allied Health casual workforce and associated expenditure to achieve a more stable workforce across the network to support:

- improving accessibility to Allied Health services across a 7-day per week service cycle
- increasing consistency of staffing and associated Allied Health therapy dosage for patient care including through periods of staff leave.

It is proposed that each Allied Health lead clinician (refer Section 5) will be responsible for their respective Allied Health discipline’s clinical competency development and assurance and staff rostering in relation to both weekend service provision, covering periods of staff leave. Close communication with Service Managers will be a critical success factor.
Analysis of the SALHN Allied Health professional workforce illustrated in Graph 2 above indicates that 19% of the workforce is aged 30-34; 17% aged 35-39; 16% aged 25-29. A declining trend in numbers of Allied Health professionals from a peak in the age range of 30-34 years is evident. The proportionally low number of Allied Health professionals in the age range of 20-24, while partially reflective of the typical duration of undergraduate degrees for each Allied Health discipline, also provides an opportunity to target attraction and retention of Allied Health professionals to support enhancement of approaches to workforce renewal. Motivators of individuals in this age range should be analysed to ascertain behavioural drivers of attraction, job satisfaction and sustained workplace performance/commitment. Testing this with students and new/early post graduate staff at SALHN is proposed to identify opportunities for tailoring the SALHN Allied Health workforce model into the future.

It is proposed that the Allied Health/Intermediate Care Directors will need to collaborate with each Allied Health discipline’s lead clinician (refer Section 5) to undertake the above analysis and to subsequently craft a targeted approach to attraction, retention and renewal strategies in conjunction with the SALHN Workforce Division.
Graph 3: Composition of the SALHN Allied Health professional workforce by employee gender

Graph 3 illustrates that more than 85% of the SALHN Allied Health workforce is female. This represents a contrasting picture to national Allied Health labour force characteristics documented in the table below:

<table>
<thead>
<tr>
<th>Allied Health discipline</th>
<th>% Female working in public sector</th>
<th>% Male working in public sector</th>
<th>% female in early career (&lt;3 years experience)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational Therapists</td>
<td>52%</td>
<td>44%</td>
<td>26%</td>
</tr>
<tr>
<td>Physiotherapists</td>
<td>33%</td>
<td>18%</td>
<td>21%</td>
</tr>
<tr>
<td>Podiatrists</td>
<td>17%</td>
<td>7%</td>
<td>n/a</td>
</tr>
<tr>
<td>Psychologists</td>
<td>29%</td>
<td>25%</td>
<td>4%</td>
</tr>
</tbody>
</table>

Development of an understanding of the attraction and retention drivers of the male Allied Health workforce is suggested to support implementation of initiatives to support greater gender balance in the SALHN Allied Health workforce.

It is proposed that the Allied Health/Intermediate Care Directors will need to collaborate with each Allied Health discipline’s lead clinician (refer Section 4) to undertake the above analysis and to subsequently develop a targeted approach to attraction, retention and renewal strategies, in conjunction with the SALHN Workforce Division, to support improved gender balance.

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14 National Health Workforce Data set 2015; Health Workforce Principle Committee December 2016
Analysis of data in Graph 4 indicates that 39% of the SALHN Allied Health workforce has worked at SALHN for 1-5 years, and 27% 6-10 years. The proportionally high number of employees of tenure of 0-5 years highlights a need for efficiency in staff orientation, induction, and other staff education processes. Given the proportionally high composition of females in the workforce, re-attracting/retaining these staff back to the SALHN Allied Health workforce following periods of maternity leave amplifies the need for successful systems of supporting flexibility in employment conditions in parallel with a workplace environment that maximises clinical care time with optimal efficiency in mandatory training and other required administrative tasks.

It is proposed that the Allied Health and Intermediate Care Directors (refer Section 5) will take a leading responsibility, in collaboration with SALHN Workforce, to determine optimal organisational development, staff training and systems development to support the above.
Graph 5 illustrates that only one staff member out of all of SALHN Allied Health workforce identifies as Aboriginal or Torres Strait Islander. Comparison with national benchmarks of numbers of Aboriginal and Torres Strait Islander Allied health professionals\(^\text{15}\) are listed in the table below:

<table>
<thead>
<tr>
<th>Allied Health discipline</th>
<th>% of national workforce identify as Aboriginal or Torres Strait Islander</th>
</tr>
</thead>
<tbody>
<tr>
<td>Occupational therapy</td>
<td>0.4%</td>
</tr>
<tr>
<td>Physiotherapy</td>
<td>0.5%</td>
</tr>
<tr>
<td>Podiatry</td>
<td>0.7%</td>
</tr>
<tr>
<td>Psychology</td>
<td>0.6%</td>
</tr>
</tbody>
</table>

The gap between SALHN’s level of employment of Allied Health professionals that identify as Aboriginal or Torres Strait Islander and South Australia’s target of 4% ATSI workforce target is self-evident. Additionally, the workforce database indicates that in 37% of cases, staff status in this area has not been asked or recorded, identifying an opportunity for improvement in data collection to assist in targeting workforce development strategies. Strategies to be explored into the future include working to establish sustained relationships with Aboriginal communities in the southern suburbs in partnership with Universities and their under and post-graduate Allied Health professional programs.

It is proposed that increasing the number of Aboriginal and Torres Strait Islanders in the Allied Health and Intermediate Care workforce is the responsibility of all leadership and management positions (refer Section 4), including but not limited to:

- EDAH
- Allied Health and Intermediate Care Directors
- Service Managers
- Lead Clinicians

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\(^{15}\) National Health Workforce Data set 2015; Health Workforce Principle Committee December 2016

Outpatient Services Clinical Reconfiguration Service Plan, April 2017. Version 1.0
Graph 7 illustrates the proportional allocation of Allied Health staff across the broad SALHN service categories of Acute; Sub-acute; Intermediate; Women’s & Children’s; and Mental Health Services. It is proposed that analysis of the number of FTE per profession according to:

- quantum of patients to receiving direct/’face-to-face’ patient care
- scale of clinical care output per profession relative to the resource allocated
- quantum of patient need currently and projected into the future based on health population data
- health impact, including impact in supporting hospital avoidance or supported discharge and transition to self-management in the community
- contemporary models of care
- state, national and where available, international benchmarks,

be pursued to support tailoring of and renewal of the SALHN Allied Health workforce over time utilising a criterion based approach to future workforce modelling, rather than historical approaches to vacancy management.

It is proposed that the EDAHIC and the Allied Health & Intermediate Care Directors (refer Section 5) will take a leading responsibility, with input from each Allied Health discipline’s lead clinician and the respective Clinical Division’s executive, in undertaking this work into the future.
Graph 8 illustrates the profile of the SALHN Allied Health workforce according to classifications of FTE and by headcount. 14.4% of positions are classified at AHP1 level. It is proposed that expansion of the proportion of AHP1 positions relative to quantum of positions of higher classification, within the context of a more formalised new graduate program across SALHN Allied Health disciplines, be explored. It is proposed that Lead Clinicians, under the leadership of the Director Allied Health and Intermediate Care Clinical Governance (refer Section 5), be chartered with the responsibility for the development of an expanded new graduate program.
Workforce clinical placement of allied health students is considered to provide the gold standard in clinical education\(^\text{16}\).

*Graphs 9(a) and 9(b): Number of student placements supported by SALHN Allied Health*

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Graph 9 (a) illustrates the number of undergraduate student placements supported by SALHN Allied Health over the six month period January –June 2017. Graph 9 (b) illustrates the number of student placements as a proportion of SALHN FTE per discipline. In interpreting the data above it is important to note that for some disciplines and placements, clinical educator support is provided or funded by the universities to support SALHN in the provision of clinical placements and that the length and total clinical placement hours can vary significantly between disciplines and types of clinical placement. Education is one of the essential pillars of SALHN business. It is not only essential in supporting the genesis of a workforce with skills to support excellence in clinical care currently but also in supporting education and renewal of the future.

\(^\text{16}\) Simulated Learning Environments in Speech Pathology Curricula; Health Workforce Australia; November 2010
Allied Health workforce in SALHN and the health and human services sector more broadly. It is proposed that strategies to enhance collaborative arrangements with South Australia’s providers of under and post-graduate Allied Health discipline programs be explored. It is proposed that a goal be to expand the number of SALHN Allied Health clinician roles with student supervision responsibilities to support a greater number of student placements, concurrent with greater therapy dosage for patients where appropriate. It is proposed that another goal of evolution in University-SALHN collaboration be to orient student learning and direct clinical care experiences to ‘real world’ scenarios, as opposed to some traditional student placement approaches that currently exist for some professions in some areas of SALHN which are described anecdotally to be more academic in nature.

It is proposed that the EDAH, Director Allied Health and Intermediate Care Clinical Governance and each Allied Health discipline’s lead clinician (refer Section 5) will lead these functions into the future.

Table 1 : Number of staff with dedicated time to clinical Allied Health research.

<table>
<thead>
<tr>
<th>Allied health research position</th>
<th>FTE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Research - Physiotherapy</td>
<td>.4</td>
</tr>
<tr>
<td>LSA; Traumatic Brain Injury researcher</td>
<td>1</td>
</tr>
</tbody>
</table>

The table above documents that 0.003% of Allied Health staff are involved in ‘formal’ research projects. It is proposed that comparison of this level with state and national benchmarks be pursued to determine a sense of relativity of performance. Additional analysis of scale of SALHN investment in Allied Health research compared to our medical and nursing colleagues is proposed.

It is proposed that each Allied Health discipline’s lead clinician will have a responsibility for supporting the genesis of research and research grant submissions for their respective discipline, within financial and clinical care activity constraints.

It is proposed that each Allied Health/Intermediate Care Director and Service Managers will have a responsibility for supporting the genesis of research and research grant submissions for their respective multidisciplinary services, within financial and clinical care activity constraints.