Recruitment and retention strategies for rural Allied Health

A city country partnership

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Rural Recruitment and Retention – Outline

1. Background
2. The Issue defined
3. An alternate solution
4. Process
5. Retention challenges
6. Outcomes
7. Inbuilt Sustainability
8. Evolving role of CSS PAH
9. Questions
Background

- **1999 AH workforce review**
  - Outcomes included AHPEP, post grad scholarships, research grants, conditional advancement, AHA training, EBP training, demand management toolkit etc

- **2005 Forster review**
  - Identified lack of AHP numbers
  - Restructured districts supported by SAHS from Feb 2007

- **2006 SAHS restructure**
  - SAAH Workforce Advisory Group
  - Clinical networks developed
  - EB6 added rural incentives

- **2007**
  - 6 AH WDO’s for each district
  - Targeted professional development eg cancer care
Issue

• **Rural situation**
  • Sole practitioners
  • Line manager not of AHP background

• **Staff profile**
  • Recent graduate
  • Experienced clinicians

• **Limited control of budget**
  • Service planning, treatment areas, office space, human and material resources
For Allied Health Professionals

• QH organisational structure and rural professional isolation limited successful recruitment unless one had another reason or commitment to living rurally

• New graduates accepted positions but unless they were to develop a connectiveness to job, location, community, felt supported, retention was limited
Opportunities for Partnership

• Sharing of discipline specific information, knowledge and skills
  • Recruitment
  • Professional development
  • Networking
  • Clinical supervision
  • Cross fertilization of ideas via rotations to rural districts
• For improved
  • Continuum of patient care
  • Quality activities to support patient outcomes
  • Best practice guidelines based on EBP
  • Understanding of local work practices based on geography, rural access, resources service delivery, facility practices
An alternate solution
The Background

• Mature Division of Clinical Support Services at Princess Alexandra Hospital
• Staff opportunities have flowed from this
• Executive Director and Directors saw opportunity to value add to their professions
• Have ability to contribute to AH workforce capability and capacity beyond their workplace
Connectiveness

• The Princess Alexandra Hospital was to become the link to providing that connectiveness

• Each individual saw the link in a different way
  • Professional development
  • Belonging to a team
  • Networking
  • Research
  • Supervision/support /mentoring

• Easier with enhanced communication modalities eg email/video conferencing/mobile phones

• Manager’s role was to recruit AH and then facilitate these links (tailored to each individual)
Process

• Needs analysis to determine AH mix
  • Developed working relationship with rural districts
  • Determined gaps in service

• Development of local teams
  • Recruitment and retention
    • Permanent positions not contract / locum
    • Rural allowance in Sept 2006 helped
    • Facilitated access to professional development
    • Orientation and support package
Program Development

• Commenced January 2006 (16 FTE)
• 5 OTs, 3 PTs, 4 SPs, 2 DTs, 1 SW, 1 AHA
• 5 teams in rural towns west of Toowoomba
• Based on local service delivery model
• Focused on QH core business
  • inpatients including NH accreditation
  • cardiac rehabilitation and CDSM programs
  • community health outreach clinics
  • management of patients with more complex needs requiring multidisciplinary treatment
## Results to Date

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Lessons Learnt for Rural Recruitment

• Recruit towards the end of the year
• Target students as they are the most mobile with least ties /commitments
• Offer support and networking opportunities
• Link to Princess Alexandra Hospital is a draw card for all staff
• Provide close supervision via experienced staff (not F2F)
• Maintain regular contact to develop a working relationship
• Discuss career pathways/opportunities as part of recruitment
• If team members aren’t happy encourage them to go, don’t try and keep them
Challenges All Round

• For new team members
• For district based allied health
• For all AH in district restructure
• For program manager

• For staff retention, need to address these challenges via team meetings, PADs, support and supervision, communication strategies, learning opportunities
For New Team Members

• Establishing a professional identity
  • of self
  • as a team member

• Promoting new positions and disciplines to local communities

• Service delivery outreach model ie more AH services in more centres
  • required high levels of travel
  • membership of many local health teams
For New Team Members (2)

- Other health workers had expectation of clinicians’ skills above their level of training and experience
- Needed to identify areas for professional development and training in discipline and QH core business
For
District Allied Health Staff

• New staff unknown quality in terms of knowledge, skill and experience
• Created more lines of communication
  • Compounded by lack of local team leader
  • Losing their sole practitioner role
• Resource sharing
  • Equipment/work areas
District Restructure

• New governance structure
  – Local control and independence as sole rural practitioner but what of the future
  – New lines of accountability - operational and professional
  – Increased supervision, support networks

• Working within a changing organisational structure
  – Need to integrate 2 teams into one locally
  – Integration into new health districts
Program Manager

• Working in an uncertain and changing environment
• Honesty in recruiting
  • +/-ives, seeking team fit, setting expectations of staff
  • Follow up on leads re staffing
• Focusing on retention of staff
  • Difficult times for inexperienced staff
  • Providing opportunities for career development/service planning and professional development
  • Education of corporate process/governance
  • Develop a good working relationship
  • Responsive to staff requests re support /supervision
  • Development of discipline specific networks within program
Outcomes

• Clinically
  • Increased services and education programs in more locations
  • Increased awareness of QH core business rurally

• Staffing
  • Increase AHP numbers in SWQ
  • Clinicians have peer support in their workplace
  • Explored opportunities re locums / secondment / transfer at level
  • Staff applied for PO3 progression and conditional advancement
  • AHPEP/work shadowing
  • Staffing innovation re locums, student placements
  • Strong partnerships with manager
Lessons Learnt from Managing this Change

- Working towards sustainability
- No ‘one size fits all’ model
- Potential staff are active participants in the recruitment process
- Ability to work in a changing environment
- Education of staff re health big picture
- Don’t underestimate parallel processes
Inbuilt Sustainability

• Needed
  • For long term AH credibility
  • Partnership and discipline network formation
• To grow workforce capacity and capability
• Promote a culture of teaching, training and support at all levels
• Need to get the governance right
In Summary

• 16 additional AHP have been recruited to SWQ, despite the cyclic nature of AHP recruitment these number have remained constant after 18 months and a period of organisational restructuring.

• The major crucial factor for staff retention has been the link to Princess Alexandra Hospital, for support, supervision, networking and training.
Evolving Role of CSS PAH

• Started small
  • With Director’s support
  • Identifying capacity
  • Identifying issues and planning solutions
  • Identifying staff interested in exchange / secondment / locum cover
  • Training and support opportunities within PAH

• Based on previous working relationships
Where To From Here

- Value rural AHP service in QH
- AHP managers to value rural service in their recruitment processes
- Enhance opportunities for secondment / transfers within SAHS
- Provide opportunities with discipline specific networking
Acknowledgements

• CSS managers group at PAH particularly
  • Julie Connell, Executive Director CSS
  • Wendy McCallum, Dir Speech Pathology
  • Sue Cumming, Dir Social Work
  • Kathy Grudzinskas, Dir Physiotherapy
  • Geoff Lau, A/Dir Occupational Therapy
  • Maree Ferguson, Dir Dietetics

• The many rural AHP and line managers who understand the big picture and have supported the concept behind this Program.
Questions?