KEY INFORMANT INTERVIEWS SUMMARY

Supporting the Transition of Allied Health Professionals to Remote & Rural Practice

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1. Participant Demography

A total of 25 qualitative interviews were undertaken. It was initially intended that the sample would be somewhat larger however saturation was reached by this point.

Interview participants included allied health clinicians at all career stages (student, recent graduate, clinician, senior clinician, discipline managers, allied health team leaders, and health service management), those working in workforce development and policy development and allied health academics.

Professional Background

Professional Background	Number
Dietetics	3
Health Promotion	2
Medical Radiation Science*	2
Occupational therapy	4
Optometry & Orthoptics	2
Orthotics and Prosthetics	1
Physiotherapy	5
Speech Pathology	4
Non-clinical workforce	2
Total Respondents	**25**

* Including: Diagnostic and Therapeutic Radiography, Nuclear Medicine and Sonography

State or Territory

State / Territory	Number
Northern Territory	4
Western Australia	6
South Australia	2
Victoria	5
Queensland	4
New South Wales	1
Tasmania	3
Total Respondents	**25**

Current Role

Current Role	Number
Student	1
Clinician	5
Senior Clinician	5
Workforce	4
AH Management roles	9
Academic	1
Total Respondents	**25**

Participants were identified either through the professional networks of the Steering Group, or were nominated by professional associations or peak bodies in response an emailed invitation to participate in the key informant process.

Interviews were conducted over the telephone and ran for between 40 and 90 minutes. Prior to the interview, participants were emailed an interview guide detailing the interview questions. At the completion of each interview, participants were emailed summary notes of the interview and invited to revise or add to the document.

A thematic analysis was undertaken to identify the key elements within each of the question areas. This summary document has been developed based on this analysis and will inform the development of a broader stakeholder survey.

2. Remote and rural practice and skills

Qu: How does allied health practice differ between remote, rural, and metropolitan settings?

Several difference between remote, rural, and metropolitan settings were identified. These included:

- Professional isolation
  - Reduced access to line management – often of different discipline or not onsite
  - Limited clinical supervision
  - Reduced access to peers within the same and other disciplines
  - Reduced access to resources (physical and staff)
  - Limited access to professional development and support. When available often involves travel and significant expense
  - Absence of specialist referral pathways
  - Often relatively inexperienced seniors

- Physical isolation: 'tyranny of distance' (particularly for outreach services and remote positions) long travel distances impacting both personal and professional experiences

- Self care
  - Social isolation - Adjustment to new community away from existing social networks
  - Less distinct professional / personal boundaries
  - Confidentiality
  - Work-life balance

- Specialist-generalist practice / Advanced Generalist
  - Increased scope of practice – within discipline practice and beyond
  - Diverse caseload and client base (socio-economic and condition diversity)
  - Increased responsibility

- Different models of service delivery
  - Outreach
  - Video Conferencing
  - Different settings of service delivery outside formal health service

- Primary Health Care service delivery
  - More holistic practice
  - Multi-disciplinary teams
  - 'Whole person' focus

- Cultural awareness (local, Indigenous and CALD)

- Specific rural workforce issues
  - Smaller number of allied health staff both within each discipline and within a health service
  - Recruitment and retention – recruitment often difficult
  - Limited, if any, access to allied health staff in the area who are available to cover short-term needs (leave, PD etc)

- Greater leadership and administrative responsibility
  - Supervision of students and allied health assistance
  - Prioritisation
  - Office based organisational load.

Participants rarely spoke about the difference between remote and rural unless prompted, instead clustering the two together. When prompted most considered all issues to be a continuum, increasing with remoteness.

Qu. What are the most challenging aspects of working in a remote and rural setting, especially when first commencing?

Participants identified several challenging elements of remote and rural practice. These included:

- Professional isolation
  - Being 'throw in the deep end'
  - Reduced access to line management – often of different discipline or not onsite
  - Limited clinical supervision
  - Reduced access to peers within the same and other disciplines
  - Reduced access to resources (physical and staff)
  - Limited access to PD and professional support – often involves travel and significant expense
  - Absence of specialist referral pathways

- Translating training (university or preceding clinical) into clinical practice

- Developing non-clinical skills not taught in University, including but not limited to:
  - Organisational skills
  - Leadership skills
  - Prioritisation
  - Technology use (eg Video conferencing facilities)
  - Developing professional networks – knowing who to contact

- Self care
  - Social isolation
  - Less distinct professional / personal boundaries
  - Confidentiality
  - Work-life balance

- Unrealistic expectation and poor preparation – not knowing what to expect
  - professional (case load, diverse practice, role)
  - community (accommodation, climate, isolation)

- Cultural awareness

- Other personal issues
  - Finding and securing suitable accommodation
  - Employment and schooling for partner/children.

Qu. What rural remote specific skills or competencies are necessary when starting in a rural or remote setting?

A large number of skills and capabilities were seen as necessary for staff commencing practice in a remote or rural setting, regardless of their specific remoteness of rurality.

- Highly develop professional skills (non-clinical)
- Highly developed foundation clinical skills
- Advanced communication skills (with a range of professionals at a range of levels)
- Highly developed capacity to establish and maintain networks (workplace, inter-sectorial, community, personal)
- Self care skills
  - Ability to define and maintain life-work boundaries
  - Resilience
  - Ability to define and maintain professional boundaries – confidentiality
  - Self management and regulation
- Problem solving , flexibility and innovation
- Capacity to work well within a diverse team
- Capacity to work independently / autonomously
- Willingness to become engaged in the community
- Openness to diversified practice (primary health, holistic approach)
- Strong cultural awareness and competence (Local, Indigenous and CALD)
- Resourceful
  - Seek resources, support and specialist referral pathway
  - Knowing when to 'ask for help'
  - Ability to access information
  - Ability to improvise
- Leadership / management skills
  - Team leadership
  - Administrative skills
  - Supervision skills (AHA, students)
  - Prioritisation
  - Time management
  - Strong awareness of own professional limitations
- High level IT skills – VC, TC, Microsoft Office products such as Outlook
- Survival skills
  - Emergency first aid
  - Safe driving and 4x4 skills, particularly in remote context.
  - Local knowledge (weather, geography, safe practice protocols)

While it was not considered necessary for new staff to possess all of these skills upon commencement, it was considered important that this skill development was rapid in order for staff to be successful.

3. Support and orientation

Qu. What are the support and orientation requirements for allied health professional entry to remote and rural practice?

Several orientation and support pathways were identified to facilitate the successful transition of staff to remote and rural practice. These included:

- Formal organisational orientation
  - Policy and procedure
  - Award and employment condition
  - Organisational hierarchy

- Formal site orientation
  - Existing staff
  - Role expectations
  - Existing resources
  - Site / community induction visits

- Community orientation
  - A local information pack about the community, including local information, health service information, and 'living in' the community information
  - Active engagement of new staff member into the community

- Clinical supervision

- Line management

- Mentoring (both professional and cultural and in both formal and informal capacity)

- 'Work buddy' support

- Work shadowing

- Early and ongoing feedback / performance review

- Ongoing professional development and review / learning program development

- Regular, formal meeting with line manager to support orientation and ongoing staff management (eg monthly supervision meetings)

- Cultural awareness training

- Checklists and guidelines
  - Orientation checklist
  - Health service directory, including regional , state, and metro specialist referral pathways
  - List of important professional contacts
  - List of important community contacts
  - Links to resources

- Networking opportunities (within the local health service, with non-local peers etc) eg. RRAHF.

- Appropriate financial support and appropriate remuneration
  - Accommodation support
  - Adequate professional development funding and support
  - Relocation assistance.

The orientation and support needs for new graduates and more experienced staff were seen to vary somewhat, dependent upon the practice experience of the more experienced staff member, and the rural

background or the new graduate. Overall: new graduates were seen to require a greater focus on the development of clinical and professional skills; all were seen to require networking and community orientation.

Key informants saw a role for health services and mangers, new staff and the community in the orientation and support process. These included:

What can staff do?

- Engage proactively in orientation process
- Seek orientation from managers
- Establish networks
- Take on shared responsibility for development (equal partnerships)
- Goal setting

What can employers do?

- Provide the above elements in/on? orientation
- Provide networking opportunities
- Encourage staff to engage in orientation process
- Recognise and encourage staff membership to relevant groups and organisations (SARRAH, Professional Ass.)
- Encourage professional development
- Recognise the limited experience of new graduates - 'do not expect them to know everything'

What can the community do?

- Provide networking opportunities such as 'meet and greet' sessions
- Provide community information and resources list

4. Website Content

Qu. SARRAH is currently developing a resource kit to support the transition of allied health professionals to remote and rural practice. What would you like to see included in the package?

Key informants identified several elements to be included in the SARRAH resource kit. These included:

- Access to resources around, or links to:
    - Professional and personal isolation
    - General rural and remote 'what to expect'
    - Relevant resources
    - Suggested networking avenues
    - Links to health service contact directories
    - Time management and prioritisation
    - Self care information – 'how to get by in a rural community' (join sporting clubs, establish networks, what is available)
    - Leadership / management resources
    - Cultural awareness and cross cultural communication skills
    - Supervision and communication
    - Self care and professional boundaries
- Resources for managers
    - Suggested orientation program checklist
    - Links to supervision guidelines
    - Links to resources to support orientation
- Suggested networking opportunities (contacts), generic first points of contact.