Carving an identity for allied health

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Dominic Dawson developed the Division of Allied Health at Lottie Stewart Hospital and was the director of Allied Health Services until January 2001.

Abstract

This paper outlines the development, growth and performance of the Division of Allied Health at Lottie Stewart Hospital, Sydney. It discusses the choice of a suitable organisational model, the findings from three evaluations conducted and a summary of the significant outcomes of the Division. An early version of this paper was presented at the 4th National Allied Health Conference in March 2001.

Background

Lottie Stewart Hospital is a third schedule hospital in Sydney. The hospital has 136 beds and provides specialist care for aged and disabled people of the Western Sydney Area.

When I began working there, the Executive consisted of the Executive Officer, Director of Clinical Services, Manager of Facilities and Manager of Hotel Services (Figure 2). The Director of Clinical Services maintained responsibility for the Medical, Nursing and Allied Health staff. The Allied Health staff had a nominated representative that was allocated two hours a week to deal with any allied health issues. The departments of Dietetics, Physiotherapy, Occupational Therapy, Speech Pathology, Pharmacy, Podiatry, Medical Records and Social Work formed the Allied Health group.

Concerns with this organisational model included the perceived lack of communication to Allied Health staff regarding organisational issues, inadequate recognition of achievements, and the lack of Allied Health representation at Executive level.

According to Boyce (1991), Allied Health is made more vulnerable to 'adverse outcomes' due to lack of attention to strategic issues. Especially in smaller organisations such as Lottie Stewart Hospital, it is vital that Allied Health is part of and has significant input into strategic issues at senior management level. Further, the Allied Health professionals need to have an identity, a leader and a strategic vision as a group, if it is to be an indispensable part of the organisation's planning, policy development and progress.

In mid-1998, the organisation was presented with an opportunity to review its structure. The Executive Officer welcomed staff input into review of the organisational structure. The Executive Officer and the managers of Allied Health departments supported the idea of investigating alternate structures that would provide Allied Health with a greater role in the organisation operations and create for itself an identity. I therefore took on the role of researching various structures in the literature, and had discussions with some eminent professionals who might assist in identifying an appropriate structure.

Formation of the Allied Health Division

The main impetus for the current structure came from many of the readings of Boyce (1991). The literature discussed four main models, as follows.

Figure 1: Current Organisational structure

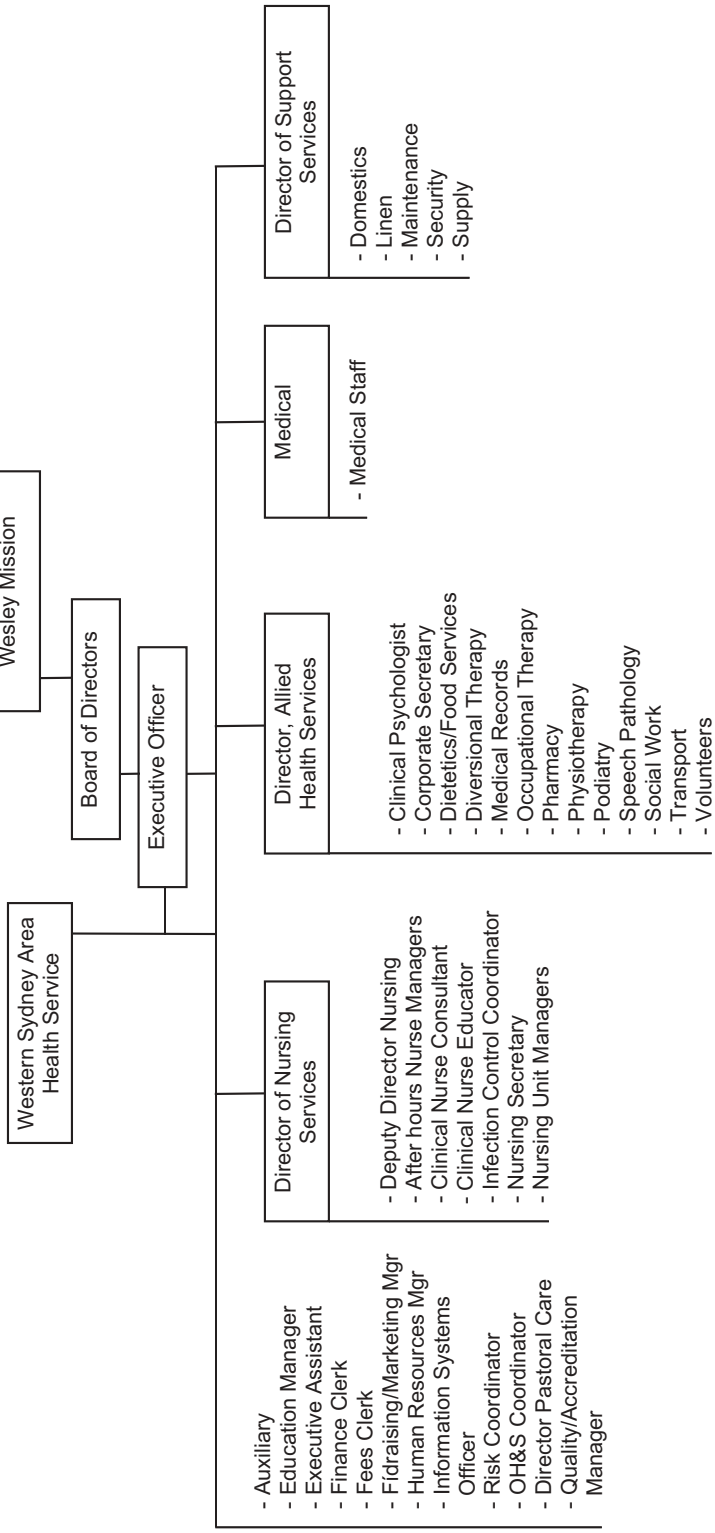
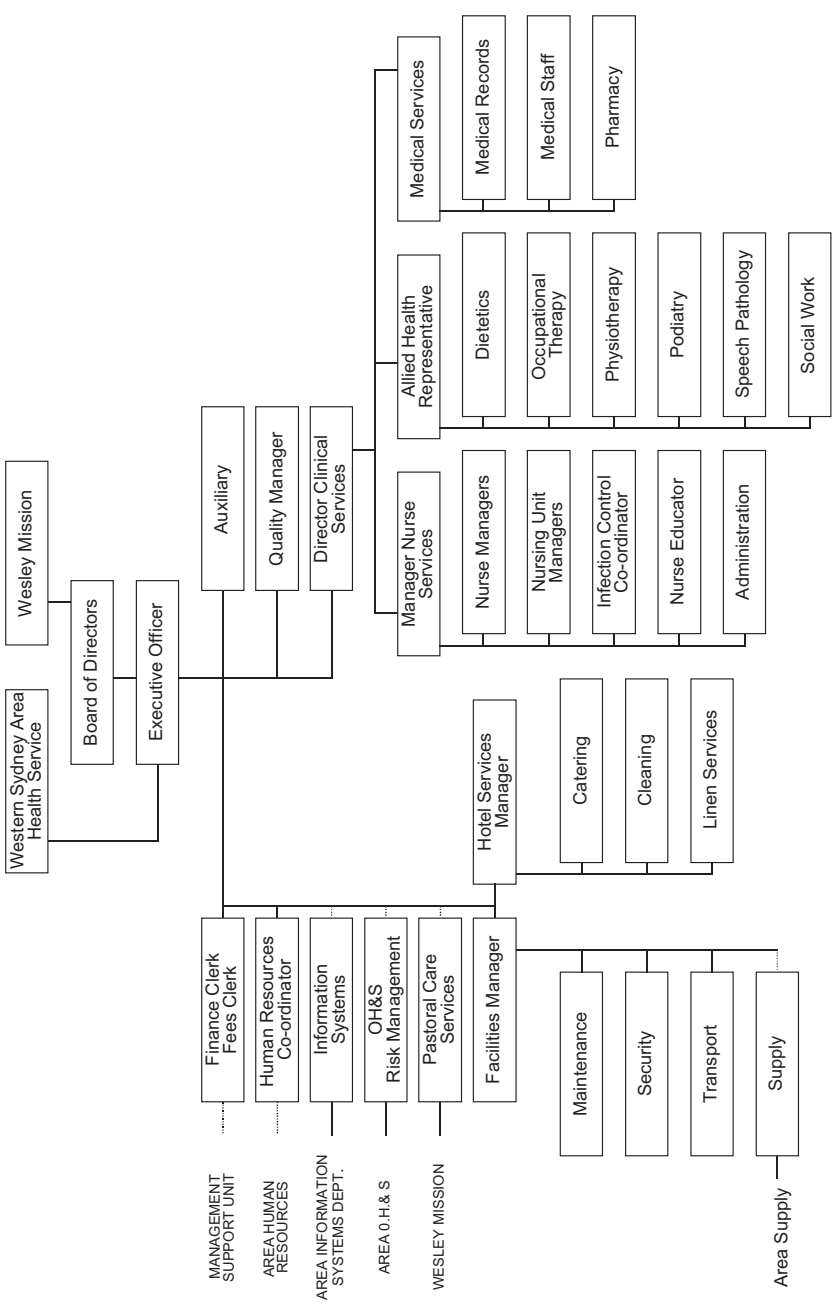


Figure 2: Organisational structure before August 1998



Department based model: This is the traditional medical model of professionals reporting to a medical / nursing head, often the person being the Director of Medical / Clinical services.

Allied Health Division: In this model there is a collective of Allied Health staff reporting to a Director / Manager of Allied Health Services. The Allied Health Manager was provided with the budget for salaries, wages, goods and services. The manager is responsible for operational, financial and human resource issues within the Division.

Dispersal Model: In this model there is an abolition of departmental budgeting for the allied health professionals. Allied Health staff is dispersed to the units who employ them and manage recruitment, induction, performance management, education and the budget.

Mixed Models: A combination of models is prevalent across many organisations with various names being given to these structures.

All the models have distinct advantages and disadvantages. The main aim was to select a model that would work for Lottie Stewart Hospital.

The objectives identified in choosing an appropriate model were that it should facilitate team identity as Allied Health professionals, provide an advocacy for Allied Health, and provide opportunities for development of senior advocate roles for Allied Health Staff. The model must allow Allied Health to get recognition for its achievements and have more autonomy over its budget with an ability to negotiate and plan within the group and with other divisions based on service priorities. Finally, the model must support education and research for Allied Health staff, facilitate work force planning, and increase ability in attracting project funding (Boyce 1991; Redford 1993). These objectives align with the benefits of Allied Health Divisions identified by The National Allied Health Best Practice Industry Report (Compton, 1997).

An evaluation paper on the area management structure of Central Sydney Area Health Service (CSAHS) reported that "... with the appointment of the Director of Allied Health it became clear that some fundamental issues had previously not been communicated to Allied Health staff" (CSAHS, p5).

Adoption of a divisional structure for Allied Health would mean that the Division would be adequately represented at Executive level, resulting in improved communication flow from senior management to departmental managers. It would also provide an opportunity for Allied Health to be more involved in the organisation's strategic direction, and be more organisationally active. It would also ensure that the Allied Health services budget were proposed and managed by an Allied Health manager who understood the services and delivery issues.

The only concern in adopting this model in the current setting would be that the manager of the Allied Health Division would also be a manager of a specific Allied Health department. This would present problems if it resulted in loss of clinical hours. Allied Health managers typically have a 50% clinical role.

A brief paper outlining various models, including their advantages and disadvantages, was presented to the Executive and Board in July 1998, recommending that a Division of Allied Health be formed with a Manager of Allied Health. The structure was approved on an interim basis, and a review was scheduled after 12 months.

The change process

Staff had to be made aware of the changes to the structure and assisted to understand the rationale for change. The reaction was mixed within the Allied Health staff, as well as among the other hospital staff. The main resistance within the Allied Health group was from a few staff who had been in the organisation for many years and felt that we would lose any representation we already had in the past. There were some managers who found the concept of having a peer manager their immediate supervisor fairly daunting, particularly with reference to performance appraisals. However 81% of the 28 Allied Health group supported the change and thought it was an opportunity for them to gain a clearer identity and recognition.

The structure establishes itself

The structure became operational on 10 August 1998. The Manager of Allied Health is a member of the executive team and participates in organisational strategic planning and policy development.

The Allied Health Division at first consisted of Physiotherapy, Occupational Therapy, Speech Pathology, Dietetics, Social Work, Podiatry, Pharmacy, Health Information (Medical Records) and Volunteers. The formation stage included setting up communication processes, policies and other systems to ensure that the Division was successful in its objectives.

The vision of the Division gradually evolved to include promotion and facilitation of best practice, becoming an integral contributor to the delivery of quality care in the multidisciplinary team, promoting outcomes and achievements of the Division internally and externally, and supporting and developing staff. The Division also became committed to implementing the Allied Health information system and to supporting discipline-specific student units. The vision is integrated in the annual business plan of the Division.

In January 1999, the Division was asked to consider including the Catering Department, which was under the Directorate of Hotel Services. Dietetics and Catering were combined under one manager and welcomed into the Allied Health Division.

The role of the Manager of Allied Health continued to grow and take on other executive responsibilities. In July 1999, the role included executive responsibility for the organisation's Occupational Health and Safety, Information Technology. It also included many other organisational projects such as Care Planning and Documentation, hydrotherapy pool planning and Y2K rectification. The role then became a full-time and permanent position, and was renamed Director of Allied Health Services to reflect responsibility and equity with the other executive roles.

In June 2000, there was an identified need to provide a more co-ordinated approach to diversional and recreational therapy to meet the service demands. The transport staff, diversional therapists and volunteers were three groups that had an interest. A new service delivery model was developed that restructured these three individual groups (two within the Allied Health Division and one from the Support Services Division). The new model combined services that previously occurred independently, thus facilitating a greater focus on professional assessment of needs. The aim was to provide clients with a more integrated and co-ordinated diversional and recreational therapy service. The model is also an opportunity to recognise the role of the Diversional Therapist as a member of the Allied Health Professionals (previously part of the Department of Occupational Therapy). The new model became operational in October 2000 and a review to evaluate the model was scheduled after 12 months.

In August 2000, the hospital identified a need for clinical psychology services. There was some funding allocated, and the Director of Allied Health was invited to develop and implement the service. Clinical Psychology is also now a part of the Allied Health Division.

Evaluation of the Allied Health Division

The history of growth in itself is a testimony to the success and identity that the Allied Health Division has achieved. However, there have also been three annual formal evaluations.

The first evaluation of the Division occurred in December 1998. This was an anonymous survey of Allied Health staff to gain an understanding of the extent to which staff were happy with the change and into their perspective and vision of the Division. The results were very encouraging in that 99% of the Allied Health Staff were supportive of the Division, wanted it to continue, and to be a part of it. This was very encouraging. The main recommendations were to establish the Division as a permanent part of the organisational structure, maintain the role of the Manager of Allied Health, and to develop clear communication processes within the Division.

This prompted the commencement of a quarterly Allied Health forum. The forum is an opportunity for all the Allied Health staff to gather as a team, have lunch, and listen to the developments and achievements. Occasionally a guest speaker is invited and most importantly staff have the opportunity to ask questions or raise issues. The forums last for about an hour and have been very useful to date.

In December 1999 the Division of Allied Health, as part of evaluating itself, completed an Allied Health staff survey and reviewed all key processes. Departmental managers were interviewed using a structured interview process. The staff survey looked at key areas such as communication, accreditation, professional development,

budget and business plan involvement. The same survey was also completed in December 2000. The results, summarised in Table 1, have been encouraging and staff needs addressed appropriately.

Table 1: Results of Allied Health staff survey (1999 & 2000)

Communication	Excessive		Adequate		Poor	
	1999	2000	1999	2000	1999	2000
Level of communication within the Division	-	-	100%	100%	-	-
Usefulness of Allied Health forum	89%	79%	-	-	11%	21%
	YES		NO		No Response	
Appraisal in last 12 months	N/A	58%	N/A	21%	N/A	21%
Knowledge of budget & progress	89%	58%	11%	42%	-	-
Involvement in business planning	89%	58%	11%	26%	-	16%
Aware of impact of Accreditation on work practices	67%	85%	22%	5%	11%	10%

Note: In 2000 Allied Health Staff survey response rate increased by 26%, with an increase from catering department.

The key processes were examined under 20 different categories, and findings from these together with the interview with each of the departmental managers formed the final recommendations from the review (Table 2). The key recommendations were that a podiatry service model be established, a review of the function of the Health Information Department be carried out, that each department develop at least one key performance indicator, and that there should be strategies to improve communication between Nursing and Allied Health Services. Other tasks that were identified included the need to update all departmental policy and procedure manuals, regularly to monitor statistics, and to conduct annual staff appraisals.

Table 2: categories used to review Allied Health departments within the Division

No.	Category	No.	Category
1	Staffing profile	11	Annual leave issues
2	Allocation of hours to services	12	Registration of professionals
3	Targets for each department -service	13	Industrial issues management
4	Policy & procedures	14	Orientation
5	Information management	15	Professional development
6	Recruitment & selection	16	Complaints handling
7	Performance management	17	Quality
8	Accident / Incident management	18	Business planning
9	Workers compensation	19	Financial management
10	Sick leave monitoring	20	Communication

The same process was repeated in December 2000, by which time all the recommendations from 1999 had been implemented. However, three departments needed to refine their key performance indicators.

Additional recommendations included the development of policies and procedures for the newly formed Diversional Therapy Department, trial of the new Allied Health Information System in early 2001, and encouragement of staff to take up special projects within the hospital. The review also recommended that some of the managers would benefit from attending a financial management training update.

In December 2000, in addition to the Allied Health staff survey and departmental reviews, a customer satisfaction survey was undertaken as a third component of the evaluation. The customer satisfaction survey included patients, carers, and the staff of the clinical units. The patient-carer survey was limited to a few departments as a part of a larger organisational survey, in order to maintain reasonable length so that it would be completed. The results of the patient-carer survey (Table 3) indicate that the staff of Allied Health are providing a service that is meeting the needs of its clients.

Table 3: Results of customer (Patient/Carer) satisfaction survey (Dec 1999 to Mar 2000)

How helpful is/was the therapy provided by the following departments?	Excellent	Good	Fair
Physiotherapy	90%	-	9.8%
Speech Therapist	100%	-	-
Occupational Therapist	90%	10%	-
Diversional Therapist	80%	20%	-
Social Worker	87.5%	12.5%	-
Dietician	85.7%	14.6%	-
TOTAL	**88.86%**	**9.5%**	**1.63%**

The staff survey was sent to nurse unit managers, and each unit was requested to complete at least two survey forms. The results (Table 4) indicated that the nursing staff were reasonably happy with care and communication provided by Diversional Therapy, Pharmacy, Occupational Therapy, Podiatry, Physiotherapy, and Speech Pathology.

Table 4: Results of clinical unit staff survey

Department	Satisfied with level of care?			Satisfied with level of communication?		
	YES	NO	N/R	YES	NO	N/R
Catering / Dietetics	73%	27%	-	73%	27%	-
Diversional Therapy	73%	27%	-	64%	36%	-
Health Information	91%	-	9%	82%	18%	
Occupational Therapy	82%	-	18%	64%	27%	9%
Pharmacy	64%	18%	18%	64%	27%	9%
Physiotherapy	55%	27%	18%	55%	36%	9%
Podiatry	64%	9%	27%	73%	18%	9%
Social Work	100%	-	-	91%	9%	-
Speech Pathology	82%	9%	9%	82%	9%	9%

(N/R - No response)

The survey highlighted the need for more input from Physiotherapy and a need for staff on the wards to receive education on allied health services - and particularly the Podiatry service. There were some concerns about the timing of meals and diets. However, this needs further analysis as the survey was completed not long after the new menu system 'C-bord' was implemented.

Positive findings were that 100% of staff indicated they knew who they could contact to raise issue, of which 91% would be happy to discuss with the relevant service provider any issues and concerns. The staff on one clinical unit also commented on the significant increase in the workload of the Occupational Therapist and Social worker for their patients.

Significant outcomes of the Division

The Division of Allied Health has contributed significantly to the quality of care provided to the patients and residents of the hospital. Listed below are the key achievements of the Division to date.

Efficiency and productivity. Each department now has a business plan that sets out its annual activity and performance indicators and targets. The departmental plans contribute to the development of the Allied Health Divisional business plan. The progress of the divisional plan is reported to the Quality Management Committee (sub-Board) on a bimonthly basis.

The Podiatry Service review was completed and resulted in a model of service that provides more and better quality services. It also provided some financial savings for the Division. A review and restructure of Health Information services was also completed.

The Diversional Therapy and Clinical Psychology service was developed to provide co-ordinated and needs-based intervention.

Quality developments. The Speech Pathology and Dietetics departments produced materials titled 'Shop to swallow' which were well received. The materials focus on providing assistance for shopping to people with swallowing difficulties. They are now commercially available.

The Allied Health staff initiated and participated in numerous quality activity projects within the hospital.

Representation at various levels. Allied Health continues to maintain a strong executive representation at Lottie Stewart Hospital and represent the hospital at various Area and association forums.

Staff Development. The Division supports staff so they can continuously participate in learning and professional development opportunities. It has supported two staff members to continue studies in Masters programs, one staff member presented at a National Conference, and many others attended National Conferences and local forums.

Reallocation of Resources based on service needs. The Division has been able to utilise its resources based on identified needs. The Diversional Therapy service was enhanced by redistribution of resources that became available from service delivery efficiency initiatives within the Division. Other savings due to improved efficiency enabled the enhancement of therapy aide hours and the purchase of special nutrition supplements for clients with swallowing difficulties.

Allied Health visible and making a difference. The Division has grown from 28 to 57 staff, the budget has increased from $965,735 to $2,304,437 and the external Commonwealth and ACHS EQUIP auditors have paid complements to the excellent work and quality projects Allied Health have initiated.

Supporting the development of students. The Division has supported numerous student clinical placements in Physiotherapy, Social Work and Occupational Therapy. It has also supported 14 Police Cadets on community placement from Charles Sturt University and 8 work experience placements.

Information Technology. The Allied Health Information System was modified to meet local needs and live data collection commenced in January 2001. The Division is committed to using IT strategies where it results in efficiencies. All the managers trained in use of KRONOS and Workforce and all staff within the Division have access to CIAP. The Stocca system was implemented in December 1999 and C-Bord was implemented in November 2000

Conclusion

The evaluations completed to date and the outcomes listed indicate the significant success of the Division. It has grown significantly since its formation in 1998 and has created a distinct identity for itself.

The main reasons for the success may be that the organisation is not particularly large and the staff are very committed to providing the best care to our clients. There is also a strong Allied Health representation and input into organisational strategic planning and development, and therefore Allied Health is always an active participant with a definite role. The staff take enormous pride in being recognised as a distinct professional group. They have carved out for themselves and the Division of Allied Health an identity of which they are proud.

Acknowledgements

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