

**IMPROVING EDUCATION AND CLINICAL SUPPORT  
TO ALLIED HEALTH PROFESSIONALS  
WORKING WITH CHILDREN**

**PROJECT REPORT**



**A collaboration between the Greater Eastern and  
Southern NSW; Northern; and Western Child Health  
Networks**

**December 2004**

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# 1. EXECUTIVE SUMMARY

## 1.1 Background

- In 2001 NSW Health established three Child Health Networks to facilitate the networking of paediatric services between Area Health Services and the three Children's Hospitals in NSW. The focus of the Networks is ensuring that all children are provided with high quality clinical care as close to home as possible.
- In 2002, the three Networks successfully sought funding from NSW Health to undertake a collaborative project in 2003/04 to identify the needs of allied health professionals in NSW in relation to education and clinical support.
- The objectives of the Project were to:
  - Identify the education and support needs and priorities of allied health professionals working with children across NSW
  - Identify currently available educational and clinical support resources
  - Provide recommendations to improve allied health professionals access to education and clinical support
  - Pilot an education and clinical support initiative
  - Produce a Project Report containing summary information, resources and recommendations.
- The Project was of six months duration and undertaken by a Project Officer. A Steering Committee was convened to oversee the Project. The consultation process included the conduct of focus groups at Area Health Service level, the conduct of a survey of allied health professionals and gathering of information from NSW Health and other relevant organisations on resources currently available to allied health professionals.
- This Report discusses the findings of the Project and makes recommendations in relation to improving education and clinical support for allied health professionals working with children in NSW. Due to time constraints, piloting an education and clinical support initiative was not achieved, and therefore not discussed in this Report.

## 1.2 Summary of findings of the survey and focus groups

- The statewide survey of allied health professionals working with children resulted in 468 completed forms being returned. As the total number of surveys distributed was unknown; an overall response rate could not be calculated.
- Respondents to the survey included speech pathologists (24%), physiotherapists (19%), occupational therapists (16%), social workers (12%), psychologists (11%), dietitians (9%) and other (9%).
- The profile of the respondents showed that the majority worked in metropolitan Area Health Services (74%). Of the total, 47% indicated that they worked in the community, 25% in a specialist children's hospital, 20% in general hospitals and 8% worked in other areas.
- With regard to current access to education and clinical support, a high proportion of allied health professionals (86%) indicated that performance appraisal was incorporated into the

management structure of their organisations; that they had access to external courses, conferences etc (86%), access to email (91%), access to work library such as journals (91%); and access to the intranet including CIAP (90%).

- Access to regular supervision was identified as an issue, with only 63% of allied health professionals reporting that regular clinical supervision was incorporated into the management structure of their organisations. Other areas of deficit included access to educational resources within the Area Health Service with 61% of respondents indicated that they had access to these resources and access to the internet. Only 57% stating that they had access to the internet, this was much less for those in rural areas (44%) and those in community (44%)
- In response to the provision of education and clinical support, 61% of all respondents indicated that colleagues with specialist skills in their own professions provided the majority of clinical education and support. Only 18% indicated that specialists from outside the Area Health Service provided this support. Attendance at out of Area Health Service was reported by 23% as the main source of obtaining education in the previous 12 months.
- The focus groups of allied health professionals conducted in all Area Health Services resulted in 154 individuals participating. Overall, the outcomes of the focus groups supported the findings of the survey. In addition to the issues identified in the survey, the increasing size and complexity of their caseload, inconsistency in the provision of clinical supervision and lack of appropriate access to information technology were identified as important considerations for allied health professionals working with children.

### **1.3 Currently available education and clinical support resources**

- Allied health professionals have the potential to access national resources such as the University Departments of Rural Health (some of which are collocated with universities in NSW) and the Australian Government Rural and Remote Health Professionals Scholarship Scheme.
- NSW Health provides assistance to allied health professionals through the NSW Rural Allied Health Postgraduate Scholarships. Allied health professionals also have the opportunity to develop clinical networking and educational initiatives through the NSW Telehealth Initiatives Funding.
- The NSW Rural Clinician Locum Program, established as a consequence of the release of NSW Rural Health Plan provides funding for the provision of locum services to enable health care professionals, including allied health to undertake continuing and professional education.
- Allied health professionals in a number of Area Health Services have developed, or are currently developing strategies to support their practice. These initiatives have included the development of Clinical Supervision policies, piloting of allied health mentoring models, establishment of new graduate support programs. Allied health professional have also been involved in the establishment of Area-wide Allied Health Advisory Groups, allied health telehealth projects funded through the NSW Telehealth Initiatives Program and development of partnerships between Area Health Services and the University Departments of Rural Health in relation to provision of post-graduate courses and continuing education. Allied health professionals in some Area Health Services also have access to a Learning and Development Unit.

- Allied health professionals working with children may access resources available through the specialist Children's Hospitals in NSW. Clinical supervision utilising telemedicine, facts sheets related to the management of specific conditions, conduct of seminars/workshops, clinical networking of individual allied health disciplines and clinical secondment are examples of these resources.
- The Child Health Networks are also engaging in the provision of support for allied health professionals working with children including the facilitation of clinical secondments, conduct of multidisciplinary conferences, provision of education opportunities; and facilitation of peer support and networking.
- Other resources available to allied health professionals include the on-line Clinical Information Access Program (CIAP), the occupational therapy list-server (paediatricots), and the Services for Rural and Remote Allied Health (SARRAH) organisation.

## 1.4 Discussion

- Whilst many educational and clinical support resources have been identified as being available to allied health professionals, many allied health professionals working with children do not have access, or are unable to access many of these resources.
- There is a need to develop a mechanism whereby allied health professionals are provided with information regarding resources currently available to them and relevant to paediatric practice. Whilst the intranet is increasingly being used as the primary means of information exchange within the health care system in NSW, many allied health professionals have limited access to computers and access to the internet is restricted.
- The trend to life-long learning in the healthcare industry and the increasing emphasis on quality patient care and demonstrated clinical competency necessitates that allied health professionals have appropriate access to clinical supervision. This includes programs to meet the needs of experienced clinicians as well as new graduates.
- Allied health professionals indicated that their caseload have increased significantly in terms of size and complexity. Other service organisations offering less direct treatment, improved survival of children with complex medical conditions and the impact of community expectations and attitudes are contributing to this change.
- To enable clinicians to appropriate manage this diverse caseload, it is important that outreach programs are established by specialist children's hospitals, resources such as fact sheets are readily available and clinical placement opportunities are established.
- The Project highlighted the need for all allied health professionals working with children to participate in regular and structured performance review. Although the survey found that the compliance rate was high among respondents, a significant proportion of clinicians working in general hospitals (22%) and in rural Areas (32%) indicated that performance appraisal was not incorporated in the management structure of their organisations.
- Whilst there are common educational and clinical elements within the allied health profession, it is important that the needs of the individual disciplines are addressed. This is particularly important for those highly specialised paediatric services with a relatively small national workforce.

- The evolution of paediatric health care in Australia necessitates that strategies be developed to maintain the skills and expertise of allied health professionals working with children. There is also an imperative to implement effective mechanisms which will support the future declining allied health workforce, particularly in rural and remote areas in NSW.

## 1.5 Conclusions and Recommendations

- The conduct of this Project has resulted in the gathering of valuable information in relation to the current resources available to allied health professionals working with children as well as identifying gaps and opportunities for the future.
- The limitations of the Project have been identified. NSW has a large cohort of private-practice-based allied health professionals who work with children, and this group was not included in the Project. With regard to the survey, there were a number of questions open to misinterpretation, less than ten completed surveys were received from some Area Health Services; and clinicians working in the three specialist children's hospitals were disproportionately represented in the survey responses.
- Despite these limitations, this Report provides a practical overview of the issues confronting allied health professionals working with children. The recommendations provide a framework for engaging the Child Health Networks, Area Health Services and allied health professionals to collaborate on the development of appropriate strategies and programs to address many of these issues.
- The issues identified during the Project were grouped into the five categories – clinical supervision, performance appraisal, caseload, access to education and training; and access to technology. The recommendations have been grouped to reflect these categories and are:
  1. That the NSW Child Health Networks, in collaboration with other key stakeholders, undertake to develop clinical supervision options, which meet the needs of the individual allied health professional working with children, including that of novice and expert clinician .
  2. That the NSW Child Health Networks collaborate with Area Health Services and allied health professionals to identify appropriate individuals as clinical leaders in the provision of clinical supervision of allied health professionals working with children.
  3. That Area Health Services, in collaboration with other key stakeholders, develop a program of training key allied health professionals working with children, to assume the role of supervisors.
  4. That Area Health Services ensure that allied health professionals working with children participate in a performance management process as discussed in Department of Health Circular 2003/12 "NSW Department of Health Coaching and Performance System (CAPS) Policy ".
  5. That relevant Area Health Services, in collaboration with the Services for Australian Rural and Remote Allied Health (SARRAH), develop a mechanism for performance management of sole allied health professionals working with children in rural areas.
  6. That the NSW Child Health Networks, in collaboration with relevant paediatric allied health professionals, develop mechanisms by which community-based allied health professionals working with children have access to colleagues working in the specialist paediatric clinics across NSW.

7. That a database of currently available paediatric allied health clinical information and management guidelines is established as a statewide resource for allied health professionals working with children.
8. That Area Health Services, in collaboration with NSW Health and NSW Children's Hospitals, develop strategies to identify areas of need for paediatric allied health services, enhance service provision and minimise duplication of services.
9. That the NSW Children's Hospitals, in collaboration with Area Health Services, formalise mechanisms for outreach clinical education and support for allied health professionals working with children in the community.
10. That NSW Health and Area Health Services ensure that allied health professionals working with children are provided with the opportunity to be involved in paediatric related GMITT and Telehealth initiatives.
11. That the NSW Child Health Networks, in collaboration with NSW Health and relevant allied health professional organisations, undertake a study to identify the current allied health workforce and the future requirements.
12. That Area Health Services and allied health professional organisations provide allied health professionals working with children with educational opportunities in the use of various technologies.
13. Allied health professionals working with children undertake research to investigate how technologies should be used to support and deliver allied health services.
14. That Area Health Services ensure that allied health professionals working with children are provided with CIAP training
15. The NSW Child Health Networks collaborate with Universities and University Departments of Rural Health to develop appropriate post graduate and continuing education courses for allied health professionals working with children.
16. That Area Health Services and allied health professional organisations develop strategies to enhance the use of telehealth as a means of networking, providing education, support and supervision for allied health professionals working with children.
17. That allied health professional organisations, together with key stakeholders conduct a comprehensive training needs assessment for allied health professional working with children.
18. That allied health professional organisations, together with key stakeholders, develop core competencies for allied health professionals working with children.
19. That Area Health Services provide access to email, NSW Health intranet and internet to all allied health professionals working with children
20. That the Computers for Rural Allied Health program is enhanced to include all allied health professionals working with children, irrespective of the primary place of work.
21. That the relevant allied health disciplines establish discipline specific list serves, similar to the OT Paediatric list serve provided though NSW Health CIAP infrastructure

## 2. INTRODUCTION

The networking of paediatric services has been promoted in NSW for a number of years. In 2002 NSW Health published the “Guidelines for Networking of Paediatric Services in NSW” which endorsed the establishment of three networks across NSW, each to include one the three Children’s Hospitals in the State. The three child health networks and network partners are summarised below (Table 1).

**Table 1 – NSW Child Health Networks**

The Greater Western Child Health Network	The Greater Eastern and Southern Child Health Network	The Northern Child Health Network
<ul style="list-style-type: none"> <li>• Central Coast AHS (Gosford LGA)</li> <li>• Central Sydney AHS (Ashfield, Burwood, Concord, Drummoyne, Strathfield LGAs)</li> <li>• Northern Sydney AHS (Hornsby, Ku-ring-gai, Hunters Hill, Ryde LGAs)</li> <li>• South Western Sydney AHS</li> <li>• Wentworth AHS</li> <li>• Western Sydney</li> <li>• Mid Western AHS</li> <li>• Far West AHS</li> <li>• Northern Rivers AHS</li> </ul> <p><b>Linked with The Children’s Hospital at Westmead</b></p>	<ul style="list-style-type: none"> <li>• Central Sydney AHS (Leichhardt, Canterbury, Marrickville, Sydney/South Sydney LGAs)</li> <li>• Illawarra AHS</li> <li>• Northern Sydney AHS (Mosman, North Sydney, Manly Pittwater, Willoughby, Warringah, Lane Cove LGAs)</li> <li>• South Western Sydney AHS (Liverpool, Campbelltown, Bankstown Hospitals)</li> <li>• Southern AHS</li> <li>• Macquarie AHS</li> <li>• Greater Murray AHS</li> <li>• Australian Capital Territory</li> </ul> <p><b>Linked with Sydney Children’s Hospital</b></p>	<ul style="list-style-type: none"> <li>• Central Coast AHS (Wyangong LGA)</li> <li>• Hunter AHS</li> <li>• Mid North Coast AHS</li> <li>• New England AHS</li> </ul> <p><b>Liked with John Hunter Children’s Hospital</b></p>

Source: NSW Health (2002) Guidelines for Networking of Paediatric Services in NSW, p7

The Paediatric Networking Steering Group, chaired by the Director-General, provides advice and oversees the progress of the Networks. NSW health funds each of the Networks and provides enhancement funding for new services/projects.

The Networking Guidelines (p 4) enumerated a number of principles in relation to networking of paediatric services including that:

- *Network-wide training programs and opportunities for staff to rotate through the networks should be provided.*
- *The networks should promote multi-disciplinary approaches and enhance and maintain professional skills across inpatient and community settings.*

In 2002, the three Networks successfully sought funding from NSW Health to undertake a collaborative project in 2003/04 to identify the needs of Allied Health professionals in NSW in relation to education and clinical support in order to improve competencies in the area of paediatrics and child health.

A Steering Committee was convened to oversee the Project (Appendix 1) and a Project Officer appointed.

The objectives of the Project were to:

- Identify the education and clinical support needs and priorities of Allied Health professionals (AHP) working with children across NSW
- Identify the resources for education and clinical support currently available to AHP
- Provide some recommendations to improve AHP access to education and clinical support
- Pilot an education and clinical support initiative
- Produce a project report containing summary information, resources and recommendations

This Report outlines the finding of the study and makes recommendations in relation to improving education and clinical support for Allied Health Professionals working with children in NSW.

## 2.1 Methodology

1. *Conduct of a survey of allied health professionals working with children in NSW.* The survey form (**Appendix 2**) was forwarded to each of the Area Services in NSW for distribution to as many allied health professionals working with children as possible.

The survey form was designed to include multiple questions and space for free text comment to facilitate obtaining as much information as possible on 4 specific areas:

- A. Employment site
  - B. Caseload and Work Peers
  - C. Current access to Education and Clinical Support
  - D. Clinical education and support needs
  - E. Opportunities available now
2. *Conduct of face-to face focus groups for allied health professionals in each of the Area Health Services and at the Children's Hospital at Westmead.* The core questions raised at each Focus Group were:
    - A. What are the internal organisational structures that enable you to access appropriate education and clinical support within your discipline?
    - B. Do you feel you have access to all the education and clinical support necessary to treat the paediatric caseload presenting?
    - C. Are there some education and clinical support issues common to Allied Health in your Area Health Service?
    - D. If you could improve your access to education and clinical support, what would you change?

Written notes were taken at each Focus Group. The major themes from all Focus Groups were collated and analysed.

3. *Review of NSW Health and Area Health Service policies relating to learning activities and funding of education* to provide a context for the provision of education in the NSW public health system.
4. *Gathering of information related to education and other resources available to allied health professionals.* These include those offered through NSW Health, within the Area Health Services or successful education and clinical support initiatives established by allied health professionals within their Area Health Services.

### 3. SURVEY FINDINGS

468 completed surveys were returned. A number of Area Health Service did not maintain records of the number of surveys distributed therefore the return rate could not be estimated.

Respondents by Allied Health Professional discipline were:

- Speech Pathology - 112 surveys (24% of total);
- Physiotherapy - 89 surveys (19%);
- Occupational therapy - 75 surveys (16%);
- Social Work - 56 surveys (12%);
- Psychology - 51 surveys (11%);
- Dietetics - 44 surveys (9%); and,
- Other (Play therapy, Audiology, Orthotics, etc and unknown) – 41 surveys (9%).

Surveys were returned from all Area Health Services and the Children’s Hospital at Westmead (**Appendix 3**). 91 surveys were returned from Hunter Area Health Service (19% of the total) and 4 from Far West Area Health Service (0.9%) of the total.

#### 3.1 Employment site

Of the 468 respondents, 346 (74%) worked in metropolitan Area Health Services and 122 (26%) in rural Area Health Services (Table 2). This metropolitan/rural split is more marked by individual discipline groups with 85% of social workers, 80% of psychologists and 77% of the physiotherapists working in metropolitan Area Health Services.

**Table 2 – Survey Respondents – Discipline, Rural and Metropolitan**

DISCIPLINE	METRO Area Health Services	RURAL Area Health Services	Number Of respondents
Speech Pathology	83	29	112
Physiotherapy	69	20	89
Occupational Therapy	43	32	75
Social Work	48	8	56
Psychology	41	10	51
Dietetics	29	15	44
Other	25	7	32
Unknown	8	1	9
<b>Total</b>	<b>346</b>	<b>122</b>	<b>468</b>

Of the 468 respondents:

- 222 respondents (47% of the total) indicated that they practiced in a community setting (Table 3);
- 118 (25%) indicated they practiced in a specialist children’s hospital;
- 94 (20%) indicated they practiced in non-children’s hospital ; and,
- 34 (8%) indicated other.

**Table 3 – Survey respondents – Site of employment by Discipline**

DISCIPLINE	Specialist Children's Hospital	Hospital	Community	Other	Number Of respondents
Speech Pathology	9	13	77	13	112
Physiotherapy	36	32	17	4	89
Occupational Therapy	10	14	46	5	75
Social Work	19	9	25	3	56
Psychology	16	1	30	4	51
Dietetics	14	20	6	5	44
Other	13	5	13	0	32
Unknown	1	0	8	0	9
<b>Total</b>	<b>118</b>	<b>94</b>	<b>222</b>	<b>34</b>	<b>468</b>

The meaning of the question “Is there a cross border organisational structure” was an issue for many of the respondents. 43% indicated that there was no cross border structure, 22% stated that there was. 16% made a comment about the “meaning” of the question. 15% did not respond to the question. Some respondents assumed “cross-border” to mean either interstate, inter-Area Health Service or intra-Area Health Service (i.e. sectors within Area Health Services). This question was particularly an issue for The Children’s Hospital at Westmead.

### 3.2 Caseload and Work Peers

52% of respondents indicated that 100% of their workload was treating children. The proportion was slightly higher (57%) for those working in metropolitan areas and much lower (36%) for those working in rural areas (Table 4).

**Table 4 – Survey respondents - % of caseload treating children**

	METRO Area Health Services	RURAL Area Health Services	Number of respondents
100% of the caseload	199	44	243
More than 90% of the caseload	28	10	38
More than 75% of the caseload	29	16	45
50% of the caseload	26	12	38
Less than 50% of the caseload	60	39	99
Nil response	4	1	5
<b>Total</b>	<b>346</b>	<b>122</b>	<b>468</b>

Of the respondents working in the community, 120 (54%) indicated that 100% of their workload was treating children and of those working in specialist children’s hospitals only 64% (76 respondents).

99 respondents (27 in the community, 44 in non-specialist children’s hospitals and 20 in specialist children’s hospitals) indicated that treating children comprised less than 50% of their workload.

**Table 5 – Composition of Allied Health practices**

	METRO Area Health Services	RURAL Area Health Services	Number Of respondents
I work in a sole position	37	59	96
With one other peer	26	25	51
Within a Department of between 2 to 4	98	29	127
Within a Department of more than 4	180	8	188
Nil response	5	1	6
<b>Total</b>	<b>346</b>	<b>122</b>	<b>468</b>

188 (40%) of respondents indicated that they worked in a Department of more than 4 peers of the same profession, with an increase to 52% for metropolitan respondents and 79% for respondents working in specialist children’s hospitals. A further 27% indicated that they worked in a Department of between 2 and 4 peers (Table 5).

Sole practitioners accounted for 96 respondents (20% of the total), 48% of rural respondents and 25% of respondents working in the community. It is interesting to note that 10 respondents working in specialist children’s hospitals indicated that they worked in sole positions.

### 3.3 Current Access to Education and Clinical Support

Respondents were asked to indicate the existing management structures within their organisations to deliver education and support in relation to that outlined in Table 6.

**Table 6 – Existing structures to deliver clinical education and support**

	METRO Area Health Services	RURAL Area Health Services	Number Of respondents
Performance Appraisal	307	83	390
Regular Clinical Supervision	234	61	295
Access to external courses, conferences	305	100	405
Regular training opportunities from resources within AHS	230	54	284
Internet access	178	89	267
Intranet access (eg CIAP)	307	114	421
Email access	308	116	424
Access to work library (eg journals)	266	86	352
Other	32	10	42

390 (83% of total respondents) indicated that **performance appraisal** was incorporated into the management structure of their organisations. For specialist children’s hospital this accounted for 91% of respondents, 81% of community based respondents and 78% of non-children’s hospital respondents. There was a significant difference between metropolitan and rural areas in that 89% of metropolitan respondents and 68% of rural respondents indicated that performance appraisal existed in their organisations to deliver support.

295 (63% of total respondents) indicated that **regular clinical supervision** was incorporated into the management structure of their organisations. For specialist children’s hospital this accounted for 69% of respondents, 69% of community based respondents and 43% of non-children’s hospital respondents. There was a significant difference between metropolitan and

rural areas in that 68% of metropolitan respondents and 50% of rural respondents indicated that regular clinical supervision existed in their organisations to deliver support.

405 (86% of total respondents) indicated that **access to external courses, conferences** etc was incorporated into the management structure of their organisations. For specialist children's hospital this accounted for 90% of respondents, 85% of community based respondents and 94% of non-children's hospital respondents. There was minimal difference between metropolitan areas (88%) and rural areas (82%).

284 (61% of total respondents) indicated that **regular training opportunities from resources within the Area Health Services** were incorporated into the management structure of their organisations. For specialist children's hospital this accounted for 74% of respondents, 60% of community based respondents and 45% of non-children's hospital respondents. There was significant difference between metropolitan areas (66%) and rural areas (44%).

267 (57% of total respondents) indicated that **internet access** is incorporated into the management structure of their organisations to deliver clinical education and support. For specialist children's hospital this accounted for 64% of respondents, 44% of community based respondents and 57% of non-children's hospital respondents. There was a 7% difference between metropolitan areas (51%) and rural areas (44%).

421 (90% of total respondents) indicated that **intranet access (eg CIAP)** was incorporated into the management structure of their organisations to deliver clinical education and support. For specialist children's hospital this accounted for 92% of respondents, 91% of community based respondents and 85% of non-children's hospital respondents. It was interesting to note that intranet access was higher in rural areas (93% of rural respondents) than metropolitan areas (89% of metropolitan respondents).

424 (91% of total respondents) indicated that **email access** was incorporated into the management structure of their organisations to deliver clinical education and support. For specialist children's hospital this accounted for 89% of respondents, 93% of community based respondents and 86% of non-children's hospital respondents. Email access was higher in rural areas (95% of rural respondents) than metropolitan areas (89% of metropolitan respondents).

352 (91% of total respondents) indicated that **access to work library (eg journals)** was incorporated into the management structure of their organisations to deliver clinical education and support. For specialist children's hospital this accounted for 91% of respondents, 67% of community based respondents and 80% of non-children's hospital respondents. Access to work library was marginally higher in metropolitan areas (77% of respondents) compared with rural areas (70% of rural respondents).

A total of 42 respondents (9% of total respondents) indicated that other resources were required.

Respondents were asked to indicate who provided the majority of their clinical education and support over the previous 12 month period with regard to the following:

- Colleagues in the Area Health Service with specialist skills within their own profession
- Specialists from out of the Area Health Service invited to present
- Out of Area attendance at Workshops, conferences etc.
- Videoconferencing opportunities
- Other.

The summary of the survey results is contained in Table 7

**Table 7 – Provision of education/support in the previous 12 months**

	METRO Area Health Services	RURAL Area Health Services	Number Of respondents
Colleagues in the AHS with specialist skills within my profession	226	59	285
Specialist from out of Area invited to present	60	26	86
Out of Area attendance at workshops, conferences etc	140	53	193
Videoconferencing opportunities	15	8	23
Other			

285 respondents (61% of the total) indicated that **colleagues with specialist skills in their own profession provided the majority of clinical education and support**. This accounted for 65% of metropolitan respondents, 48% of rural respondents, 66% of respondents from specialist children’s hospitals, 62% of community-based respondents and 54% of other hospital respondents.

Only 86 respondents (18% of total respondents) indicated that the majority of the clinical education and support over the past 12 months had been provided by **specialists from outside the Area Health Service invited to present**. This accounted for 41% of respondents from specialist children's hospitals, 19% of community-based respondents, 18% of other hospital respondents. The difference between metropolitan respondents (17%) and rural respondents (21%) was marginal

193 respondents (41% of the total) indicated that **attendance at out of Area Health Service workshops, conferences etc** provided the majority of their clinical education and support in the previous 12 months. The percentages between the various groups was very similar - 40% of metropolitan respondents, 43% of rural respondents, 41% of respondents from specialist children's hospitals, 41% of community-based respondents and 40% of other hospital respondents.

The use of **Videoconferencing** opportunities used as a means of obtaining clinical education and support over the past 12 months was identified by only 23 respondents (5% of the total) to the survey – 4% of metropolitan respondents and 7% of rural respondents.

78 respondents (17%) identified **other** means of obtaining clinical education and support.

Respondents were asked to identify the main methods of clinical education and support received by the individual during the previous 12 months with regard to:

- Training or supervision from resources within the Area Health Service
- Training from specialists outside the Area Health Service that have been invited to present
- Attendance at courses, workshops etc out of the Area Health Service
- Computer based learning
- Other.

The summary of the survey results is contained in Table 8.

**Table 8 – Methods of clinical education/support accessed in previous 12 months**

	METRO Area Health Services	RURAL Area Health Services	Number Of respondents
Training or supervision from resources with the Area Health Service	200	47	247
Training from specialists outside the Area Health Service that have been invited to present	25	13	38
Attendance at courses workshops etc out of the Area Health Service	78	31	109
Computer based learning	8	11	19
Other	25	11	36
Nil response	10	9	19

247 respondents (53% of the total) indicated that they had received **training or supervision from resources within the Area Health Service** as the main method of clinical education and support in the previous 12 months. This is compared with 58% from metropolitan respondents, 38% from rural respondents, 58% of respondents from specialist children's hospitals, 58% of community-based respondents and 40% of other hospital respondents.

Only 38 respondents (8% of total respondents) indicated that they had received **training from specialists outside the Area Health Service invited to present** as the main method of clinical education and support over the past 12 months. This accounted for 10% of respondents from specialist children's hospitals, 8% of community-based respondents, 8% of other hospital respondents. The difference between metropolitan respondents (7%) and rural respondents (11%) was marginal

109 respondents (23% of the total) indicated that they **attendance at out of Area Health Service workshops, conferences etc** was the main method of obtaining clinical education and support in the previous 12 months. The percentages between the various groups was very similar - 23% of metropolitan respondents, 25% of rural respondents, 17% of respondents from specialist children's hospitals, 23% of community-based respondents and 28% of other hospital respondents.

19 respondents (4% of the total) indicated that they used **computer-based learning** as the principal method of obtaining clinical education and support over the past 12 months – 2% of metropolitan respondents and 9% of rural respondents.

36 respondents (8%) identified **other** means of obtaining clinical education and support.

Respondents were asked to indicate the number of clinical education and supported programs which they had attended in the past 12 months which were directly related to their **paediatric workload**.

**Table 9 – Number of programs accessed in previous 12 months.**

	METRO Area Health Services	RURAL Area Health Services	TOTAL	METRO Area Health Services	RURAL Area Health Services	TOTAL
	Out of Area Programs			Within Area Programs		
None	113	55	168	117	54	171
One	105	35	140	54	27	81
Two	62	19	81	45	13	58
Three	26	4	30	28	11	39
More than 3	35	5	40	95	12	107
Nil response	5	4	9	7	5	12

168 respondents (36% of the total) indicated that **no out of Area Health Services paediatric related programs were attended in the previous 12 months** and that a further 29% attended one program. Although the rate of non-attendance was similar for within Area Health Service programs, only 17% of respondents had attended one within Area program. 107 (23%) had attended more than three in-Area programs.

393 (84% of the total) of respondents indicated that they determined their clinical education and support needs, 85% of metropolitan respondents and 80% of rural respondents.

176 (38%) respondents reported that the Department head had budgetary control over clinical education and support opportunities, a further 23% reported that budgetary control was with the Line Manager and 22% with the Centre Manager.

193 respondents (41% of the total) reported that **a funding for programs utilised over the past 12 months** was from a combined contribution of the individual allied health professional and the employer. This accounted for 43% of metropolitan respondents and 34% of rural respondents.

**Table 10 – Source of funding to access programs over the past 12 months**

	METRO Area Health Services	RURAL Area Health Services	Number Of respondents
Self funded	61	30	91
Employer funded	78	25	103
Combination of self and employer funded	151	42	193
Other	16	4	20
Nil response	39	21	60

### 3.4 Clinical education and support needs

Allied health professionals were asked to nominate, in order of priority from the following, the clinical education and support that were currently required by the individual to effectively manage their paediatric workload:

- A supported face-to-face Area clinical education and support network utilising Area Health Service resources;
- Regular face-to-face clinical education and support utilising out-of-Area opportunities;

- Regular access to specialist information using interactive technology; and,
- Access to other aspects of professional development.

The priority rating for the four options presented was consistent between all respondents, metropolitan and rural respondents (Appendix 9) in that:

- *A supported face-to-face Area clinical education and support network utilising Area Health Service resources* was identified as **Priority 1** by the highest number of all respondents (45%), metropolitan (47%) and rural respondents (40%).
- The same resource (*A supported face-to-face Area clinical education and support network utilising Area Health Service resources*) was also identified as **Priority 2** by the highest number of all respondents (41%), metropolitan (39%) and 50% of rural respondents
- *Regular access to specialist information using interactive technology* was rated as **Priority 3** by the highest number of all respondents (37%), metropolitan (35%) and rural respondents (45%).
- *Access to other aspects of professional development* was rated as **Priority 4** by the highest number of all respondents (51%), metropolitan (49%) and rural respondents (58%).

The final question in the survey asked allied health professions to identify any clinical education and support activities which would have significant impact on their paediatric practice if they were developed or available immediately.

The 225 people responded to this question (less than half of all respondents to the survey). A long list of education/support opportunities were suggested, many of which were noted by less than three people. The comments were categorised into the following major themes shown in Table 2.

**Table 11 – Clinical education/support activities which would make a difference now**

	METRO	RURAL	Total
Access to specialised clinical practice education	17	18	35
Access to non-clinical professional development programs	7	0	7
Access to the internet	27	2	29
Access to clinical supervision and mentoring	12	8	20
Access to computers, IT support and computer training	9	0	9
Access to journals, e-journals, text books	7	1	8
Access to conferences etc	6	1	7
Access to specialist therapists at children's hospitals/relevant organisations – visits, workshops with experts	3	2	5
Increased funding for allied health education eg attendance at conferences, courses	15	2	17
Time for education, research,	4	0	4
Current arrangements are adequate or good	17	3	20
No comment	186	57	243

Access to specialised clinical practice education rated highly and included a wide variety of topics, the majority of which were identified by less than three individuals. The higher percentage was from rural respondents. Examples of this type of education included:

- treatment of children with cerebral palsy, management of autism, Lidcombe and Hanen programs, child development, talipes equinovarus, management of post natal depression,

splinting/taping/management of the upper limb, feeding neonates post discharge from NICU, management of adolescent mental health clients, sensory integration workshop

- Access to the internet and computers and IT support was identified as important by respondents from metropolitan Area Health Services.
- Access to clinical supervision, mentoring, was identified as important by metropolitan respondents
- Access to other professional development programs included medico-legal training and advice, presentation and public speaking skills and report writing

## 4. OUTCOME OF FOCUS GROUPS

The following summaries the discussions in the focus groups:

### 4.1 Increased size and complexity of the caseload

- The issue of caseload was identified by allied health professionals as their most pressing need.
- Allied health professionals noted that over the last few years their paediatric caseloads have increased significantly in size and complexity as other service organisations are offering less direct treatment. Community Health in particular is having its resources stretched as there seems to be a perception in the community that Health would meet the increased need for treatment without an increase in resources to do so.
- Caseload issues placed considerable stress on physical and staffing resources, and the service that can be offered. A 'generalist' allied health professional seeing children now more than ever needs access to specialist clinical information to be able to effectively and safely treat all the children on the caseload. One allied health professional referred to it as "...the pressure of clinical divergence".

### 4.2 Access to education and clinical support

- Focus group discussions have indicated that some allied health professionals do not have appropriate access to the Internet or professional journals.
- Clinical supervision is inconsistent across the allied health professionals due to time and resource limitations. There are significant restrictions on allied health professional's financial support for out of Area Health Service clinical training, a situation they report as becoming more stringent over time.
- Allied health professionals, agreed that, in the main, they have been supported by allied health professionals in authorising paid leave for education and clinical support. There was also a ready acceptance that education and clinical support was a shared responsibility between the employer and the employee. The survey data supports the notion that allied health professionals are prepared to share in the financing their own education and clinical support. However, with the current need for more training, the cost of maintaining those skills is proving prohibitive for the profession, particularly in rural and remote areas where travel and accommodation costs can be substantial.
- The strong message conveyed by allied health professionals was that the specialist information they were seeking was driven by the caseloads they were managing, and was therefore 'core business.'
- Whilst allied health professionals acknowledged that face to face instruction was the best way of gaining the necessary clinical skills, there was agreement that the pivotal need is reliable and speedy access to specialist clinical information by any means. Currently, allied health professionals have inadequate options to obtain that information.

### 4.3 Access to clinical supervision and mentoring

- Allied health professionals are very well organised in utilising the clinical expertise within their own AHS. There were many examples of discipline specific Special Interest Groups, Departmental Meetings with an educational component, regular in-service activities and inter-agency training forums.
- However, allied health professionals have indicated that access to regular supervision is inconsistent for both new clinicians and experienced senior clinicians. Whilst a number of Area Health Services had an Area wide or discipline specific supervision policy, adherence to that policy was variable and heavily dependent upon factors such as time demands, staffing levels, work site and distance.
- Many senior allied health professional commented on the difficulty of finding time with the expectation to provide supervision, run a Department, and undertake a clinical caseload of their own. In most cases their time was not specifically funded to supervise. There was also concern from seniors that their own professional development opportunities through supervision were extremely limited. "We have a supervision policy, but that doesn't create time". As a consequence, there is diversity within and between Area Health Services with regard to the provision of regular supervision and very few examples of a structured supervision AHS program across all allied health provisions.

### 4.4 Access to information technology – internet, electronic journals

- Access to reliable information technology, and particularly access to the Internet and email, was an important issue expressed in all of the focus groups. Metropolitan allied health professionals identified it as their first priority.
- In many cases whilst computers were available access to internet services varied, not only between Area Health Services but within Area Health Services (eg Community Health/Hospital). In the majority of cases, connection to the internet was restricted. Allied health professionals were unclear as to the rationale behind restricted access, however it was assumed to be financial.
- Allied health professionals strongly expressed that with limited opportunities to attend out of Area courses, and without access to professional journals, appropriate access to a computer was a vital component in accessing clinical information. An allied health professional stated that "*we experience considerable difficulty accessing computers...this really slows our clinical learning.*"
- The importance of being able to obtain journals or journal articles was expressed by some allied health professionals. Across the State very few allied health professionals have reliable access to journals or a service that can provide journal articles. The statement was made that "*Not having access to journals is a pressing issue and having a negative impact on staff satisfaction levels...we are attempting to make best practice part of our work and gaining copies of articles is our biggest hurdle.*"

## 5. EDUCATION POLICIES

### 5.1 NSW Health

The NSW Department of Health is responsible for setting policy direction to health organisations. The 'NSW Health Strategic Directions 2000-2005' espouses a learning organisational culture that seeks to ensure learning and development programs are competency based. The document states (p 18) that: "*A skilled and valued workforce is one of the key priorities of NSW Health. Learning and development programs are widely available, co-ordinated and linked to the learning needs of NSW Health.*"

A key principle in the NSW Health Framework of 2004 is to "*Develop innovative approaches to health education and training*".

Several strategies to do so are contained in the '*Workforce Learning and Development Strategy for NSW Health*': Circular No 97/120, November 1997, including that:

- "An early stage is to identify the workforce competencies required to achieve the organisation's goals" and that there is,
- "...matching workforce resources to workforce requirements".

### 5.2 Area Health Services

Allied health professionals are informed by NSW Health policy '*NSW Health Learning and Development Leave Policy*', Circular 2000/61', (July 2000), however the implementation of that policy with regard to expenditure is at the discretion of the Area Health Executive. The policy points out that:

- Chief Executives are also responsible for allocating an appropriate budget for learning activities, which may include replacement costs for rostered staff that are on leave to attend an approved workshop, conference or tertiary studies
- Leave for learning activities should be made available to all eligible employees within the Health Service to promote the development of a highly trained, skilled and versatile workforce supporting the provision of safe, quality health care
- All employees must share the responsibility for their own development
- Within this context, there is enormous variation in the Area Health Service interpretation and implementation of the NSW Health Learning and Development Strategic Direction and policies.

## 6. The 2002 S.A.R.R.A.H Report

Services for Rural and Remote Allied Health (SARRAH) is a national organisation of allied health professionals in Australia. In 2002 SARRAH released a Report titled "A study of Allied Health Professionals in Rural and Remote Australian". The study examined the support, education and training needs of allied health professionals working and living in rural and remote areas across the country.

Although the findings and recommendations concern the broader allied health professional working in rural and remote areas in Australia, the following are relevant to the paediatric setting (p v-vi)

- *Programs aimed at the long term retention and support of skilled and experienced allied health professionals are urgently required to maintain the significant proportion of the workforce in rural practice.*
- *Allied health professionals should be formally represented on advisory groups, working parties, policy and program groups, management bodies and others that impact on rural health to ensure allied health needs, views and expert input is considered.*
- *Research and evidence is required to guide the development of sustainable models of allied health outreach practice.*
- *Employers should ensure that rural and remote allied health professionals have access to same discipline support and professional development. Where the direct supervisor is not of the same profession, alternatives such as mentor programs or contracted clinical support should be arranged. This support person need not be colocated but should work with the allied health professional and the line manager to ensure appropriate standards of clinical and non-clinical responsibilities are provided.*
- *Due to the prevalence as sole allied health professionals, resources should initially be allocated to assist the preparation of physiotherapy, occupational therapy and speech therapy graduates for sole allied health practice.*
- *The type of education and mode of delivery for allied health professionals living in rural and remote Australia must be tailored to the needs of the individual disciplines.*
- *Professional associations need to continue to develop appropriate programs and delivery means for rural and remote allied health professionals.*
- *Employers support sole allied health professionals intending to undertake postgraduate study to reduce the requirement for sole allied health professional to leave their positions. This will reduce the likelihood of communities having a gap in services, and ensure continued improvement of allied health programs and skills in the community.*
- *Educational opportunities in the use of various technologies should be provided by employers and professional associations.*

## 7. CURRENT EDUCATION/SUPPORT RESOURCES

Currently there are a variety of national, statewide and Area Health Service clinical education and support resources available to allied health professionals. Whilst these are not specifically paediatric, they are available to allied health professionals working with children.

### 7.1 National resources and initiatives

The University Departments of Rural Health are funded by the Commonwealth Government to facilitate and encourage undergraduate students. In NSW the Departments are located in:

- Department of Rural Health Broken Hill (University of Sydney)
- Northern Rivers University Department of Rural Health, Lismore (Northern Rivers Area Health Service, Southern Cross University, University of Sydney)
- Northern NSW University Of Rural Health, Tamworth (University of Newcastle)

The Australian Government Rural and Remote Health Professionals Scholarship Scheme offers scholarships to rural and remote health care professionals to pursue continuing professional education opportunities, including short courses, individual clinical placements, postgraduate tertiary study and attendance at conferences. The scholarship scheme is administrated by Services for Australian Rural and Remote Allied Health (SARRAH). Applications are assessed on merit, with the scholarship amount depending on the type and duration of the course undertaken.

The Queensland Allied Health Professional Enhancement Program. This Program is coordinated by Rural Health Training Units in partnership with the Health Advisory Unit, Allied Health Brisbane and provides allied health professionals across Queensland with improved access to quality professional development. It is divided into 3 zones – Toowoomba, Rockhampton, Cairns. The Professional Support Programme is a structured program that is open to any Queensland Health Allied Health employee currently working within one of the target districts. It is designed to meet individual as well as organisational goals, including improved access to support and resources, improved clinical and organisational knowledge and practice, improved leadership skills, autonomous practice, and improved recruitment and retention of staff.

The Occupational Therapy list-server “paediatricots” has been operating for a number of years and currently has 600 members who regularly logon.

### 7.2 Statewide resources and initiatives

Over the past five years a number of developments have been undertaken in NSW which Some important resources which have been established in NSW which

- The NSW Health Rural Health Plan launched in 2002 outlined initiatives which the NSW Government was funded to assist in the enhancement of the provision of health care in rural NSW. These initiatives included (p2):
  - Establishment of the NSW Institute of Rural Clinical Services and Teaching
  - Establishment of three new Rural Training Units
  - Expansion of the NSW Rural Allied Health Scholarships Program
  - Establishment of a statewide Rural Allied Health Forum to be held every two years commencing in 2003

- Establishment of a Chair in rural pharmacy
- The NSW rural Clinician Locum Program, established as a consequence of the release of NSW Rural Health Plan provides funding for the provision of locum services to enable health care professionals, including allied health to undertake continuing and professional education.
- Rural Health Training Units (RHTU) have expressed the desire to engage with allied health professionals in exploring opportunities to establish educational partnerships. One such partnership has been the Central West Mentoring Project in the Mid West AHS.
- The NSW Health Telehealth Initiatives Program. The Program provides seeding funds for telehealth projects (primarily for capital, initial service development and evaluation costs) In 2004/05 \$4m of funding was available for Projects.

### **7.3 Area Health Service resources and initiatives**

Allied health professionals continue to explore ways of improving education and clinical support within the financial and time constraints that are the reality of all health care providers.

Currently allied health professionals are developing projects both statewide and at Area Health Service level examining the issues of competency and credentialing in allied health interventions. This has arisen from an increased focus on clinical skills development and clinical risk management.

Some examples of initiatives within Area Health Services assisting allied health professionals working with children are included below.

#### *7.3.1 Clinical supervision, mentoring and professional support*

- Hunter, Northern Rivers and Macquarie Area Health Services have developed an Area or service-based 'Supervision Policy'.
- Services for Rural and Remote Allied Health secured Commonwealth funding and is currently piloting an 'Allied Health Mentoring Project' in the central western of NSW. The objective of the Project is to develop a comprehensive model of mentoring that is accessible to allied health professionals working in small communities and across sectors (public, private, NGOs etc, is replicable and cost effective.. The project has involved a partnership with the Central West Division of General Practitioners.
- Mid Western Area Health Service has established a "New Graduates Support Programme". Whilst the program was initially intended for occupational therapists, it has now been expanded to include other allied health disciplines. A key component of the program is the development of a professional development plan for each participant and the provision of appropriate supervision to each participant.
- Both Mid North Coast and South East Health have established a Paediatric Physiotherapists Network comprising public and private therapists. These Networks have been successful in providing professional support and professional development and is a major source of paediatric clinical information.

### *7.3.2 Learning facilities, libraries and journals*

- Each Area Health Service in metropolitan NSW has a Learning and Development Unit. There is a wide variation in the size and scope of each of these Units, and are frequently closely aligned with the Area's Human Resource Departments in offering primarily courses such as management training and computer usage.
- In rural NSW there are established training facilities in all eight Area Health Services. Originally called Rural Health Training Units, the structure, function and names of these facilities vary. However, in general, the Units have been incorporated into the broader learning and development structure with the Area Health Service. Their aim is to provide education and training for existing and future rural health staff. The eight facilities are:
  - New England Rural Training Unit
  - Broken Hill Training Unit & University
  - Greater Murray Organisational and Learning Development Unit
  - Mid West Rural Health Training and Development Unit
  - Macquarie Organisational Development Unit
  - Southern Service Improvement Unit
- Library facilities are provided in all Area Health Services in NSW and The Children's Hospital at Westmead. In addition, services of the NSW Health Brian Tutt Library are available to all health care professionals in NSW.
- Whilst the functional relationships of libraries vary between Area Health Services, all libraries are able to provide allied health professionals with a large range of relevant services including gateways to journals, assistance with information queries, conduct of research including literature reviews.
- The Clinical Information Access Program (CIAP) website provides critical clinical information via the Internet for health professionals in the public health system in NSW. It delivers information through access to online journals, books and reference databases, local policies, procedures, clinical pathways, clinical practice guidelines and links to clinical web sites world wide.

### *7.3.3 Leadership and professional representation*

- All Area Health Services have an identified allied health professional as a contact point for issues relating to Allied Health. This position takes many forms including an Allied Health Director/Chair/Representative. This group of senior Allied Health professionals meets regularly with the Chief Allied Health officer at the NSW Department of Health.
- Most Area Health Services also have an Allied Health Forum/Council/Group which assumes a leading role for allied health issues relating to planning, discussion, feedback and communication with the Area Executive.

## 7.4 Children's Hospital's Education and Clinical Support Initiatives

The three Children's Hospital's in NSW provide a range of education and clinical support resources for allied health professionals within the hospital setting and in the community.

All Allied Health Departments in these Hospitals will:

- Provide specialist clinical information and support to allied health professionals in metropolitan, rural and remote areas on request.
- Provide Lecturers to speak on specific clinical areas at external hospitals/sites.
- Take external allied health professionals for "observation" in requested clinical areas to up skill competence.
- Provide consultation to allied health in other services and areas.
- Provide supervision on an individual or group basis to allied health in other services or areas. Some are able to provide these services using telemedicine.

The Hospitals have developed a range of facts sheets for allied health professionals and these are available electronically and on the Hospitals' websites. Information packages, on a number of treatment techniques; and written resources/handouts/brochures, can be made available on request.

Dieticians from the three Children's Hospitals have formed Paediatric Network and occupational therapists are active participants in the email group for paediatric occupational therapists.

Occupational Therapists, Physiotherapists and Social Workers provide education and support for local allied health professionals during outreach clinic visits. Consultation services for individual case study videos sent by rural/remote video. This may be replaced in the future with the increasing use of Telehealth facilities and dedicated Telehealth officer.

The Allied Health Departments extend invitations to colleagues when educational sessions at conducted by the Children's Hospitals.

## 7.5 Child Health Networks

Since its establishment in 2001, the Northern Child Health Network has funded a range of initiatives related to the provision of allied health services within the Network. The 2002 – 2005 allied health initiatives and enhancements projects have included:

- Conduct of needs analysis/surveys.
- Staff Secondments
- Preceptorships
- Provision of educational sessions close to home
- Conduct of multidisciplinary conferences
- Financial assistance to attend out of Area education sessions and conferences
- Evaluation of education sessions
- Facilitation of peer support.

## 8. DISCUSSION

The result of the survey of allied health professionals, the outcomes of the Area Health Service focus groups and a review of the current literature relating to clinical practice for allied health disciplines has produced a wealth of information and identified a number of specific issues for discussion in this report and these are:

- Clinical supervision
- Performance appraisal
- Caseload
- Access to education and training
- Access to technology

Each of the issues is discussed and recommendations have been incorporated.

### 8.1 Clinical supervision

Clinical supervision is a well established and universally accepted component of pre-registration training for all health care disciplines. Clinical supervision has been defined as “a structured, formalised approach (for which time is set aside) for discussing professional practice with a colleague or peer that encourages reflection on, and evaluation of, clinical decision-making and outcomes.” (UK DOH Allied Health report 2003).

The UK Chartered Society of Physiotherapy (2003 p3) has further defined that clinical supervision is *not* fieldwork/clinical education, mentorship, appraisal, peer review, counselling and preceptorship.

Currently, there are numerous theoretical models of clinical supervision to be found in the literature. However, whilst the development and utilisation of models of clinical supervision has been a feature of contemporary post-registration nursing and psychiatric practice for many years, this is not generally the case for allied health disciplines (Burton 2000).

The findings of this study support the notion that regular clinical supervision is an issue for allied health professionals working with children in NSW. Over one third of all survey respondents indicated that regular clinical supervision was *not* part of the management structure of their organisations. The proportion was similar for allied health professionals working in children’s hospital (30%) and in the community (30%). However, the proportion was much higher for all dietitians (65%), physiotherapists (58%) and allied health professionals working in general hospitals (57%).

The survey found that 61% of all health professionals cited colleagues in their own Area Health Service and specialist skills in their own disciplines as being the primary source of clinical education and support. This compares with 18% identifying “out of Area” resources as their primary source of support. Speech therapists were the highest users of “in Area” support (71%). Physiotherapists were least likely to access “out of Area” supported (11%).

Paediatric allied health professionals were able to identify a number of clinical supervision initiatives established by individual Area Health Services in NSW. Whilst some Area Health Services had developed clinical supervision policies, the feedback from the focus group participants was that adherence to the policies was variable and that there was inconsistency of supervision for both new and experienced senior clinicians.

Senior clinicians expressed concern with regard to finding time to provide supervision amongst all other demands on their time and the difficulty senior clinicians have in sourcing supervision for them-selves.

The increasing focus on professional accountability, clinical governance and clinical risk management is requiring allied health professionals to provide effective and high quality patient care based on contemporary clinical practice. As such, there is a need for life-long learning and the demonstration of professional competency. This requires allied health professionals having access and engaging in continuing professional development (CPD) including clinical supervision.

Much of the recent literature relating to clinical supervision has emanated from the United Kingdom where health professional groups have been engaged in the development of CPD programs as mandated by the NHS in its document "*A First Class Service: Quality in the new NHS*". In addition, the requirement for professional self-regulation reform to ensure that the systems of self-regulation are (NHS 1999 3.44) "responsive to changing clinical practice and service needs", has resulted in professional bodies developing mechanisms for ensuring competency of clinicians.

The international experience provides an indication of the likely future direction for allied health professionals in this country in terms of mandatory CPD. More importantly, it raises particular issues for the relatively small group of allied health professionals who work with children. It is timely and important that clinical supervision for paediatric allied health professional groups is addressed. Initially, there needs to be recognition that every allied health professional is entitled to and should have access to clinical supervision. The Hunter Health Allied Health Clinical Supervision Policy has identified a minimum frequency as "an equivalent of two hours at least every three months."

It is understood that there needs to be investment in clinical supervision. The outcomes of focus group discussions in this study highlight that the ability of integrating clinical supervision into the everyday clinical practice is complex. Allied health professionals identified heavy workloads, a decline in the already relatively small paediatric allied health workforce and the geographic isolation of many practitioners as barriers to initiating or maintaining clinical supervision mechanisms. Allied health professionals in managerial positions cited the added responsibilities of managing department as compounding the difficulty in engaging in clinical supervision. As Darley (1995 p14) states "clinical supervision will, when properly set up and evaluated, provides evidence of its positive effect on care and staff development. "

Whilst the existing barriers to establishing a program of clinical supervision for paediatric allied health professionals in NSW are acknowledged, it is important the paediatric allied health professionals, the Child Health Networks and NSW Health begin exploring options for progressing clinical supervision in the short and longer term.

There is no "one-size fits all" model of clinical supervision. Clinical supervision programs must be adapted to meet local needs of the individual allied health professional or the allied health discipline. The survey has highlighted the variety of settings in which paediatric allied health professionals practice in NSW. Clinical supervision programs need to be tailored to cater for the needs of the sole practitioner in a remote area as well as the practitioner in a large team in a specialist children's hospital. In addition, the programs must be responsive to the changing career cycles of the individual allied health professional, including the novice as well as the competent and advanced practitioner.

An important aspect in determining the future model/s of clinical supervision is applicability to the Australian context. The "tyranny of distance" coupled with a relatively small allied health workforce in NSW requires that an innovative approach is taken to clinical supervision for paediatric allied health professionals, particularly for individual disciplines and practitioners in

remote areas. This means that challenging the traditional model of individual “one-on-one and face-to-face” clinical supervision to exploring the model of “group”, “peer” or “multidisciplinary” clinical supervision and, most importantly, the expanded use of technology in terms of videoconferencing, the internet and emerging telecommunications (Miller et al).

The success of any clinical supervision program is largely dependent on the availability of a cohort of clinical leaders to assume the role of supervisor/mentor. In addition, there is a requirement for these leaders to be provided with appropriate training and preparation for their roles.

There is a need to invest in and sustain an infrastructure of clinical supervision for allied health professions working with children to ensure a critical mass of expertise in the longer term. There is also a need to establish a cohort of skilled supervisors and provide the opportunity for life-long (career) based learning.

A robust and sustainable system of clinical supervision for allied health professionals working with children in NSW is essential to:

- Support the multidisciplinary allied health team approach to managing children
- Respond to the need for team-building and the development of effective allied health clinician networks.
- Provide support for the sole practitioner
- Facilitate the delivery of allied health care as close to home as possible.

### **Recommendations:**

1. That the NSW Child Health Networks, in collaboration with other key stakeholders, undertake to develop clinical supervision options, which meet the needs of the individual allied health professional working with children, including that of novice and expert clinician.
2. That the NSW Child Health Networks collaborate with Area Health Services and allied health professionals to identify appropriate individuals as clinical leaders in the provision of clinical supervision of allied health professionals working with children.
3. That Area Health Services, in collaboration with other key stakeholders, develop a program of training key allied health professionals working with children, to assume the role of supervisors.

## **8.2 Performance appraisal**

Performance management is an integrated and planned system for continuously improving the performance of all people working in an organisation, including those working as health professionals.

Effective performance management mechanisms enable individuals to define their work goals and standards, measure performance against these standards, actively managing all levels of performance and maintaining learning and development. Central to the process of performance management is a performance review/appraisal, usually undertaken on an annual basis between an individual employee and their manager.

A well designed appraisal system contains several essential elements:

- A statement of performance objectives for the individual including outcomes expected of them, how they are measured, and when they are to be completed
- A statement of the specific support to be provided by the organisation so the individual can reach agreed objectives. This describes any skills and training required to ensure an individual can meet current and future goals.
- Enables review of overall performance against previously agreed outcomes. It should also look to the future and identify goals and objectives for the individual's career development and how these can be supported by the organisation.

Participation in a process of performance management, along with an annual performance review/appraisal should be an expectation of all allied health professionals working with children in all working environments, both metropolitan and rural. It should also be linked to regular ongoing clinical supervision.

The findings of this review, supports the notion that regular performance review/appraisal is an issue for allied health professionals working with children. Only 83% of total respondents identified that performance review/appraisal was incorporated into the management structure of their organisations. Not surprisingly, 91% of respondents from the specialist children's hospitals identified a clear process for ongoing performance review. Unfortunately, beyond the children's hospitals, this figure was much lower (81% for community based respondents, and 78% of general hospital respondents). There was a significant difference between metropolitan and rural areas, with 89% of metropolitan respondents and only 68% of rural respondents indicating that performance review/appraisal part of the management structure of their organisations.

The focus groups have highlighted that allied health professionals working with children in rural and remote areas of NSW often report to line managers who do not have the same allied health professional background as their own, and in many cases report to managers of medical, nursing and administrative backgrounds. This in effect results in the allied health professional operating as a sole clinician (48% of rural respondents). It is therefore vital that effective clinical support is provided to those allied health professionals.

A programme of performance management for allied health professionals working with children must be developed and sustained across all working venues including hospitals; community; metropolitan; and rural and remote areas. This will ensure that issues pertaining to individual employees in relation to work performance, identification of work goals and standards, and identification of clinical support and education needs required to maintain and enhance clinical competence are monitored and addressed on a regular basis.

The allied health professional will benefit by timely feedback on work performance, identification of education and support needs and a consequent improvement in job satisfaction which has been shown to improve employment retention. The client will benefit by being managed by a well supported and trained allied health professional which will maximise the outcomes of the interventions provided. The organisation will also benefit by the improved recruitment of allied health professionals and also an enhanced ability to retain staff.

## **Recommendations:**

1. That Area Health Services ensure that allied health professionals working with children participate in a performance management process as discussed in Department of Health Circular 2003/12 "NSW Department of Health Coaching and Performance System (CAPS) Policy ".

2. That relevant Area Health Services, in collaborate the Services for Australian Rural and Remote Allied Health (SARRAH), develop a mechanism for performance management of sole allied health professionals working with children in rural areas.

### 8.3 Caseload

A significant number of allied health professionals involved in this Project have identified an increasing size and complexity in their caseload as an important issue for their practice. The principal reasons for this increase are:

- Other service organisations offering less direct treatment
- The significant advances in medical practice and technology which has resulted in the marked improvement in the survival rate of children with ongoing and complex management issues.
- Community expectations and attitudes
- The availability of, and access to, improved equipment and technology; and the growing trend to integrate children with ongoing medical conditions and disabilities into the community and school.

Today children with burn injury involving more than 80% of total body surface are surviving. These children require intensive and long term allied health intervention, particularly from paediatric physiotherapists, occupational therapists and social workers.

Spinal cord injuries in children also require long term intervention, particularly with regard to high level lesions with resulting quadriplegia. This requires intervention by a range of paediatric allied health professionals well into adolescence and includes specialised equipment, coordinating school and home environmental modifications, rehabilitation and management of activities of daily living.

Survival of very low birth weight babies (many of whom have required neonatal intensive management) and those “at term” babies born with complex medical and/or surgical conditions require early intervention and long term follow-up to give them the best opportunities to maximise their potential.

The introduction of the State Wide Infant Screening Hearing (SWISH) program in 2002 has facilitated the identification of profoundly deaf babies post birth. Whilst this initiative has resulted in positive early intervention for a large number of children, it has generated considerable stress on parents/family, particularly for those who had no indication that their child had a significant disability.

In the past, children requiring long-term ventilation and requiring a tracheostomy to breath, have been required to remain hospitalised, in many instances for over a year. The change in philosophy of management is to facilitate, as much as possible, the return of the children to their home and the family environment. Long-term ventilated children require the intervention of the multi-disciplinary team on a regular basis.

The introduction of the use of botulinum toxin and multi-level surgery in the management of cerebral palsy has created a need to provide intensive therapy for a period of time to maximise the benefit of these new treatments. Early evidence indicates that new treatments such as botulinum toxin are more effective if followed up immediately with specialised allied health treatment (Wallen et al).

In addition to the impact of improvement to medical management and new technologies, the trend to providing health care to children as close to home as possible, has created a need for allied health professionals to treat children whilst still in the acute stage of their condition.

The allied health professionals participating in this study identified the lack of resources as a major issue in their ability to provide appropriate services in a timely manner. This was particularly an issue for sole practitioners and those in rural and remote areas.

91 respondents (27 in the community, 44 in non-specialist children's hospitals and 20 in specialist children's hospitals) indicated that treating children comprised less than 50% of their workload. They considered that 'generalist' allied health professionals seeing children need access, now more than ever, to specialist clinical information to be able to treat these children effectively and safely. They also indicated that paediatric caseload issues placed considerable stress on physical and staffing resources, and the service that can be offered.

In terms of looking to the future paediatric allied health professionals workload, it is highly likely that as well as the caseloads already described there will be a significant impact following the improvements in diagnosis for conditions such as autistic spectrum disorder (including Aspergers disorders); attention deficit disorders etc as well as the major public health issues such as obesity and diabetes.

### **Recommendations:**

1. That the NSW Child Health Networks, in collaboration with relevant paediatric allied health professionals, develop mechanisms by which community-based allied health professionals working with children have access to colleagues working in the specialist paediatric clinics across NSW.
2. That a database of currently available paediatric allied health clinical information and management guidelines is established as a statewide resource for allied health professionals working with children.
3. That Area Health Services, in collaboration with NSW Health and NSW Children's Hospitals, develop strategies to identify areas of need for paediatric allied health services, enhance service provision and minimise duplication of services.
4. That the NSW Children's Hospitals, in collaboration with Area Health Services, formalise mechanisms for outreach clinical education and support for allied health professionals working with children in the community.
5. That NSW Health and Area Health Services ensure that allied health professionals working with children are provided with the opportunity to be involved in paediatric related GMIT and Telehealth initiatives.
6. That the NSW Child Health Networks, in collaboration with NSW Health and relevant allied health professional organisations, undertake a study to identify the current allied health workforce and the future requirements.

## **8.4 Access to education and training**

Learning and development should be competency based, widely available, coordinated and linked to the learning needs of NSW Health (NSW Health Strategic Directions 2000 – 2005).

NSW Health's Learning and Development Policy (July 2000) recognizes that learning and development is a shared responsibility between the employee and the employer. For allied health professionals working with children in NSW, there does not appear to be a coordinated learning and development strategy that meets the expressed needs of practitioners or the organisation as a whole.

Access to education and training is essential for all staff. It is particularly so for staff who are working in isolation in specialised fields, or generalist workers who have to provide a wide variety of services, but is no less essential for staff not in those categories.

Ongoing education and training is recognized as an essential component of allied health work, corroborated by the fact that professional associations now have targets for Continuing Professional Education (CPE) points for continued registration, association memberships or accreditation. This includes medical, nursing and allied health.

In areas where sole practitioners are working, attending a training session, course or conference may be the only contact with clinicians working in similar fields, and one of the main opportunities to 'catch-up' with current research and developments in particular areas.

According to the NSW Public Health Bulletin June 2001, "NSW Health has a strong commitment to providing learning and development services to the health workforce". The Bulletin goes on to say that the Department of Health recognizes the need for competency-based workforce development, based on "vocational education and training (VET), that is, on the learning needs of the workforce and what people need to know in order to function effectively in their jobs."

The Bulletin also states: "NSW Health must provide its staff with wider choices of VET qualifications, and greater access to a variety of learning pathways, to improve the workforce development necessary to drive changes in the way health care is delivered to the people of NSW. The aim is to provide the health workforce with choices from a suite of recognised qualifications delivered through a diversity of pathways and approaches to on-the-job learning, with in-built articulation to higher level qualifications."

This Project has shown that the opportunities for training were less for those employed in rural areas and non-specialist children's hospitals. Access to external courses and conferences were similar, but regular training opportunities from resources within the area health services were much less for allied health professionals in rural areas. Allied health professionals in rural areas have greater difficulty accessing external courses when you take into consideration the tyranny of distance. For the sole practitioner or those services with limited practitioners, the question of covering workloads during clinical absence can have an impact on the decision to attend training and development opportunities out of area.

SARRAH recommended that professional associations need to develop appropriate programs and delivery options for rural and remote Allied Health professionals, in collaboration with allied health professionals and that employers should explore and utilise a range of delivery networks for education and training.

SARRAH (2000) has recommended that there is a need for the development of appropriate programs and delivery options for rural and remote allied health professionals in collaboration with a range of providers.

The focus groups also identified that Allied Health professionals agreed that, in the main, they have been supported by Allied Health management in authorising paid leave for education and clinical support. There was also a ready acceptance that education and clinical support was a shared responsibility between the employer and the employee. The survey data supports the notion that allied health professionals are prepared to share in financing their

own education and clinical support. However, with the current need for more training, the cost of maintaining those skills is proving prohibitive for the professions, particularly in rural and remote areas where travel and accommodation costs can be substantial. These issues, identified by survey and focus groups also support SARRAH's recommendations.

There is a culture of allied health professionals contributing to their own professional development. The strong message conveyed by the respondents, particularly in rural settings, is that the specialist information they are seeking is driven by the caseloads they are managing, and therefore should be considered "core business".

Improved access to education and training will result in a competent workforce that is providing services to families that are evidence-based, using up-to-date information. It will also result in clinicians feeling supported and valued by the services in which they work.

### **Recommendations:**

1. That Area Health Services and allied health professional organisation provide allied health professionals working with children with educational opportunities in the use of various technologies.
2. Allied health professionals working with children undertake research to investigate how technologies should be used to support and deliver allied health services.
3. That Area Health Services ensure that allied health professionals working with children are provided with CIAP training
4. The NSW Child Health Networks collaborate with Universities and University Departments of Rural Health to develop appropriate post graduate and continuing education courses for allied health professionals working with children.
5. That Area Health Services and allied health professional organisations develop strategies to enhance the use of telehealth as a means of networking, providing education, support and supervision for allied health professionals working with children.
6. That allied health professional organisations, together with key stakeholders conduct a comprehensive training needs assessment for allied health professional working with children.
7. That allied health professional organisations, together with key stakeholders, develop core competencies for allied health professionals working with children.

## **8.5 Access to technology**

Information technology has the potential to address some gaps in relation to accessing appropriate education and support and this has been highlighted in both the survey and focus groups.

The NSW Rural Health Report (2002, p 27) states that the use of technology can facilitate the enhancement of patient care; provision of peer support and education opportunities for metropolitan as well as rural and remote health practitioners.

It is considered that timely access to specialist support has the potential to increase productivity, work satisfaction, retention of staff, and reduced training time and associated costs. In addition, it has the potential to create equal opportunities for those with both access to technology infrastructure and the knowledge and skills to use it (SARRAH, 2000, p 100).

Technology can range from the everyday such as telephones and faxes to computer based technology such as email and access to the NSW Health Intranet and the internet, to new mediums such as videoconferencing. In particular, sole practitioners and those in rural and remote areas should obtain most benefit from access to a range of technology.

Not all allied health practitioners who completed the survey or attended the focus groups had access to computer based technology including email, NSW Health Intranet and even fewer had access to the internet.

Although a majority of rural allied health practitioner survey respondents (95%) and 89% of metropolitan respondents reported access to email, the limited access to a computer was an issue.

Up to 11% of metropolitan and 9% of rural survey respondents did not have access to the NSW Health Intranet thus limiting their access to CIAP (Clinical Information Access Program) that enables journal and other information searches. In addition, to lack of access to CIAP, allied health professionals reported that they did not have access to a work library.

Close to half (43%) of respondents did not have work related internet access with over 65% of rural survey respondents reporting that they were unable to access to the internet. Only 4% of survey respondents indicated that they used computer-based learning as a method of obtaining clinical education and support over the 12 month period prior to the survey.

The use of videoconferencing as a means of providing and obtaining education and support has been limited. Only 23 of the 468 survey respondents (5%) indicated that the use of videoconferencing opportunities as a means of obtaining clinical education and support over the 12 months prior to the survey.

There are a limited number of technology based education and support initiative that should be applauded and these include the Occupational Therapy list-server "paediatricots", the NSW Health Clinical Information Access Program (CIAP) website and the NSW Telehealth Initiatives Program which funded the "Dubbo Community Health Centre Telehealth Project for Allied Health" in 2003/04 "*...enhance outreach allied health and nursing services provided by allied health and nursing clinicians from Dubbo to rural towns across Macquarie Far West Area Health Services*" (NSW Health Telehealth Newsletter No 10, p3)

### **Recommendations:**

1. That Area Health Services provide access to email, NSW Health intranet and internet to all allied health professionals working with children.
2. That the Computers for Rural Allied Health program is enhanced to include all allied health professionals working with children no matter irrespective of the primary place of work.
3. That the relevant allied health disciplines establish discipline specific list serves, similar to the OT Paediatric list serve provided though NSW Health CIAP infrastructure

## 9. CONCLUSION AND RECOMMENDATIONS

The conduct of this Project has provided important and valuable information with regard to the educational and clinical support needs of allied health professionals working with children in the NSW public health system.

It should be acknowledged, however that there are limitations in this Project, and, as such, the findings should not be generalised to the broader allied health professional community. NSW has a significant cohort of private-practice allied health professionals working who work with children and this group was not included in this Project. With regard to the survey used, a number of questions contained in the form were subject to misinterpretation; the number of returned surveys for some individual Area Health Services was very small (less than 10) and clinicians working in the three specialist children's hospitals were disproportionately represented in the survey responses.

Despite these limitations, this Report provides a practice overview of the issues confronting allied health professionals working with children and contains recommendations which provide a framework for addressing many of these educational and clinical support issues. It is anticipated that, Child Health Networks, Area Health Services and allied health professionals will collaborate in the identification, implementation and evaluation of strategies recommended in this Report.

The Project found that, whilst there are many educational and clinical support resources available to allied health professionals, many allied health professionals working with children do not have access, or are unable to access many of these resources. Issues identified have been grouped into the four categories – clinical supervision, performance appraisal, caseload and access to education and training. The recommendations have been grouped accordingly.

### 1. Clinical supervision:

1. That the NSW Child Health Networks, in collaboration with other key stakeholders, undertake to develop clinical supervision options, which meet the needs of the individual allied health professional working with children, including that of novice and expert clinician.
2. That the NSW Child Health Networks collaborate with Area Health Services and allied health professionals to identify appropriate individuals as clinical leaders in the provision of clinical supervision of allied health professionals working with children.
3. That Area Health Services, in collaboration with other key stakeholders, develop a program of training key allied health professionals working with children, to assume the role of supervisors.

### 2. Performance appraisal:

1. That Area Health Services ensure that allied health professionals working with children participate in a performance management process as discussed in Department of Health Circular 2003/12 "NSW Department of Health Coaching and Performance System (CAPS) Policy".
2. That relevant Area Health Services, in collaborate the Services for Australian Rural and Remote Allied Health (SARRAH) to develop a mechanism for performance management of sole allied health professionals working with children in rural areas.

### **3. Caseload:**

1. That the NSW Child Health Networks, in collaboration with relevant paediatric allied health professionals, develop mechanisms by which community-based allied health professionals working with children have access to colleagues working in the specialist paediatric clinics across NSW.
2. That a database of currently available paediatric allied health clinical information and management guidelines is established as a statewide resource for allied health professionals working with children.
3. That Area Health Services, in collaboration with NSW Health and NSW Children's Hospitals, develop strategies to identify areas of need for paediatric allied health services, enhance service provision and minimise duplication of services.
4. That the NSW Children's Hospitals, in collaboration with Area Health Services, formalise mechanisms for outreach clinical education and support for allied health professionals working with children in the community.
5. That NSW Health and Area Health Services ensure that allied health professionals working with children are provided with the opportunity to be involved in paediatric related GMITT and Telehealth initiatives.
6. That the NSW Child Health Networks, in collaboration with NSW Health and relevant allied health professional organisations, undertake a study to identify the current allied health workforce and the future requirements.

### **4. Access to education and training**

1. That Area Health Services and allied health professional organisation provide allied health professionals working with children with educational opportunities in the use of various technologies.
2. Allied health professionals working with children undertake research to investigate how technologies should be used to support and deliver allied health services.
3. That Area Health Services ensure that allied health professionals working with children are provided with CIAP training
4. The NSW Child Health Networks collaborate with Universities and University Departments of Rural Health to develop appropriate post graduate and continuing education courses for allied health professionals working with children.
5. That Area Health Services and allied health professional organisations develop strategies to enhance the use of telehealth as a means of networking, providing education, support and supervision for allied health professionals working with children.
6. That allied health professional organisations, together with key stakeholders conduct a comprehensive training needs assessment for allied health professional working with children.
7. That allied health professional organisations, together with key stakeholders, develop core competencies for allied health professionals working with children.

## **5. Access to technology**

1. That Area Health Services provide access to email, NSW Health intranet and internet to all allied health professionals working with children
2. That the Computers for Rural Allied Health program is enhanced to include all allied health professionals working with children, irrespective of the primary place of work.
3. That the relevant allied health disciplines establish discipline specific list serves, similar to the OT Paediatric list serve provided through NSW Health CIAP infrastructure

## 10. APPENDICES

### Appendix 1 - Project Steering Committee

Ms Robyn Adams	Head Physiotherapist Bathurst Base Hospital <a href="mailto:Robyn.Adams@mwahs.nsw.gov.au">Robyn.Adams@mwahs.nsw.gov.au</a>
Ms Virginia Binns	Director of Allied Health Sydney Children's Hospital <a href="mailto:binnsv@sesahs.nsw.gov.au">binnsv@sesahs.nsw.gov.au</a>
Mr Bart Cavalletto	Program Manager Statewide Paediatric Services Networking NSW Health <a href="mailto:bcava@doh.health.nsw.gov.au">bcava@doh.health.nsw.gov.au</a>
Ms Leanne Friis	Senior Speech Pathologist Child and Family Health Centre Lismore <a href="mailto:LEANNEF@nrhs.health.nsw.gov.au">LEANNEF@nrhs.health.nsw.gov.au</a>
Ms Alison Jones	Chair, Division of Allied Health The Children's Hospital at Westmead <a href="mailto:alisonj@chw.edu.au">alisonj@chw.edu.au</a>
Ms Joan Murphy	Occupational Therapist In Charge Dubbo Community Health Centre <a href="mailto:Joan.Murphy@mahs.nsw.gov.au">Joan.Murphy@mahs.nsw.gov.au</a>
Ms Margaret Piper	Director of Community Child Health and Allied Health Kaleidoscope in Greater Newcastle (KGNS) <a href="mailto:Margaret.Piper@hunter.health.nsw.gov.au">Margaret.Piper@hunter.health.nsw.gov.au</a>
Mr Stephen Rue	Project Officer

## Appendix 2 – Survey Form

Area Health Service	.....
Town	.....
Facility (Hospital/Community Health etc)	.....
Allied Health profession	.....

### A. EMPLOYMENT SITE

*This survey will enable us to gathering state-wide data on the clinical education and support needs for allied health clinicians working with children.*

*In analysing this information, this section will enable reflection to employment site differences that may impact on those training needs eg metropolitan/rural, Hospital/Community, specialist/generalist and the differences that may exist between and within Area Health Services across NSW*

1. Please indicate your employing organisation  
(more than one box can be ticked)

Hospital	Major Teaching Hospital?	yes	no
Community Health			
Other (please specify)	.....		

2. Which best describes the location of your principal place of employment?

Metropolitan capital city/city with population over 100,000 people)  
 Provincial city – 50,000 to 1000,000 people  
 Regional centre – 20,000 to 50,000 people  
 Large Rural Town – 10,000 to 20,000  
 Medium Town/Community – 2,000 to 5,000  
 Town/community with less than 2,000 people  
 Other (please specify)

3. Is there a cross border organisational structure?

Yes                      No

.....

4. Where is your principal place of employment based?

Metropolitan site  
 Less than 100 kms from a capital or provincial city  
 Between 101 and 250 kms from a capital or provincial city  
 Between 251 and 500 kms from a capital or provincial city  
 More than 500 kms from a capital or provincial city (Estimated distance .....kms)

**B. CASELOAD AND WORK PEERS**

*It stands to reason that there will be specific clinical educational and support needs for allied health clinicians working with children in different contexts eg sole clinician in remote location.*

*This section will allow us to look at data for clinicians in varying work contexts such as being in a rural environment, being part of a multidisciplinary team, working with varying caseload mixes and the differing sizes of Departments and work based teams.*

1. How much of your caseload involves treating children?

- 100%
- More than 90%
- More than 75%
- 50%
- Less than 50%

2. Do you have a specialist paediatric role? If so, what is it?

- Yes .....
- No

3. How many of your same profession in paediatrics do you work directly within your organisation?

- I work in a sole position
- With one other peer
- Within a Department of between 2 to 4
- Within a Department of more than 4

4. Where is your nearest peer of the same profession and also working in paediatrics?

- Co-located in the same workplace
- In the same town/suburb
- Up to 50 kms away
- 50 to 100 kms away
- 100 to 300 kms away
- More than 300 kms away

5. Are you part of a specialist paediatric team?

- Yes
- No

If 'yes', who else is in the team?

.....

6. What other professionals do you work with in your organisation?  
(more than one box can be ticked)

Other Allied Health (please specify)

.....

Other Community Health Workers (eg Health promotion, sexual assault work)

Medical practitioner: GP Paediatrician

Nurse

None

Other (please specify) .....

Do you have access to formal or informal network of multi-disciplined clinicians working with children within your

C. CURRENT ACCESS TO EDUCATION AN CLINICAL SUPPORT

*This section will enable an analysis of what paediatric clinical education and support is currently available to Allied Health, who determines access to these activities, who provides the education and support, and what type of education and support is regularly made available to clinicians.*

1. What management structures exist within your organisation to deliver you clinical education and support? (more than one box can be ticked)

Performance Appraisals

Regular clinical supervision

Access to external courses, conferences etc.

.....

.....

Regular training opportunities from resources within Area Health Service

.....

.....

Internet access

Intranet access (eg CIAP)

Email access

Access to work library (eg journals)

Other (please specify)

.....

.....

2. Who has provided the majority of your clinical education and support over the past 12 months?

Colleagues in the Area Health Service and specialist skills within my professional

Specialists from out of Area invited to present

Out of Area attendance at workshops, conference etc

Video-conferencing opportunities

Other (please specify) .....

3. What was the main method of clinical education and support you have received in the last 12 months?

- Training or supervision from resources within the Area Health Service
- Training from specialists outside the Area Health Service that have been invited to present
- Attendance at courses, workshops etc out of the Area Health Service
- Computer based learning
- Other (please specify) .....

4. How many clinical education and support programs have you attended in the last 12 months out of Area that have related directory to you paediatric work?

- None
- One
- Two
- Three
- More than three

5. How many clinical education and support programs have you attended in the last 12 months within your Area Health Service that have related directly to your paediatric work?

- None
- One
- Two
- Three
- More than three

6. Who determines you clinical education and support needs?

- You do
- Department Head (of the same profession)
- Line Manager (eg Team Leader)
- Other (please specify) .....

7. Who has budgetary control over your clinical education and support opportunities?

- Supervisor of the same profession (eg Department Head)
- Line Manager (eg Team Leader)
- Centre Manager
- Other (please specify) .....

8. If you have access to clinical education and support activities over the past 12 months who has paid?

- Self-funded
- Employer funded
- Combination of self an employer funded
- Other (please specify) .....

D. CLINICAL EDUCATION AND SUPPORT NEEDS

*We know from previous investigation that access to clinical education and support is an important issue to Allied Health, not only in terms of maintaining and developing clinical skills, but also with issues such as recruitment and retention of staff*

*This section seeks to gain from Allied Health Clinicians working with children an indication of specifically what clinical education and support they need to do their job.*

*In seeking to collect state-wide information it is important that the data is standardised to some extent to enable a useful collation and comparison of results.*

*Below are broad 'categories' of clinical education and support activities, out of which specific initiatives will be developed as recommendations in a final report and hopefully implemented as a second phase of this project.*

*There may well be other 'categories' which you are invited to add this list.*

*In each category there is opportunity to briefly comment on some of the issues you feel are pertinent to the successful provision of clinical education and support within this category*

Please nominate in prioritised order for the clinical education and support you need now to continue to effectively manage you paediatric caseload.

**A supported face-to-face Area clinical education and support network utilising Area Health Service resources**  
Eg

- Regular access to specialist clinical personnel within the Area Health Service in hands-on instruction
- Supported discipline specific professional development program across the Area Health Service eg clinical supervision, regular meetings etc

Comments

.....  
.....  
.....

**Regular face-to-face clinical education and support utilising out-of-Area opportunities**  
Eg

- Regular access to out-of-Area workshops, seminars etc
- Regular invitation of out-of-Area clinical specialists to present within Area Health Service
- Access to rotation and/or secondment to specialist facilities out-of-Area

Comments .....

.....

**Regular access to specialist information using interactive technology**  
 Eg

- Access to specialist clinical consultation such as phone helpline
- Access to good quality equipment to enable consistent use of teleconferencing and videoconferencing and video conferencing
- Access to good quality computers and software (eg Internet, email)
- Provision of good quality IT support

Comments .....

.....

**Access to other aspects of professional development**  
 Eg

- Access to training in areas such as management, clinical supervision, policy development, submission writing, financial management
- Access to broadly based work related mentoring

Comments .....

.....

Others:

.....

.....

eg

Comments .....

.....

**E. OPPORTUNITIES AVAILABLE NOW**

Are there any clinical education or support activities you'd like to access or develop immediately that you feel would have a significant impact on your paediatric practice?  
 (please specify)

.....

.....

.....

.....

.....

Thank you very much for completing this survey.

### Appendix 3 - Survey Findings – Respondents Profile by Discipline

	Speech Pathology	Physiotherapy	Occupational Therapy	Social Work	Psychology	Dietetics	Unknown	Other	Total
Central Coast		4	2					1	7
Children Hospital at Westmead	6	2	2	12	7	3		6	38
Central Sydney	1	2	1		1	3	1		9
Far West		2	2						4
Greater Murray	8	2	5	1	2	4		4	26
Hunter	23	25	7	17	11	5	2	1	91
Illawarra	8	5	2	4	2	1		1	23
Macquarie	1	4	3	2	1	3		1	15
Mid North Coast	4	1	5		4				14
Mid Western	3	2	6	2		5			18
New England	1	1			1				3
Northern Rivers	9	6	5	1		2	1		24
Northern Sydney	11	5	7	4	5	1	1	1	35
Southern	6	2	6	2	2	1		2	18
South Eastern Sydney	6	17	7	3	7	10	1	7	58
South Western Sydney	12	2	1	2	1	2			20
Wentworth	7	5	5	1		4			22
Western Sydney	9	2	9	5	7		3	8	43
<b>Total</b>	<b>112</b>	<b>89</b>	<b>75</b>	<b>56</b>	<b>51</b>	<b>44</b>	<b>9</b>	<b>32</b>	<b>468</b>

### Appendix 4 – Survey Findings - Respondents by practice location

	Hospital	Community	Both	Other	Total
Central Coast	5	1			7
Children Hospital Westmead	38				38
Central Sydney	4	5			9
Far West	3	1			4
Greater Murray	10	15	1		26
Hunter	41	44	2	4	91
Illawarra	9	10	4		23
Macquarie	3	10		2	15
Mid North Coast	2	11	1		14
Mid Western	7	6	5		18
New England	1	2			3
Northern Rivers	3	18	2	1	24
Northern Sydney	13	18		4	35
Southern	2	12	4		18
South Eastern Sydney	53	4	1		58
South Western Sydney	8	10	2		20
Wentworth	10	12			22
Western Sydney	0	43			43
<b>Total</b>	<b>212</b>	<b>222</b>	<b>22</b>	<b>12</b>	<b>468</b>

## Appendix 5 – Survey Findings – Provision of education/support

	Community	General Hospitals	Children's Hospitals	Other	Total
Colleagues in the AHS with specialist skills within my profession	137	51	78	19	285
Specialists from out of Area invited to present	41	17	22	6	86
Out of Area attendance at workshops, conferences etc	91	37	49	16	193
Video-conferencing opportunities	10	7	1	5	23
Other	31	19	24	4	78

## Appendix 6 – Survey Findings - Methods of education/support accessed

	Community	General Hospitals	Children's Hospitals	Other	Total
Training or supervision from resources within the Area Health Service that have been invited to present	128	38	69	12	247
Training from specialists outside the Area Health Service that have been invited to present	17	8	12	1	38
Attendances at courses, workshops etc out the Area Health Service	50	26	20	13	109
Computer based learning	7	5	2	4	18
Other	13	10	12	1	36

## Appendix 7 – Survey Findings - Out of Area programs attended

	METRO Area Health Services	RURAL Area Health Services	Number Of respondents
None	113	55	168
One	105	35	140
Two	62	19	81
Three	26	4	30
More than three	35	5	40
Nil response	5	4	9

## Appendix 8 – Survey Findings - Within Area programs attended

	METRO Area Health Services	RURAL Area Health Services	Number Of respondents
None	113	55	168
One	105	35	140
Two	62	19	81
Three	26	4	30
More than three	35	5	40
Nil response	5	4	9

## Appendix 9 – Survey Findings - Current resource requirements

ALL RESPONDENTS	PRIORITY			
	1	2	3	4
A supported face-to-face Area clinical education and support network utilising Area Health Service resources	181	167	63	41
Regular face-to-face clinical education and support utilising out-of-Area opportunities	113	130	110	58
Regular access to specialist information using interactive technology	65	77	152	87
Access to other aspects of professional development.	37	27	79	205
Other	2	2	2	6
<b>Total respondents</b>	<b>399</b>	<b>405</b>	<b>409</b>	<b>401</b>
Nil response	70	63	62	67

METROPOLITAN RESPONDENTS	PRIORITY			
	1	2	3	4
A supported face-to-face Area clinical education and support network utilising Area Health Service resources	147	123	55	38
Regular face-to-face clinical education and support utilising out-of-Area opportunities	86	102	86	48
Regular access to specialist information using interactive technology	50	63	111	72
Access to other aspects of professional development.	28	25	63	156
Other	2	2	2	1
<b>Total respondents</b>	<b>314</b>	<b>317</b>	<b>320</b>	<b>319</b>
Nil response	33	29	29	28

RURAL RESPONDENTS	PRIORITY			
	1	2	3	4
A supported face-to-face Area clinical education and support network utilising Area Health Service resources	34	44	8	3
Regular face-to-face clinical education and support utilising out-of-Area opportunities	27	28	24	10
Regular access to specialist information using interactive technology	15	14	41	15
Access to other aspects of professional development.	9	2	16	49
Other	0	0	0	4
<b>Total respondents</b>	<b>86</b>	<b>90</b>	<b>92</b>	<b>85</b>
Nil response	37	34	33	41

## Appendix 10 – Survey Findings - Comments in regard to access issues

### Budget restrictions for external courses

- I feel professionally buried in the country
- As a generalist I desperately require training in specialist areas
- I'm expected to pay my travel and accommodation, which is the majority of the cost
- Even high priority clinical areas are knocked back
- There is variation of support for external courses across the Area Health Service
- Community Health seems to have less access to courses than the Hospitals
- We need to attend course for best practice, specialist support and to develop common clinical pathways
- Access to external courses is limited by the cost unless I can afford to pay
- We are constantly told there are no funds to access courses outside our AHS
- When budget gets tight we get the veto from cluster management
- We get time off but no dollars
- AHS not able to support anything. Finance Department rules
- We have been forced to raise our own funds."
- Insufficient funding to allow all staff in the Department to attend training
- I've got a mixed caseload and I can't dedicate my training dollars to paed
- I have a mixed caseload with an adult bias. Paediatric education is not particularly supported
- Access to education seems so much more limited now than before."
- 5 days leave per year with an allocation of \$50 - \$100 per person per year
- External courses are limited to 2.5 days per year."
- \$200 per person per year is not enough

### Supervision

- We would like greater support from the major Hospitals on a formal bases eg sharing the management of difficult cases
- We must make time for ourselves otherwise I don't think we can keep delivering the service we are at the moment
- There is not enough time or encouragement for clinical supervision
- We need Area wide paediatric in-services to support generalist clinicians
- We feel there is an inequity of access for PD across the Area
- We need better communication across the Area to maximise our resources
- Access to training...placed on a lower priority list behind waiting lists and treatment
- Access to supervision is very difficult and especially so as a lot of our staff are not very experienced
- As a sole clinician I feel the need for some sort of feedback. I often get problem cases that I really need help with
- Meetings are rotated around the Area and that means I sometimes face a round trip of 400-500kms
- I'm often rung because I am in a specialist position; however I am not paid or supported as a Supervisor
- Senior clinicians need more support for their own supervision

### Access to computers

- Parents are telling me what latest treatment they have found on the net. We are a laughing stock
- I shouldn't have to use my computer at home to access the net
- Access to computers, and good ones, is vital to my job
- Area not networked so email is useless in outreach areas
- Hard to get IT support-they spends all their time dealing with viruses
- FTEs and we share one old computer
- The internet is the future. Our service is still living in the past
- We experience considerable difficulty accessing computers...this really slows our clinical learning
- We have to seek out available computers and request their usage. Highly unsatisfactory. I am an educator and I don't even have access to the internet
- Access to the internet is very important with complex caseloads to check evidence. I don't have access to the net."

### Journals

- We have a library however they have no books on paediatrics...they don't order in journals and don't have journal resources on site
- Senior clinicians need more support for their own supervision

## Appendix 11 - References

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