



Queensland Health

*Evaluation of the Queensland Health Allied Health Rural
Generalist Training Program (AHRGTP)*

Final report March 2015

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GLOSSARY OF TERMS / ACRONYMS AND ABBREVIATIONS

AHA	Allied Health Assistant
AHP	Allied Health Practitioner
AHPOQ	Allied Health Professions Office of Queensland
AHRGTP	Allied Health Rural Generalist Training Program
AHRT	Allied Health Rural Training
EOI	Expression of Interest
FTE	Full time equivalent
HHS	Hospital and Health Service
HP	Health Profession (HP3, HP4 HP5 – levels within the QH professions framework)
HREC	Human Research Ethics Committee
MoC	Model of Care
OT	Occupational therapist
PD	Professional development
QH	Queensland Health
SARRAH	Services for Rural and Remote Allied Health
VC	Video conferencing

EXECUTIVE SUMMARY

The Allied Health Rural Generalist Training Program (AHRGTP) was introduced by the Allied Health Professions' Office of Queensland (AHPOQ) (Department of Health, Queensland) in 2014. The initiative was funded through the disestablishment of the allied health rural scholarship scheme and a number of other, smaller allied health workforce programs.

The AHRGTP provided funding to Queensland Hospital and Health Services (HHS) to enable them to create a supernumerary allied health graduate role in a rural or remote health service. Funded teams implemented new services and / or role redesign using the additional workforce resource.

AHPOQ commissioned Southern Cross University to undertake a qualitative evaluation to examine the benefits of the AHRGTP and inform decision-making regarding post-trial continuation and / or changes to the initiative. This document reports the findings of that component of the evaluation. AHPOQ managed the internal evaluation of the program, including the capture of metrics and performance data which are reported separately.

Aims/objectives

The AHRGTP was established to address allied health rural generalist workforce and service development priorities of Queensland public health services. The specific aims of the AHRGTP were to:

- Increase employment opportunities for early career allied health professionals (AHPs) in rural and / or remote health services.
- Establish and evaluate a model for early career employment in rural and remote areas including training, development, and on-going support.
- Enhance opportunities for exposure to rural and / or remote service, incentivise rural and remote practice for early career professionals, and support sustainability of the rural and remote allied health workforce.
- Trial the development of rural and remote allied health generalist models of care (MoC) in AHRGTP sites which may include implementation or expansion of telehealth services or other forms of service re-design, and / or workforce re-design including delegation and skill sharing / trans-disciplinary practice.

Eleven positions were created, incorporating five different allied health professions across nine HHSs. Two positions were delayed or failed to recruit and required an amended implementation strategy.

METHODS

A mixed methods approach to the data collection was used which included review of available literature on the allied health rural generalist role, documentary analysis, in-depth stakeholder interviews, and an online survey of staff who work with the AHRGTP in each context. Data were analysed using inductive logic reasoning.

RESULTS

Data sources included 61 documents, 34 stakeholder interviews, and 16/22 online survey respondents (73% response rate).

The qualitative findings from the first 11 AHRGTP placements in this evaluation suggest that the AHRGTP was successful in achieving all of the program aims, at least to a certain extent, and has had several unexpected and unintended positive consequences beyond this. The program was deemed successful by the majority of interviewees and 100% of the survey participants described the AHRGTP as 'valuable and successful'. In the majority of cases, implementation of the initiative exceeded expectations.

The reasons that services chose to participate in the AHRGTP were so they could: create rural generalist practitioners, overcome barriers to recruitment and retention in rural areas, increase service capacity, and address specific gaps in service provision in rural and remote communities.

Each of the AHRGTP projects developed their MoC using one or more of the following activities:

1. Delegation (vertical task substitution) to allied health assistants (AHA) and other support workers or delivery of support functions by other practitioners (e.g. radiographers training licenced operators to perform x-rays);
2. Skill sharing (horizontal task substitution) between AHPs;
3. Service expansion using technology, including telehealth to deliver remote services, videoconferencing (VC) to deliver training, and use of integrated technology (e.g. iPads) to manage clinical notes and videoconferences;
4. Capacity building through expanded relationships, new partnerships and inter-professional teamwork. These relationships occurred at several levels, resulting in expanded, networked, external support and training opportunities for the services as well as the development of new local services.

In many cases, the AHRGTP was implemented using combinations of the above approaches. For example, four services increased service capacity by introducing telehealth services supported by delegated models to remote allied health assistants. HHSs were encouraged to align the workforce development plan for the AHRGTP incumbent to the requirements of the generalist service model of the team.

THE IMPACTS OF THE AHRGTP WERE:

1. The new role was seen as a 'disrupter' to the status quo. From a service perspective, the AHRGTP facilitated new discussions and enabled organisations to implement change.
2. Increased staff satisfaction by reducing personal stress, reducing extended periods of on-call or extended work hours, and increasing collaboration.
3. Reduced travel times for patients and staff, particularly through the use of increased outreach services delivered via telehealth.
4. Enhanced team and organisational training capacity by capitalising on the additional professional development (PD) time available to the incumbent and using this to provide training to the team.
5. Development of rural and remote practitioners by developing, in situ, a relevant skill set and support structures for new graduates.

6. Improved service integration by improving communication within and between multidisciplinary teams; enhanced referral and service pathways; and the creation of networks with regional and metropolitan services.
7. Increased service development opportunities due to the establishment of clearer data collection processes and the need for an explicit focus on service development in the projects.
8. Increased service capacity by providing more remote services (e.g. through telehealth), through new models of care (such as group services), and the use of AHAs.
9. Improved service quality, such as: increased continuity of care for patients; increased service access due to longer opening hours; increased multidisciplinary input to patient care.

KEY FINDINGS IN RELATION TO THE 2014 IMPLEMENTATION TO SUPPORT SUBSEQUENT DEVELOPMENT OF THE AHRGTP

The key findings from the evaluation to inform the ongoing development and implementation of the AHRGTP role are outlined below.

To optimise the implementation of the AHRGTP:

1. Recruitment to the role needs to be organised well in advance, tailored to specific professions and clearly communicate the goals of the AHRGTP;
2. Strong models of supervision and support are required at professional, clinical, and personal levels.

The following key operational issues need to be considered for the continued development of the AHRGTP:

3. Clearer communication of, and alliance between, the strategic goals of allied health rural generalist roles and the goals and activities of the work teams;
4. Clarification of the rural generalist training pathway, including the clinical and non-clinical service capabilities required for the role;
5. Optimising the program length to maximise outcomes. Most participants recommended two year appointments for the AHRGTP incumbent to support a longer development program and continuity of staffing;
6. Greater support for the scoping and development of the service development projects including access to project management, evaluation skills and data collection resources, encompassing appropriate outcomes to capture the impact of the program supported by data collection and reporting systems;
7. Optimising the benefits of the AHRGTP through facilitated handover and supporting future employment opportunities.

CONCLUSIONS

The AHRGTP was a successful strategy for addressing challenges associated with recruitment and retention of rural and remote allied health practitioners. Moreover, this initiative revealed that a structured, high quality training and support model for new graduates linked to a service development project can add significant value well beyond the additional clinical capacity created by the new role.

New graduates in these roles built capacity in terms of training support and development for the whole team, fostered integrated inter-professional relationships and established networks to benefit the wider service.

This trial has demonstrated that well developed rural and remote positions can be established as sought after roles for graduate AHPs. The roles and frameworks established through this initiative have formed a foundation for further work on the development of rural generalist service and workforce models for selected AHPs.

The AHRG role is a complex concept which was implemented rapidly through this program, and the requirements of teams evolved and expanded in the early stages of implementation. Consequently, the way that the services understood, interpreted and implemented the AHRGTP model was inconsistent and often lacked clarity. An improved description and general agreement regarding a framework for allied health rural generalism is required to progress the initiative. Additionally, the initiative needs to be supported by a clearly articulated rural generalist training pathway which incorporates clinical and non-clinical skills. This project also has wider implications for the training of AHPs (role evolution), and support for new graduates generally.

RECOMMENDATIONS

RECOMMENDATION 1: CLARIFY AND CLEARLY ARTICULATE A RURAL ALLIED HEALTH GENERALIST TRAINING FRAMEWORK TO PARTICIPATING SERVICES

RECOMMENDATION 2: FACILITATE EARLY RECRUITMENT AND PROFESSION-SPECIFIC MARKETING OF AHRGTP POSITIONS

That the AHRGTP is clearly marketed, well in advance of student graduation so that potential applicants understand that these are clearly differentiated roles that reflect the specific structure and purpose of allied health rural generalist model of care. Incumbents who understood the goals and benefits of the program had a clearer understanding of the expectations and were better able to capitalise on the opportunities provided. Alumni could be used to advertise and market the program to their own, and other professions. Early recruitment also allows incumbents to plan their PD early in the program.

RECOMMENDATION 3: DESIGN RURAL GENERALIST SERVICE DEVELOPMENT PROJECTS THAT ARE TIGHTLY FOCUSED, WELL SCOPED AND REALISTIC

That the projects linked to the roles have a tight focus, are well scoped and realistic with basic data collection systems in place to support the data requirements for the project. Specifically, projects should include one or more of the following components:

- Delegation (vertical task substitution) to AHA and other support workers or delivery of support functions by other practitioners (e.g. radiographers training other licenced practitioners to perform x-rays);
- Expanded scope, including skill sharing (horizontal task substitution) between AHPs;
- Service expansion using technology: including telehealth to deliver remote services, VC to deliver training; and use of integrated technology (e.g. iPads) to manage clinical notes and VC;
- Capacity building through expanded relationships, clinical partnerships and inter-professional team work.

RECOMMENDATION 4: DISTINCT SUPPORT AND GOVERNANCE STRUCTURES FOR THE AHRGTP ARE IMPLEMENTED AND MONITORED BY THE HHS SPONSOR AND STAKEHOLDERS, AND BY THE FUNDING PROVIDER

That the processes required to support the AHRGTP are reported to the funding provider and implemented by the host service from the commencement of the role. Specifically:

- Professional, clinical, and personal/pastoral support networks for the incumbent;
- The lines of accountability (including formal supervision and line management);
- The financial and administrative accountabilities are made clear and accessible to AHRGTP incumbents to limit the barriers to accessing PD;
- A formal governance process for service development projects is defined in the implementation plan and monitored by the HHS sponsor and funding provider;
- A formal handover to the new incumbent is implemented by sites where possible, to create mechanisms to build capacity from the additional learning by the incumbent.

RECOMMENDATION 5: ALIGN THE LENGTH OF THE AHRGTP WITH THE GOALS OF INCREASING EXPOSURE TO RURAL PRACTICE WHILE OPTIMISING CAPACITY BUILDING

Review the length of the AHRGTP to optimise exposure to rural practice while capturing the capacity created by the roles. The 12 month training time, and the lack of in-built handover, limits the opportunities to capture the capacity created by the incumbents. A review of the training times needs to consider the transition to practice of the new graduate, the change management implications of implementing and embedding new service developments, opportunities to capture and cascade (such as mentorship) the skills developed in and by the incumbent, and the return on investment to the service arising from their development of the incumbent.

RECOMMENDATION 6: ESTABLISH A FORMAL TRAINING PATHWAY THAT OUTLINES THE KEY SKILLS AND PATHWAYS REQUIRED FOR RURAL PRACTICE

A need was identified for a formal training pathway to support the AHRGTP and the incumbents coming into the graduate positions. Such training would need to include profession-specific and inter-professional clinical training. In addition, we identified a number of non-profession specific capabilities which are outlined below:

- a. Delegation skills: The ability to delegate tasks to AHAs or others. In particular, training in the use of the Calderdale Framework.
- b. Training skills: The ability to break down activities into tasks that an AHA can perform in an outreach setting and be clear about the expected outcomes.
- c. Cultural competence: Particularly if implementing services in Aboriginal and Torres Strait Islander communities.
- d. Telehealth systems training: Including the ability to develop, implement and apply telehealth technologies and clinical service models.
- e. Evaluation skills: To be able to evaluate the new service or change in service.
- f. Project management skills.
- g. Skills assessing population health needs.

- h. Health system orientation: To understand health system organisation and structures to be able to negotiate the system and know how to broker change.

Agreement on a common framework for allied health rural generalist skills and compatibilities is required in order to formalise training requirements across clinical and non-clinical domains for relevant professions.

1. INTRODUCTION

Health workforce shortages and maldistribution are well documented in rural and remote areas (Pashen, Murray et al. 2007). Rural and remote communities experience a disproportionate burden of illness, yet have much poorer access to and variety of health services. These disparities are attributed to a range of factors, including geographic isolation, socioeconomic disadvantage, shortages of health care providers, inaccessible health services, and increased risk of injury.

Inequities in the health workforce distribution also apply to allied health professionals (AHPs). More AHPs per capita work in metropolitan areas compared with rural settings (Keane, Smith et al. 2008). In part, this is because smaller populations cannot sustain a wide range of speciality services. However rural areas also face difficulties attracting and retaining allied health staff even in areas of need. Additionally, lack of access to or availability of services can mean that they “fall off the radar” of referring practitioners, so referrals may not be made to appropriate services (Kingston, Judd et al. 2014).

Rural clinical practice requires a different, and often broader skill-set in contrast to work in metropolitan areas (Nielsen 2014, Quilty, Valler et al. 2014). Another necessity of rural practice is a greater reliance on teamwork and multi-disciplinary practice (Smith, Brown et al. 2009). It is well established that inter-professional practice enhances safety and quality of care (Zwarenstein, Goldman et al. 2009) and rural practice is particularly well placed to afford opportunities for inter-professional practice and skill sharing (McNair, Stone et al. 2005, Smith, Brown et al. 2009, Nielsen 2014). The challenges faced by rural areas mean that they often incubate innovative service delivery models (Larkins, Panzera et al. 2014). There is some evidence that having practitioners with generalist skills can improve health service efficiency in rural areas, including reduced length of stay reduced admissions and reduced inter-hospital transfers (Quilty, Valler et al. 2014).

The Australian Primary Health Care Research Institute commissioned a systematic review of the role of the rural generalist in Australia (Pashen, Murray et al. 2007). This review focussed purely on the medical profession, but identified issues that are relevant to the whole health workforce, including greater difficulties recruiting and retaining staff; less access to training; longer working hours and difficulties obtaining backfill and locum support.

Another recent review explored the factors that motivate retention and recruitment in rural and remote allied health professionals (Campbell, McAllister et al. 2012). This study included 35 international papers, capturing views from over 3000AHPs from across 16 allied health disciplines. The motivators were categorised into intrinsic and extrinsic, positive and negative factors, which are summarised in Table 1. The most common positive extrinsic incentives were rural lifestyle and diversity of caseload. The most commonly reported extrinsic factors with a negative influence on recruitment and retention were poor access to professional development (PD), professional isolation and insufficient supervision. Negative intrinsic incentives were reported less frequently than positive intrinsic incentives, but feeling overwhelmed and undervalued by the community were the most common.

Table 1: Factors that motivate rural and remote recruitment and retention in allied health professions

	<i>Intrinsic</i>	<i>Extrinsic</i>
Negative	Feeling overwhelmed Work not valued by community Lack of community acceptance Increased emotional exhaustion Lack of autonomy Fear of deskilling Decreased feelings of personal accomplishment	Lack of access to PD Insufficient supervision Lack of financial reward Large professional load Insufficient resources Long working hours Living costs Lack of personal space / time Lack of community knowledge about role Poor team culture
Positive	Autonomy Community connectedness Challenge Teamwork Desire to work in an area of need Fast-track career Extend professional role Client relationships Feeling valued Community trust Flexibility	Rural lifestyle Diversity of caseload Cross cultural environment Sound financial reward Multidisciplinary team Family nearby

Adapted from (Campbell, McAllister, & Eley, 2012).

Exposure to rural practice has been shown to increase recruitment and retention in rural areas (Laven and Wilkinson 2003, Walters, Prideaux et al. 2011). However, evidence of the effectiveness of rural clinical placements on future rural practice intent is more sparse in the AHPs (Playford, Larson et al. 2006).

A recent review of supervision, support, and mentoring interventions for health practitioners in rural and remote contexts (Moran, Coyle et al. 2014) distilled the following mechanisms associated with successful retention outcomes:

- Active involvement of all stakeholders
- Organisational commitment to the role
- Access to training, skills or knowledge for the specific human resources intervention
- A needs analysis prior to the implementation
- External support for the role
- Regular feedback and evaluation opportunities
- Marketing the programs
- Having access to appropriate resources
- Networking and relations

The quality of the data to inform this review was relatively weak; however the authors concluded that programs that incorporated these factors had better recruitment and retention outcomes.

These data suggest that the rural context provides an opportunity for innovative and potentially rewarding prospects for health professionals to meet community needs. However the context also presents a number of challenges that can compromise realisation of these outcomes if a supportive environment, appropriate supervision and adequate resources are not provided. In under-resourced environments, support for the role is often neglected. The Queensland Health AHRGTP aimed to overcome several of these challenges.

1.1. THE QUEENSLAND HEALTH ALLIED HEALTH RURAL GENERALIST TRAINING PROGRAM

Prior to the introduction of the AHRGTP Queensland Health (QH) administered a small number of rural scholarship programs. The main program was the *Queensland Rural and Remote Scholarship Scheme*, which bonded undergraduate students to rural employment within Queensland Hospital and Health Services (HHS): The AHPs component of this scheme commenced in 1996. The overall program faced several challenges including its management being very labour intensive and expensive, and difficulties sourcing an adequate number of vacant rural or remote positions appropriate for a new graduate in which the scholarship holder could complete the return of service period. One indicator of the lack of success of the scheme was the need to place a number of scholarship holders in metropolitan regions. At the same time there were changes in the profile of the workforce and requirements for training. From the late 1990s to the early 2000s, there was a shift from a shortage of students to a shortage of employment opportunities for new graduates in rural and remote services. This suggested that the scholarship 'product' was not working as a workforce sustainability tool. QH reviewed their organisational approach to workforce sustainability, and in response, repurposed funding from the scholarship scheme and several smaller rural and remote initiatives in order to introduce the AHRGTP.

Implementation of the initiative received high level support, with sign off from the Director General and sponsorship of the Chief Allied Health Officer. The new initiative was presented at a state-wide meeting of Directors of Allied Health where unanimous and strong support was shown. The rural and remote allied health team leaders and Directors of Allied Health provided feedback on the implementation process including the processes of selecting the sites. The aims of the AHRGTP were to:

- Increase employment opportunities for early career AHPs in rural and/or remote health services.
- Establish and evaluate a model for early career employment in rural and remote areas which includes addressing requirements for training, development, and on-going support.
- Enhance opportunities for exposure to rural and/or remote service, incentivise rural and remote practice for early career professionals, and support sustainability of the rural and remote allied health workforce.
- Trial rural and remote allied health generalist model of care (MoC) in each AHRGTP site which may include implementation or expansion of telehealth services or other forms of service re-design, and / or workforce re-design including delegation and skill sharing / trans-disciplinary practice.

Funding allocation was designed to optimise the geographic spread and range of professions represented in the AHRGTP implementation in 2014. Queensland HHS submitted expressions of interest (EOI) to host a position through the AHRGTP in a rural or remote location. A merit-based selection process was used in which each service was required to demonstrate unmet needs and unmet service demand in their community. The

EOIs were then sorted to ensure even spread by geographical location and professions. To secure this funding, HHSs had to adhere to the following five criteria:

Criteria 1: Position

The applicant service/HHS will undertake to create and maintain on establishment 1 FTE (full time equivalent) Health Professions (HP) 3.1 AHRT (Allied Health Rural Training) position. This position is to be filled by a graduate on a temporary basis and each incumbent may remain in the position for a maximum of 12 months. Beyond these requirements, the service can develop a proposed model to meet local requirements.

Criteria 2: Location

The HP 3.1 AHRT position will be located and provide services to rural and/or remote location/s of Queensland. Rural is defined as Category A locations, and remote as Category B locations as per Attachment 4 Human Resources Policy C15.

Criteria 3: Clinical governance

The rural/remote facility/work unit in which the AHRT position is to work has an existing position of the same profession.

Criteria 4: Service

The rural or remote work unit has adequate unmet service demand to warrant an increase in establishment for that profession.

Criteria 5: Training and Support

The AHRT positions have a mandatory focus on education and training, including quarantined time for engagement in development activities such as in-services, independent learning, professional support, clinical placements, and training courses/conference attendance. The training component of the position is notionally 0.2 FTE (Allied Health Professions' Office of Queensland 2013).

The EOI process resulted in selection of 11 positions across nine HHSs in the latter part of 2013. Nine of 11 positions commenced between January and March 2014, with the remaining two experiencing delayed or failed recruitment processes and requiring an amended implementation strategy. One of these positions was filled in September 2014 and the other position remained unfilled, with the funding being repurposed to support the HHS to achieve the service development objectives listed in their local site implementation plan. The trial phase of the implementation of the AHRGTP will conclude on 30 June 2015 with the completion of a review of 2014 outcomes and benefits realisation assessment. This will guide decision-making regarding post-trial phase continuation and/or changes to the initiative.

2. METHOD

This evaluation of the AHRGTP consisted of two parts:

1. A qualitative evaluation of the 2014 cohort of the AHRGTP to guide decision-making relating to the post-trial continuation/changes to the initiative.
2. Development of a comprehensive evaluation framework for assessing the ongoing effectiveness of continuing the implementation of the AHRGTP across all sites within QH.

This report presents the result of the qualitative evaluation. The evaluation framework was presented as a separate project deliverable.

Due to the heterogeneity of the positions within the overall AHRGTP, and their drivers, the methodology chosen for the study was inductive logic reasoning (Blamey and Mackenzie 2007, Baxter, Killoran et al. 2010, Nancarrow, Roots et al. 2013). Inductive logic reasoning incorporates the principles of realistic evaluation (Pawson and Tilley 1997) and theories of change (Aspen Institute 2003) and examines what intervention works for whom and under what circumstances.

The objective of the evaluation was to investigate the benefits realised for QH by exploring the following questions relating to the AHRGTP:

1. What were the background, drivers, local approaches, and barriers / facilitators for the implementation of these positions?
2. What strategies were successful in implementing these positions?
3. What is the value of these positions?
4. What impacts and outcomes are associated with the positions?

A mixed methods approach to the data collection was used. This included available literature on the AHRGTP, documentary data specific to the initiative provided by Allied Health Professions Office of Queensland (AHPOQ), stakeholder interviews, and a brief online survey.

2.1. DOCUMENTARY DATA FROM THE PROGRAM

Documents relating to the development and implementation of the AHRGTP were examined to address the following questions:

1. What were the background and drivers for the development and implementation of the AHRGTP?
2. What local initiatives / approaches were used to guide the development of the AHRGTP?
3. What perceived barriers / risks existed for the implementation of the AHRGTP?
4. What were the perceived facilitators of the implementation of the AHRGTP?

2.2. INTERVIEWS

In-depth interviews were undertaken with purposively sampled stakeholders involved in the implementation of the AHRGTP. These stakeholders were individuals who were directly associated with the 11 positions created under the AHRGTP. They included the early career professionals employed into an AHRGTP (referred to as the 'incumbent' in this report), their professional and operational managers, and others directly involved in the initiative at the State and local level.

The interviews took place between October 2014 and January 2015 and were conducted by telephone and recorded (with permission), but not transcribed. Detailed interview notes were entered contemporaneously into a question-based structured template and analysed thematically.

2.3. E-SURVEY

The interview data was augmented by an online Qualtrics™ survey tool to capture the perspectives of staff who work with, or whose roles were impacted by, a position introduced through the AHRGTP in each context. Participants were professional peers of the incumbent. AHPOQ provided a contact list of relevant stakeholders for the distribution of the E-survey. The survey was distributed at the same time the interviews were being conducted. The survey remained open for four weeks during which time two reminder notices were sent to the potential participants.

The survey focussed on:

- Perceived benefits, challenges, and barriers associated with the AHRGTP
- Strategies that were successful in the implementation of the positions
- General perceptions of the value of the position/initiative
- Impacts and outputs associated with the positions
- Recommendations related to the local implementation of service development activities in sites participating in the AHRGTP
- Recommendations for changes to the overall AHRGTP
- Suggestions for the further development and sustainability of the AHRGTP

The survey and interview questions are provided in Appendix A.

The data were extracted, organised, and analysed using components of a logic model to identify drivers, contexts, mechanisms (facilitators and barriers), outputs, and outcomes to tell the emerging story of the implementation of the AHRGTP. The learning from the synthesis of these components was then consolidated in a logic model and used to provide recommendations to guide the continuation/modifications for the implementation of future years of the AHRGTP and develop an evaluation framework to capture the ongoing effectiveness of initiative. The evaluation framework was submitted in a separate report as an output of the project.

2.4. PROJECT GOVERNANCE

This evaluation received ethical approvals from the Human Research Ethics Committee (HREC), Southern Cross University, Approval Number ECN-14-218, and Gold Coast HHS HREC, Approval Number HREC/14/QGC/168. In accordance with the requirements of QH, Site Specific Approvals were obtained from each HHS where positions involved in the AHRGTP were located.

The project was overseen by a project manager and fortnightly meetings were held with the project team and a representative of AHPOQ. The project was also overseen by a project steering committee which had the following membership:

External Members:

Dr Scott Davis, Greater Northern Australia Regional Training Network

Tanya Lehmann, Services for Australian Rural and Remote Allied Health

Fiona McKenzie-Lewis, Queensland Health

Rachel McCullagh, Queensland Health

Julie Hulcombe, Queensland Health

Ilsa Nielsen, Queensland Health

The committee met twice throughout the project.

3. RESULTS

3.1. RESPONSE RATES

3.1.1. DOCUMENTS

Sixty one documents relating to the AHRGTP were provided by AHPOQ. These included the background to the initiative, EOI provided by the nine HHSs where the 11 positions were located, subsequent implementation plans and reports, and meeting documentation.

3.1.2. INTERVIEWS AND SURVEYS

Interviews were conducted with 34 stakeholders. The online survey was distributed to 22 recipients, 16 responded (73% response rate). Table 2 summarises the roles and geographic locations of stakeholders who were interviewed / surveyed.

3.2. SYNTHESIS AND ANALYSIS OF THE FINDINGS

3.2.1. DESCRIPTION AND CONTEXT OF ROLES

Eleven positions under the AHRGTP were funded in nine HHSs. Of these 11 positions, nine had quick and successful recruitment, one took more than six months to be filled, and one remained vacant in 2014. The professions associated with these positions were:

Physiotherapy	4 positions
Radiography	3 positions (2/3 positions had difficult or failed recruitment)
Dietitian	2 positions
Occupational Therapy	1 position
Pharmacist	1 position

Table 3 outlines the initial roles and expectations of each of the positions, based on their initial EOIs and implementation plans.

Table 2: Stakeholders interviewed or surveyed by geographical location and position

	<i>Interviewed</i>	<i>Invited to participate in Survey</i>	<i>AHRGTP Incumbents</i>	<i>State / HHS Executive Member</i>	<i>Professional Manager *</i>	<i>Operational Manager *</i>	<i>Local Supervisor *</i>	<i>Other – Project Officer, Research Officer, Clinical Educator, Allied Health Assistant, Professional Colleague, etc.</i>
Cairns & Hinterland	6	5	2	1	2	2	2	2
Torres & Cape	2	2	1	1	1	1	1	1
Central Queensland	4	1	1	1	1	1	1	0
Central West	1	0	0	0	1	1	1	0
Darling Downs	7	6	2	1	2	2	2	4
Mackay	3	2	1	1	1	1	1	1
North West	2	0	1	1	0	0	0	0
South West	4	3	1	2	1	1	1	2
Wide Bay	3	3	1	1	1	1	1	1
State Level	2	0	0	1	0	0	0	1

* In some locations the same individual occupied more than one of these roles concurrently

Table 3: AHRGTP locations and initial expectations for positions (extracted from HHS EOIs and implementation plans)

1.	<p><i>Wide Bay HHS – Physiotherapy</i></p> <p>Focus – Based in Gayndah with service to 5 rural locations</p> <ul style="list-style-type: none">• Pre/post op care in rural locations (hub & spoke model from Gayndah)• Slow stream rehab for aged care/long stay residents <p>Expected outputs</p> <ul style="list-style-type: none">• Workforce – reduced waitlists in all categories of physiotherapy clients, expanded inpatient services• Service delivery – introduction/expansion telehealth and group clinics
2.	<p><i>South West HHS – Physiotherapy</i></p> <p>Focus – Based in St George with service to 3 smaller rural towns</p> <ul style="list-style-type: none">• Healthy ageing/pain clinic• Inpatient service for chronic obstructive pulmonary disease, cerebral vascular accident <p>Expected outputs</p> <ul style="list-style-type: none">• Workforce – expanded inpatient services,• Service delivery – introduction/expansion telehealth, increase Emergency Room presence, introduction of AHA MoC
3.	<p><i>Darling Downs HHS – Physiotherapy</i></p> <p>Focus – Based in Kingaroy with service to 4 smaller communities</p> <ul style="list-style-type: none">• Waitlist problems - exceeds appropriate timeframes, population increasing, low levels of private insurance, low social-economic profile of communities• Higher population than state average of aged people and large Indigenous community <p>Expected outputs</p> <ul style="list-style-type: none">• Workforce –reduced length of stay for rehab clients, increased occasions of service, decreased waitlists• Service delivery – commence pulmonary rehab services, increased use of telehealth, delegation model to AHA
4.	<p><i>Cairns and Hinterland HHS – Physiotherapy</i></p> <p>Focus – Based in Innisfail, predominantly hospital-based with some outreach to 2 communities</p> <ul style="list-style-type: none">• Has been no increase in FTEs for 61 years• Waitlist exceeds appropriate timeframes, population increasing, low levels of private insurance, low socio-economic profile of communities• Aged care/Indigenous community <p>Expected outputs</p> <ul style="list-style-type: none">• Workforce – increased occasions of service (inpatient/outpatient), increased access, decreased waitlists• Service delivery – development of delegation model to AHA

5. *North West HHS – Dietetics*

Focus – Based in Mt Isa – was initially proposed as an Indigenous focused position, focus changed after recruitment

- Acute/sub-acute service delivery in hospital
- More service to rural communities
- Priority areas – chronic disease, diabetes, cancer, renal

Expected outputs

- Workforce – increased occasions of service (inpatient/outpatient), increased access, decreased waitlists
- Service delivery – implement *Queensland Health Nutrition Standards for Meals and Menus*, increase service delivery in women’s and child health stream, improve cultural competency for AHPs

6. *Cairns and Hinterland HHS – Dietetics*

Focus – Based in Atherton – outreach to 4 centres (no increase in number of FTEs for 20 years)

- In patient/outpatient services
- Home visits
- Food service responsibilities
- Priority areas – Aboriginal and Torres Strait Islander populations, aged care

Expected outputs

- Workforce – increased occasions of service (inpatient/outpatient), increased access, decreased outpatient waitlists
- Service delivery – implement model of inpatient dietetic services, development new MoC using telehealth

7. *Mackay HHS – Radiography/Sonography trainee*

Focus – 2 year program – incumbent a graduate radiographer, undertaking sonography training program - person to rotate with Mackay Base Hospital sonography trainee position (rotate every 3 months)

Expected outputs

- Workforce – produce 2 fully trained radiographer/sonographers with rural/regional experience
- Service delivery – provide increased radiographer services, allow for on-call service in rural location, increase use of tele-radiography, decrease waitlists, improved access to ultrasound, increased supervision/visits to hinterland x-ray operators

8. *Cape York HHS (now Torres and Cape HHS) – Radiography*

Focus – Based in Weipa – position unfilled > 6 months, filled in September 2014

- Meet operational requirements in Weipa,
- Provide outreach to radiographic operators in 4 communities
- Waitlist too long

Expected outputs

- Workforce – increased occasions of service (inpatient/outpatient), increased access, decreased waitlists
- Develop a training and supervision framework for x-ray operators in Cape York HHS

9. *Central West HHS – Radiography*

Focus – Based in Longreach – unsuccessful recruitment

- Increase access - position designed to allow senior radiographer to focus on service development

Expected outputs

- Workforce – increased access

Position never filled – funding used to backfill current HP5 radiographer/sonographer position to release local staff to assist with meeting service improvements and x-ray operator support.

10. *Darling Downs HHS – Occupational Therapy (OT)*

Focus – Based in Chinchilla – outreach to 5 centres

- In patient/outpatient services
- Development of shared competencies with physiotherapy/nursing for assessing patients (cognitive assessments, gross motor assessment, activities of daily living assessments)

Expected outputs

- Workforce – maintain current services while releasing current staff to develop new models of care
- Service delivery – release HP4 staff from clinical duties to increase their ability to conduct whole service cluster evaluation and planning focused on more efficient ways to deliver current services. Expected that by the end of 12 month period all western cluster OTs will be able to implement the developed models to better meet service demands.

11. *Central Queensland HHS – Pharmacy*

Focus – Based in Emerald with service to a number of other smaller satellite hospitals

- Develop and implement a suitable skill development plan for new MoC to increase medication reviews and delegation to rural AHA in satellite hospitals

Expected outputs

- Workforce – increased medication reviews
- Service delivery – develop delegation model to pharmacy AHA, development of telepharmacy, pharmacy drop-in services, and in-house medication packaging service for rural hospitals

The data arising from the interviews and questionnaires are summarised in Table 4 and described below under the logic model headings of *Drivers*, *Contexts*, *Mechanisms* and *Outcomes*. Due to the small number of participants the quotes have not been labelled to maintain participant anonymity.

3.3. DRIVERS / RATIONALE FOR IMPLEMENTATION

The drivers for the implementation of the AHRGTP were to create rural generalist practitioners and overcome barriers to recruitment and retention in rural areas while at the same time meet service needs in rural communities.

3.3.1. TO CREATE RURAL PRACTITIONERS

A key driver for this initiative was QH's need for practitioners who possess a broad range of skills relevant to practice in rural and remote settings. The AHRGTP was designed to assist new graduates to acquire these skills in a focused program in the rural context.

They need to learn the skills and techniques that they will require when they are working on their own in a rural location.

3.3.2. PROMOTE RURAL RECRUITMENT AND RETENTION

Other drivers included the perception that staff who train in a rural area are more likely to stay in a rural area.

Hopefully it will result in better retention of staff, and also more experienced staff members, which greatly benefit our team, especially in the sole practitioner roles.

I believe that if new graduates come to rural settings and have opportunities, such as increased levels of professional support and professional development opportunities, that will enhance their clinical practice and they will be more likely to consider staying within the rural sector and -/or promote rural positions to their peers.

The new positions also provided an opportunity for services to attract staff to a rural area and to fill vacancies. For example, one service only had a part-time position available, which they could not fill. They used the AHRGTP to offer a full-time position.

Table 4: AHRGTP logic model

<i>Drivers</i>	<i>Contexts</i>	<i>Mechanisms</i>	<i>Outcomes</i>
<i>Rationale for undertaking the intervention</i>	<i>External factors that influence the expected results</i>	<i>Triggers for behaviour change</i>	<i>Changes arising from the intervention</i>
Create rural practitioners	Recognising the additional administrative requirements of the AHRGTP	Timely and informative recruitment approaches	Increased staff satisfaction
Meet service needs	Optimising the program length to maximise outcomes	Generic and clinical competencies that support rural generalist practice and service development	Reduced travel time
Promote rural recruitment and retention	Working within networked support structures	Supervision and support at professional, clinical and personal levels	Building team and organisational capacity
	Engagement of key stakeholders	Personal attributes	Developing rural and remote APHs
	Minimise disruptions caused by job vacancies and turnover in key support posts	Capturing the benefits of the AHRGTP through facilitated handovers and by supporting future employment opportunities	Improved service integration
	Access to appropriate and adequate resources	Supportive team and organisational structures	Increased service capacity and quality
	Access to project management, evaluation skills and data collection resources	Expanding capacity through the use of allied health assistants	System disrupter and enabler of change
	Contexts to support the new role	Expanding outreach through technology	
	Practical support for living in a rural / remote area		
	Protected PD time		
	Recognising interdisciplinary differences and needs		
	Contexts to support service development		
	Focus on a specific, clearly defined project that emphasises service development		
	Creating service pathways to access allied health where there have been no services		

3.3.3. TO MEET SERVICE NEEDS

Another important driver for the implementation of the new roles was to increase service capacity and address gaps in service provision. HHSs welcomed the access to additional funding for services as it enabled them to meet strategic priorities and fill service gaps. In some locations, teams were able to use this funding to provide services that had not previously been accessible locally to community members.

These people are not used to having a service at all. It [demonstrated] that having a service is of benefit to them, instead of making do with nothing. If you're only there once every six months, it doesn't turn into anything.

There were several examples of regions that have been underserved by allied health for long periods. For instance, some sites involved in the AHRGTP had access to only one sole practice role in the profession for more than two decades. Another site reported that they had not experienced an increase in staffing in the relevant profession and rural location for several decades despite escalating population and service demands.

Specific service goals included a desire to increase service provision, reduce waiting lists, and enhance the capacity of existing staff by freeing their time. Some services identified specific service needs, in particular to:

- a) increase access to sonography,
- b) introduce or expand telehealth
- c) provide outreach services (in one case the expansion of outreach services was necessary for hospitals to achieve accreditation),
- d) improve service provision to local hospitals,
- e) prevent hospital admission by increasing services in emergency departments,
- f) improve patient continuity and follow-up,
- g) increase the geographic spread of specific services,
- h) facilitate earlier supported discharge home for patients using telehealth support,
- i) develop a rural generalist MoC, and
- j) implement formalised delegation processes (some using the Calderdale Framework).

3.4. OUTCOMES AND IMPACTS OF THE AHRGTP

The AHRGTP was deemed successful by almost everyone who participated in the interviews. Every survey participant described the AHRGTP as 'valuable and successful'.

In the majority of cases, implementation of the AHRGTP exceeded expectations.

Our position has increased the focus on teaching and training, provided an extra FTE to help with the clinical workload on occasions, and lead to the recruitment and retention of a trained employee, as the incumbent will be employed at [location] in 2015. This has assisted with a ready-made competent new starting employee [the incumbent].

Yes – definitely, 140%. Really good, couldn't have asked for more.

The way that it's been undertaken is very thorough and we've had lots of support. It's enabling us to drive the reform agenda that we normally wouldn't have the resources to do and that will give us future leverage.

I think because rural positions, if they are part of a regional hospital, can tend to get swallowed up by that major hospital and they tend to take positions from rural. What this position, with the training pathway, has helped to do is make them realise how important it is to keep this service in rural.

An important impact of the introduction of this initiative was that the new role was seen as a 'disrupter' to the status quo.

It gave them [staff] permission to do things in different ways and gain new insights about ways to deliver services, allowed us to change the language and gave us the capacity to loosen some of the hard-wiring to increase some of the connections.

Let them challenge the existing paradigms they were operating within.

We are very fortunate in a rural environment to be able to explore different ideas and ways of doing things. It has been a positive disrupter. Because of the language it has created around the rural generalist and the opportunity for the expansion of scope, how they delegate, how they skill share, has been a success in itself ... it's the change in conversations that have helped to propel/cause the changes in practice. This is a new language. Having a rural generalist has helped this to happen. The change is much bigger than just the role.

3.4.1. INCREASED STAFF SATISFACTION

Several of the service delivery initiatives had a positive effect on exiting staff by reducing their personal stress, reducing on call commitments and extended service hours, and increasing job satisfaction. This was facilitated because it enabled existing staff to:

- work to their full scope of practice and edge into extended scope (e.g. HP5 staff in the team).
- *get things done - mostly administration, but it allows staff to work 'normal' hours.*
- have better rotations – *We used to have four month rotations three times a year, now we have three month rotations four times a year. Good for fatigue management.*

There's more collaboration. In the ward there are two of you. In outpatients there are more [professionals] there too – one person doing outpatients all the time and now someone doing it with you. You don't feel as isolated. You used to be on your own in each ward, inpatients, and outreach. Now we can talk about patients together. We have set times for case conferences. It has relieved some of the pressure – the pressure of workload is high and hard to keep up.

3.4.2. REDUCED TRAVEL TIME

The increased use of telehealth in sites prioritising this form of service change meant that staff and patients benefitted from reduced travel time, resulting in better use of time and less fatigue.

It now only takes a few minutes to have the [service provided] by the [professional] and sent by telehealth to the specialist and a decision made, instead of 6 to 8 hours driving, a nights accommodation in town, and you know, a couple of days disruption to their lives.

Patients don't have to travel for two and a half hours to access a service.

3.4.3. BUILDING TEAM AND ORGANISATIONAL TRAINING CAPACITY

Several sites used the AHRGTP role to increase training capacity for all of their staff. This included providing in-service training to other health professionals and learning about how to share roles. This was highlighted in the following quotes:

The presence of the incumbent has allowed the further development of telehealth and teaching/support to the [other professionals] in the [number] rural hospitals in the district. We are also instigating a standard approach to get standardise [approaches] and quality in all [services] across the district; this is very important for the [profession]. That is pretty exciting. We don't know of anywhere else that is doing this. The incumbent is working on this. The [other professionals] also don't feel so isolated anymore. Most of them are working in quite remote locations, and now they know they can have the incumbent as a support and they have fortnightly catch-up sessions where they can go over [services provided] or how to do something, or how to work the [profession specific] computer system.

In 2015 I will make it very clear about what some of the sharing of knowledge will be in the district: Sharing the skills and the PD from the role development.

3.4.4. DEVELOPING RURAL AND REMOTE PRACTITIONERS

This initiative provided incumbents with the opportunity to develop an interest in, and the skills set necessary for, a career pathway specific to rural and remote practitioners. The model allowed them to develop specific skills, establish support networks that they perceived will assist them in the future, and control their own PD through the additional protected time for PD. For those who were able to obtain a post-graduate qualification in rural and remote working “this is a privilege”.

The structure of the program provided support, supervision and training, and a reduced the sense of isolation, which resulted in incumbents understanding, valuing and succeeding in the rural environment. The model was described as:

Well-supported new graduate model where they were able to learn a lot through exposure to a wide variety of conditions.

The incumbents perceived that by the end of the program they were more highly skilled and more employable than other new graduates who were not on the program. Several indicated a desire to continue working in the rural setting.

The importance of this program in developing rural and remote practitioners was recognised by the majority of the people participating in the evaluation, not just the incumbents, and is highlighted in the quotes below:

I have been around forever; this is one of the first initiatives that I have seen that is addressing some of the isolation of rural areas and really trying to improve health care in rural areas.

In most rural hospitals you've got one [AHP] working on their own. In the bad old days, back a decade, we used to get these young people and put them out in 'training positions', as a sole provider and the training consisted of the fact that if you could survive out there and didn't go cuckoo then you were pretty good. Thankfully we don't do that anymore. So [this initiative] has allowed us to take younger people and co-locate them with a person with a bit more experience who is able to support them.

If the purpose of these positions is to recruit people to work in rural and remote locations, then it served its purpose because I want to stay working out here. When I finished uni I did not think I wanted to do this, but getting the job gave me the opportunity and then coming out here. Then there are the other things you don't hear about. That is the side outside of work; I think that needs to be promoted more, about the positive things

that come with living in a small town. People are very friendly and they become family when you are working so far away from home. That is one aspect of why I want to stay out here.

The incumbent is getting lots of clinical work that a new graduate wouldn't get without the supervision. The incumbent is professionally supporting [other members of the healthcare team]. It's a great opportunity, developing a skill set that a new graduate wouldn't normally have the opportunity to do. There are lots of great opportunities, for delegation and responsibility that you wouldn't normally have at that level as a new graduate.

We recently started a sub-acute rehab service at [location] hospital for CVA [cerebral vascular accident], brain injury, and step down. Then I might go to another town and see patients with pneumonia and chest infections. I've learnt a lot through being exposed to such a range of conditions.

Because we didn't have this opportunity before, we were actually training people in urban and regional hospitals before they go out to rural areas but the issues are different and the job's different and then they don't play well when they get out there.

Medicine has a rural career pathway developed for medical careers. What might this look like for AHPs? What next after the new grad experience in a rural community?

Part of this included enhanced skill sharing and inter-professional practice.

We are now also looking at skill sharing both within the discipline and with other disciplines, by using the Calderdale Framework. OT/Speech Pathology/Dietetics/Physiotherapy – this will be within the new clinics we will be implementing in January.

Role sharing (OT / physio), for example, a physio learning discharge planning from the OT.

3.4.5. IMPROVED SERVICE INTEGRATION

The networking facilitated by the new roles, as well as the service development initiatives, led to improved communication between multi-disciplinary teams, better relationships with other existing services, increased interdisciplinary referrals (e.g. speech and OT referrals for children), established new service pathways and reduced the perception of isolation of existing staff because the incumbent was moving in and out of the team/community. One service reported that the whole team had grown and developed because of the introduction of the position and the associated changes.

I'd not worked with [profession] before. I [would] just go to the [department] to borrow a set of scales, that's about it. But having them involved in our allied health team, they have become part of the AH [allied health] team. In other places where I've worked, [profession] seems to sit very much on their own, whereas what this has done is brought them into being part of the whole AH team. That's a big impact as well and having that understanding of other people's professions.

Working as part of a multidisciplinary team promoted structured professional support through job shadowing, sharing inpatient workloads, delivering multiple profession treatment sessions, enabling high quality handovers and supporting the delivery of seamless services. In addition, multidisciplinary teamwork provided opportunities for skill sharing and task delegation to assistants, the prioritisation of workloads, and cross-disciplinary support and understanding.

3.4.6. SERVICE DELIVERY

3.4.6.1. INCREASED SERVICE CAPACITY AND QUALITY

For the sites involved in the AHRGTP, the project requirement to trial the implementation or expansion of new / different forms of service delivery became an incentive to focus on improvements in service capacity and quality. The new forms of service delivery undertaken by the sites included telehealth, the use of AHAs, increased outreach services, and the promotion of skill sharing across professions. Increased planning for service delivery and the collection of data to demonstrate changes has also occurred. Overall this has resulted in enhanced service development opportunities, increased service capacity and opportunities to enhance quality. This was highlighted in the following quotes:

It allowed me to undertake a full review of these particular services for the area, not just in our location but the whole [region of HHS], and to put together another project that addressed [specific population] services in this specialty for the [region]. We redeveloped the way [specific population] services were delivered by [profession] and are now going to be working more closely with other related services that will be rolled out starting January 2015. It would not have been possible for me to do that if I had had to provide all the clinical services for the area. Because we have been able to step back and evaluate our existing services and figure out how to do them better, we have been able to increase our use of telehealth by three times in the first six months of the project. We have also been able to put in place data collection measures so we can determine if our services are doing what we need them to do, we have outcome measures now. None of this would have been possible without the new grad position.

We have improved our outreach time and services to outlying hospitals so not as many patients have to be transferred to the hospital here. We are now seeing patients in outlying hospitals twice a week, rather than once a week or once a fortnight. If we visited on a Tuesday and a patient was admitted on Wednesday, they'd have to wait to the following Tuesday to be seen by a [profession]. Now we're going twice a week.

The introduction of a telehealth model allowed the service to develop group clinics by gathering a critical mass of participants with similar conditions, so they could run regularly scheduled clinics for [specific conditions].

They also have time now for the advance allied health assistants so that they can see people for us in the community. They can help with category 2 and category 3 waitlists. In time, she [AHA] can do more for us and see some of the flow-through rehab patients. They are the two achievements from this year. From an administration point of view, we have more non-patient time, more peace of mind, research time to look at what we are doing in ED [emergency department] and the wards. For example, should we be doing groups sessions to prevent admissions? We seem to have thousands of COPD [Chronic Obstructive Pulmonary Disease] patients. Can we cut back on the number of admissions by offering outpatients style programs so they don't have to come into the ward as much?

However, in some situations the training and support requirements of the initiative resulted in reduced service capacity in the short term.

Because the incumbent [practitioner] examinations take up to twice as long to complete, therefore the number of appointments daily has reduced.

Quality improvements driven by the AHRGTP included:

- Medication safety initiatives
- Ability to provide on-call service for x-rays on the weekend which had previously not been possible with a single operator

- Improved continuity of care for patients. In some cases having the incumbent meant that services could stay open when staff went on leave (when previously, they would have had to close the service)
- Improved quality of the patient experience. For example, introducing a dietitian to contribute to the gestational diabetes groups, and the ability to provide new services (e.g. to rural chemotherapy patients) which weren't previously available

When I started there were lots of things we should have done but didn't. For example, we didn't do a risk screen before a home visit. It's a no brainer. Now we have a fortnightly meeting, with all the [professionals] in the area, to make sure we're all doing the same thing.

Although most services experienced reduced waiting lists over the implementation period, some services did not. In some cases it was reported that waiting lists increased initially because more time was needed to support AHAs as part of the implementation of a delegated practice model. In other settings the reconfigured services meant that the complexity of the patients increased and more time was spent with patients, so the capacity increased but the actual waitlist did not.

3.5. CONTEXTS TO SUPPORT THE AHRGTP

The contexts are the external factors that may influence the expected results.

3.5.1. RECOGNISING THE ADDITIONAL ADMINISTRATIVE REQUIREMENTS OF THE AHRGTP

The new roles, and the conditions attached to the roles, created some unintended additional administrative burden including: altering work schedules to accommodate the incumbent's PD requirements; completion of paperwork necessary to obtain the approvals for this training; complying with internal systems necessary to obtain approvals; and in highly competitive posts, recruitment processes. One physiotherapy position received 78 applications, creating a large recruitment workload.

The amount of paperwork and approvals for one person has been massive -for 0.2 PD lots of extra paperwork to get permission and approval for so many different activities.

The way our health service is set up is that the cost centre control doesn't live with the (local team) or my team leader position. It sits with the person above us just to get things signed. If you're going to an executive director, you need to book an appointment with the executive director to get them to sign a form.

3.5.2. WORKING WITHIN NETWORKED SUPPORT STRUCTURES

Several sites and professions reported that the introduction of the AHRGTP appears to have both created, and been supported by, the development of a range of networks. These networks were larger than the local area and were formed through liaison with large metropolitan hospitals, rotations with other new graduates, and links via videoconferencing to a journal club at the metropolitan hospital. The incumbents valued these networks and felt they were supported by the strong personal connections they were able to make with new graduates in the metropolitan areas. These networks created opportunities to share information/learning across other new graduate positions. Some services were able to achieve economies of scale by combining projects and networks across their region. This was both facilitated by AHPOQ, and through smaller, local networks.

We need to share the resources. They have limited resources. This is an amazing initiative; they can get more out of it.

The networks created by the AHRGTP benefited the whole service, not just the incumbent, by breaking down some traditional geographic barriers, and creating relationships that supported the whole team and patient flow.

Each of the AHRGTP roles developed differently, and the team structures and contexts varied for each role. This was very important to the success of each position and the overall initiative. As an example, one position introduced through the AHRGTP was developed to work within the cluster organisational model. Other roles were established to work closely and provide services with local doctors, therefore involved close collaboration with medical practitioners.

One service reported that having higher level organisational support (i.e. at allied health rather than profession level) led to a more integrated approach to the implementation of the role and a greater ability to learn more extensively from the findings across the service.

The structure of the team and organisation into which the AHRGTP roles were introduced was important to promote change, enhance PD opportunities, and provide further formal and informal supervision support structures.

The overall AHRGTP was centrally coordinated and supported by AHPOQ. This centralised, “realistic and flexible” support and overall project management by AHPOQ was valued by the supervisors, allied health leads, and the incumbents.

AHPOQ has been very honest about the unknowns, as well as being accommodating, understanding, and accepting of ‘fluid’ being acceptable – this has been very reassuring and supportive to achieving a good outcome that meets local need. It’s positive to have honest feedback that AHPOQ doesn’t know how specific things might unfold.

Other networking mechanisms introduced by AHPOQ included quarterly video conferences which enabled participants to share and learn from each other’s experiences. Overall the political environment at the time of implementing the AHRGTP was seen as being supportive.

There was significant HHS executive level support for new MoC, particularly in the delivery of rural and remote services.

The board is keen on providing services close to home so that patients don’t have to travel.

We had everyone in the canoe when we were going forward. It did challenge the paradigm, but everyone was paddling in the same direction. It wasn’t forced upon them so there wasn’t a lot of resistance.

3.5.3. ENGAGEMENT OF KEY STAKEHOLDERS

Effective implementation of the AHRGTP also required the full support and understanding of the new roles by key stakeholders at a number of levels of the local health care system

If you don’t have support from higher management it can make the job challenging for everyone and that’s even with the facility manager looking after the team at [rural location]. For example, if they don’t deal with the HR [human resources] issues or the dirty bathroom in the (staff) accommodation then that has an impact on my team.

Without this understanding and engagement in relation to the expectations of the position, misinformation could threaten or damage the effectiveness of the new role.

At one point the fact that we hadn’t shared either verbally or in writing what the position was about to the facility manager – even the main base at [name] Hospital, it was just seen as, “Oh now you’ve got a second [profession] and so you can just do all this stuff. Why aren’t you on the wards?” I had to sit in a meeting and tell everyone, “Actually this position is not an extra [professional] at your disposal. This position is here to train and

do special programs in A and B [outlying centres] and that's what they're being utilised for so please don't expect them to do extra work for your hospital". So we hadn't really set the boundaries around that position to make them safe and so those were the barriers that came up.

In addition, those directly involved in approving training and PD activities needed to understand the role.

The barriers were up the chain, with managers who didn't know about the position. It was not helped by having three different supervisors (during the implementation period).

3.5.4. MINIMISE DISRUPTIONS CAUSED BY JOB VACANCIES AND TURNOVER IN KEY SUPPORT POSTS

Disruptions to staff in any key positions required to support the AHRGTP had a substantial impact on the incumbent as well as the associated service development projects. Several sites reported turnover of supervisory staff, which interrupted continuity of the role and impacted on project implementation. In one site, the manager who had developed the AHRGTP role had left by the time the incumbent arrived, so the new acting manager had to re-create the support structures for the position. At another site, staff turnover caused challenges with supervision and support.

I have had three supervisors this year. With the current supervisor I get weekly supervision, so that is really good, but prior to that it has definitely been challenging. I have used the mentors within the program [across different regional and metropolitan locations/centres] – I set this up myself because of the need for assistance and support, but it has definitely been challenging with the lack of supervision here. There have been periods where I have been the only clinician in my profession at the hospital because of lack of staff.

I was supervised by lots of people. That was confusing. The local supervisor who was there on the day I started had less hospital training than I did, but we dragged ourselves through it. She was from a different discipline.

High turnover, or an inability to fill assistant positions that were associated with the AHRGTP role, impacted on the capacity of the new role. Conversely, in one service, an injection of resources increased the number of new graduates in the team, which substantially increased the capacity of and support for the incumbent.

3.5.5. ACCESS TO APPROPRIATE AND ADEQUATE RESOURCES

In some cases the incumbent reported a lack of resources necessary to support their role, including:

- Access to research resources (journals)
- Vehicles to get to communities/locations they needed to visit
- Insufficient equipment such as laptops when trying to implement new services
- Office/clinical treatment space.

3.5.6. ACCESS TO PROJECT MANAGEMENT, EVALUATION SKILLS AND DATA COLLECTION RESOURCES

Some teams benefitted from access to support with project planning, evaluation, and data collection, while teams without these resources identified them as barriers to ongoing monitoring and reporting.

A number of sites had difficulty accessing the information they required for reporting or to monitor progress of their program and also lacked administrative support to help with data collection.

We would love to be able to quantify how many people have been able to be served in the local community because of this person, but we have not done this so far and have not been able to figure out what we would do to get this statistic, though we know it is increasing the number of people who do not have to travel. A lot of the evidence is anecdotal.

Teams that had access to research fellows found them invaluable in terms of establishing the scope of the project, framework for evaluation, approaches for data collection, and then producing a report documenting the success or otherwise of the new service development.

The practitioners are not used to doing research so this was very important for helping to establish and evaluate the research project.

3.5.7. OPTIMISING THE PROGRAM LENGTH TO MAXIMISE OUTCOMES

There was some debate about the optimal length of the AHRGTP role. This was compounded by the fact that this was the first year of the new model and a great deal of effort was needed to establish each new role and the overall project. Most sites identified that they had invested substantial resources to develop the role, resulting in a significant amount of service disruption, for a position that they could only expect to last 12 months. Other challenges with the project timeframe were trying to achieve a great deal of change in a short time and acknowledging the time it takes for the incumbent to become established.

It takes six months for the incumbent to find her feet.

The high levels of training and PD embedded within the role meant that the incumbent was often away for blocks of time (e.g. one to two weeks). This was often on an inconsistent pattern and required reconfiguring service delivery clinics, making planning difficult.

Many, but not all, of the respondents supported the extension of the program to two years.

The implementation of the position has gone as planned. One year would have been enough if we had known more about what we trying to do at the beginning, but having the flexibility to have the 2nd year has been so good. From the rural generalist point of view one year is definitely enough.

There would be great value in extending this position to a two year, not a 12 month period. There has been great development, but you need another 12 months to see that growth, where you have a strong rural clinician at the end of it. It doesn't happen in a 12 month period – they need this time to find their feet, feel confident.

I know the funding came over from rural scholarship holding. I've supervised six of those in [profession]. I can compare their learning curve - there would be great value in extending this position to a two year, not a 12 month period. There has been great development, but you need another 12 [months] to see that growth, where you have a strong rural clinician at the end of it. It doesn't happen in a 12[month] period – they need this time to find their feet, feel confident. It's not there fully.

Had a similar initiative in the Northern Territory. They decided they would make it a two year program instead of one year. It was excellent – in year one a lot of the PD and settling in occurred. In year two, it was building capacity and giving back – it ticked off so many more boxes, it was a mutual thing. Not that 12 months isn't beneficial, they need to make the most of it.

One supporter of the 12 month period for the AHRGTP highlighted that these positions create capacity for the whole of the system, not just for the local health service. From this perspective, having more practitioners going through the system was seen as beneficial. However, it was widely acknowledged that the process for capturing continuity or benefit of the AHRGTP roles has not been well established in a way that builds on the benefits of these roles in other areas.

Yes. I like the 12 months. You learn a little bit each time and the project itself changes over time. So make changes to the project each time but not necessarily to the position.

In addition, the short-term funding of posts created uncertainty about the duration of the program and associated service developments. Participants reported that if the role was to become a standard process it would make it easier to manage and finance it within the local health system.

It's the old story with Aboriginal programs. This one was funded for 12 months. The shortcoming is that there is no follow-up from our side. We've left them with a deficit.

3.6. CONTEXTS TO SUPPORT THE NEW ROLES

There were several contexts that specifically facilitated the support of the new role, as opposed to the service development projects. These are outlined below.

3.6.1. PRACTICAL SUPPORT FOR LIVING IN A RURAL / REMOTE AREA

While not unique to this project, the challenges of living in rural and remote areas were identified as a barrier for many of the incumbents. Specific issues that were identified included: (a) lack of access to accommodation, or substandard accommodation; (b) not wanting to live in the same town as patients (so they don't run into them); (c) difficulty getting 'home' regularly; (d) difficulties for partners to find employment in the same region; (e) lack of activities outside work; (f) cost of travel to access training if travel is required (especially flights out of rural areas); (g) cultural differences between the available service and the clients, particularly Aboriginal Health services, and the challenges of integrating mainstream services into those; and (h) relocation costs to a rural area.

Not all HHSs provided funding to cover relocation or accommodation, and the lack of access to accommodation and the high costs of relocation was a challenge for some incumbents. One service covered the relocation costs, and provided accommodation for the incumbent in the nursing quarters when she first arrived. This provided the benefits of social support, while allowing time to find accommodation, recognising that the incumbent can "have a life as well in the rural location".

The short term nature of the recruitment period for roles involved in the AHRGTP (12 months) was also considered an important feature for overcoming the challenges of the rural environment.

Main issue is a commitment issue. People don't know what they are getting into. Historically, they had lots of trouble recruiting – rural work puts them out of their comfort zone. Short term placements are good to give people a chance to decide if they want to stay.

3.6.2. PROTECTED PROFESSIONAL DEVELOPMENT TIME

The AHRGTP specified that 20 per cent of the incumbent's working time should be protected for PD. Access to this protected time for PD was very attractive to all incumbents. However, not all the incumbents were aware of this benefit when they applied for the position. The PD also included funding which was used to attend conferences, pay for professional memberships and external training. In some cases PD was facilitated through access to a clinical educator or used to undertake specific training or certification.

For this particular position I chose a post grad certificate in rural and remote allied health, I wanted something that was going to be a university qualification, something they could put on their CV [curriculum vitae], that they could go away with—'Yes, I have been to this [rural/remote service] and I have been able to gain this qualification and I am coming away with this and personally richer, this is what you can get by working in an outback location'. I am not sure if that is the best course because they are new graduates and they want to consolidate their skills

set so they are really crying out for more clinical skill development. It would be fantastic if there was some kind of outback subject in their profession, working with low socio-economic people in poverty, or public health, but this was the best on offer.

The ability to pre-plan and structure PD was found to be valuable in several cases. Some services required the incumbent to establish clear goals for their training and formally document their PD. One respondent recommended establishing a PD plan and allocating resources prior to starting the role, to make the most use of these resources and ensure access to appropriate programs. In one service, where the role was introduced later than intended, the incumbent missed out on some PD opportunities due to lack of places.

Access to protected PD time meant that services were able to use the resources of the incumbent to perform important, non-clinical activities, such as gathering information from other services, and making personal contact with other services (e.g. kindergartens for early intervention programs). However, some of the incumbents reported difficulties protecting their PD time. In some cases this was due to other staffing shortages; in other instances it was due to the job structure as illustrated below.

There's usually only one other [appointee in my profession] at a site and there were very few days when we were both here. It was very hard to have the protected time.

Additionally, the structure of some of the training (such as metropolitan-based blocks of training) took the incumbents away from their community role intermittently for blocks of time. This introduced challenges for managing rosters and workloads.

3.6.3. PERSONAL ATTRIBUTES APPROPRIATE FOR AN AHRGTP ROLE

There were a number of personal attributes associated with the successful development of the role and implementation of the position. These included:

- Flexible, able to work well with both others and independently.
- Strong organisational and time management skills.
- Self-motivated, self-directed and with a reasonable level of confidence.
- Self-aware and an ability to self-care
- Understanding of the rural context and its personal and professional implications.

If the incumbent was still dependent and worked more within a student clinical supported model than as an independent practitioner, this required additional support to increase their confidence. The short-term nature of the role also meant that it was difficult for anyone who was not single, or had dependents, to consider applying.

3.6.4. CONTEXTS TO SUPPORT SERVICE DEVELOPMENT

In addition to the objective of developing a rural allied health generalist in a particular profession, the AHRGTP has the objective of improved service delivery for the community as a result of the one year position. Each position was expected to generate new service activities or initiatives. The following contexts are associated with the service delivery projects developed during the AHRGTP.

3.6.5. FOCUS ON A SPECIFIC, CLEARLY DEFINED PROJECT THAT EMPHASISES SERVICE DEVELOPMENT

Several managers and supervisors highlighted the importance of focussing on a specific, simple, and clearly defined project that was clearly linked to the new position, supported by a clear implementation plan from commencement.

Keep the project simple in terms of impacts and information needs. Don't try to take on the world.

Having a clear focus for each of the AHRGTP projects meant that they were designed with goals, outcomes, and impacts in mind. Implementing the new or changed activities created an obvious impact in many cases. This increased support for the AHRGTP.

It was also important to have a clear focus on service development, not just additional staffing capacity. Some HHSs were initially surprised by the extra conditions imposed on the funding (e.g. data collection); however, over time they found that this model extended the abilities of the team leaders and supervisors in terms of greater accountability for funding of new positions.

In some cases, the service development project was compromised due to a lack of clear focus or engagement. In one setting, a lack of consultation with, and engagement from, existing medical and nursing staff about the proposed changes was a barrier to implementing a new MoC. Another site reported that they had not considered the cultural issues of implementing services in Aboriginal sites. Some participants reported starting out over-ambitiously with what they were trying to achieve and then realised that having a single focus would be preferable.

We proposed four new models of care; we knew some would fall over because of other stakeholders being involved, not enough time to negotiate.

3.6.6. CREATING PATHWAYS TO ACCESS SERVICES IN AREAS WHERE THERE HAVE BEEN NO SERVICES FOR A LONG TIME

In some locations the introduction of the AHRGTP role and its associated service development activities created a demand for services that the community was not used to receiving, so part of the service development included communication about and creation of access pathways to ensure the optimal use of that position.

This position raised the profile of [profession], identifying, treating and monitoring patients and groups who would otherwise not have had access to this level of [professional] care. Establishing the telehealth service did this.

3.7. MECHANISMS THAT SUPPORTED IMPLEMENTATION OF THE AHRGTP

Mechanisms are the triggers for behaviour change within an intervention. In the context of the AHRGTP, the mechanisms are those factors that specifically supported the implementation of the new roles or service initiatives.

3.7.1. TIMELY AND INFORMATIVE RECRUITMENT APPROACHES

There were profession specific, and in some cases, regional differences in the approaches to advertising and recruitment for the AHRGTP positions. The different recruitment approaches influenced the number and quality of applicants, and their expectations and understanding of the positions. Important considerations in recruitment were the timing of the advertisement and the amount of information given about the position.

Physiotherapy has a state-wide centralised recruitment process, therefore services wanting to recruit physiotherapists needed to have their job description established in time to be included in this process. The state-wide recruitment process provided a great deal of information for the applicants and resulted in the successful incumbents being well informed about the position and its role, particularly in contrast with some of the other professions. One site delayed advertising for their position until January 2014, by which time most potential applicants had already taken positions. Ideally, the positions needed to be advertised by October / November 2013.

3.7.2. COMMUNICATION AND INTERPRETATION OF THE ALLIED HEALTH RURAL GENERALIST FRAMEWORK

The lack of clarity and understanding of the rural allied health generalist role was evident at several levels. For instance, a number of incumbents reported that they commenced the positions without a clear understanding of the role and its structure. One incumbent said she was unaware for a few months that she was part of a special training position. It was not until she realised she was receiving more training than other new graduates, who were not part of the program, that this became clear.

I think when they recruit they need to let the person know they are being recruited in the generalist training program and it is different to other HP3 positions and explain the details behind the position and the expectations, this should be at time of application. The five new graduate training positions in [profession] (three metropolitan and two regional/rural) were all advertised together: other than picking the preferred location they were all the same. It would have given me more insight into what I was getting into. I wanted to work in a rural setting, but it would have been good to know what a rural generalist training position meant as opposed to a Brisbane-based training position.

The need for clarity around the role description, and specifically the term ‘allied health rural generalist’, was also raised by incumbents, suggesting a lack of clarity of the allied health rural generalist role.

I think the wording of the role description should change. I felt overwhelmed. I wondered how I could ever learn all the OT skills and physio and speech skills.

3.7.3. CLINICAL AND NON-CLINICAL COMPETENCIES THAT SUPPORT RURAL GENERALIST PRACTICE AND SERVICE DEVELOPMENT

There were a range of clinical and non-clinical and profession-specific and inter-professional clinical skills which were necessary for the incumbent to perform their roles. In many cases, these were developed on the job, although in some cases (such as the ability to supervise AHAs), the incumbents had received some formal tuition through their professional training.

The non-clinical competencies identified by respondents that contributed to the development and implementation of the new AHRGTP roles were:

- a) Orientation to the QH organisation and structures
- b) Delegation skills: In particular, training in the use of the Calderdale Framework
- c) Training skills: Ability to break down activities into tasks that an AHA can do in an outreach setting and be clear about the expected outcomes
- d) Ability to supervise AHA
- e) Cultural issues/cultural competence, particularly if implementing services in Aboriginal and Torres Strait Islander communities
- f) Telehealth systems training: this should occur prior to starting the role if possible
- g) Evaluation skills: in order to be able to evaluate the new service or change in service
- h) Project management skills
- i) Skills assessing population health needs

In addition, the specific rural health modules developed by Services for Rural and Remote Allied Health (SARRAH) (National Rural and Remote Support Service) were valued by the incumbents who used them and created a mutually supportive framework for achieving the outcomes of both the AHRGTP and the SARRAH modules.

The generalist nature of the AHRGTP required the development of diverse clinical skills while providing the benefit of experiencing of different client groups and clinical areas.

I got to do a little bit of everything. Before starting the position I did not think that [rural area] was an area that I wanted to work in, but now I really enjoy it. The generalist idea is really good, it allows you to try different areas within your first year to allow you to know what you might want to do in the future.

It was recognised that a specific skill set and associated knowledge was required for this generalist role. This skill set needs to be defined and then educational programs developed to meet this need.

We've looked at the rural and remote generalist skill set – it would be good to see that [coming] from the AHPOQ level; that this might be for a rural physio, in a rural position... this is what we need them to develop as a graduate skill set. For instance is there opportunity for in-house training to simplify this process? For example, they have formal orthopaedic training, could they have formal rural 'generalist' training, to be a "rural generalist specialist"? They've identified what [knowledge and skills] they would like them to have; now they need for that training course to be provided in Queensland.

3.7.4. SUPERVISION AND SUPPORT AT PROFESSIONAL, CLINICAL AND PERSONAL LEVELS

The inclusion of structured, regular supervision as part of the AHRGTP was consistently reported as one of the most important facilitators for successful implementation of the role. Each position was supported in a slightly different way, but this generally included a blend of local supervision, professional mentorship (which was often accessed remotely and sometimes through the professional association), and localised peer support. Having access to high quality, local supervision by someone who understood the role was particularly important. The best supervision approaches recognised the need for both professional and personal support to prevent isolation.

A number of different models of supervision were used. These included work shadowing, clinical observation, and in many cases, VC to provide additional remote supervision. Despite the protected time set aside for supervision and PD within the AHRGTP, some incumbents undertook their supervision outside work hours. Respondents also reported that they found the supervision resources provided by the Cunningham Centre to be valuable.

Generally, the model of supervision was established by the service; however there were several examples where the incumbent initiated their own support. One incumbent had a high turnover of supervisors, so she set up her own mentors within the wider State-level professional program. Access to high quality supervision was a drawcard for applicants in roles that had been well advertised; this was particularly true for the physiotherapy roles. Incumbents also reported that they felt welcomed into their new environment because they were wanted and supported.

However, in other sites the increased level of support and training afforded to the AHRGTP incumbent caused some concerns, and regular meetings with other services stopped relatively early in the project, resulting in some reduced support.

A lot of the other HP3s were really jealous that she got to spend 20% time doing PD, and I was really forceful that she got that. I told the other HP3s that if they factored in 20% PD I would give it to them too if that meant they were going to stay, as the evidence shows that if you give them that they will stay longer. But they struggled with that because their bosses were not supportive, so there was peer jealousy or peer envy. The permanent HP3 in the team has inferior development and less time devoted to them than the temporary worker.

Access to personal support networks was important to the incumbents. As an example, in one region there were a number of new graduates working together, they were able to provide a great deal of support for each other. In another case, the incumbent had undertaken her student placement with the host organisation so was familiar to the team and the setting.

Some services highlighted that much of the additional service capacity created by the AHRGTP was absorbed by the need for more senior staff to supervise and support the role; although these participants acknowledged that this burden reduced the longer the incumbent was in the role.

There are days where I don't see any outpatients because of the supervision requirements.

Being a new graduate position, the orientation, support, and supervision in the first two to three months requires significant input from the senior clinician, which impacted on her clinical workload during that period of time. The ongoing supervision associated with the position allows at best for her clinical time to be 0.8 FTE. The same issues of orientation and starting professional practice will be repeated each year. There is a risk that the demands placed on the one senior [AHP] in the region supporting this new graduate position each year may be unsustainable over the long term.

A number of managers and supervisors identified the need for existing staff to have training in how to undertake clinical supervision of more junior staff. Without this background they felt they could not effectively take on this role.

In order to implement this position you need to be an educator as well. I have taught in this profession before and I have a teaching qualification. I have been a supervisor for [number] years, so I have the background to teach these students. I think that this is a requirement for this position; you have to be able to teach them [Incumbent] and understand when they are learning and how to help them learn.

3.7.5. CAPTURING THE BENEFITS OF THE AHRGTP THROUGH FACILITATED HANDOVERS AND BY SUPPORTING FUTURE EMPLOYMENT OPPORTUNITIES

Several respondents highlighted lost opportunities to capitalise on the new roles and learning from the incumbents at the end of the one year programme.

As this was the first year of the rural generalist role, there were few examples of handovers between the incumbent and new graduates. One challenge with handovers was the employment of locums to cover leave during the Christmas period, in the handover period between roles. One service overcame this by developing an orientation folder and providing the handover to the locum to then handover to the new incumbent.

Where the outgoing incumbent had taken another QH position, it was proposed that they consider having a face to face meeting with the new incumbent. Irrespective of variations in professions or working locations, some form of written handover, as a minimum, was seen as a benefit to the incoming incumbent.

Several respondents highlighted the lack of specific employment support for incumbents at the end of their one year post. For incumbents who wanted to stay in rural areas, greater support with career planning and job transitions should be implemented throughout their tenure in the AHRGT position.

The graduates feel a bit dropped at the end of the year. They are given no help with planning their future careers. It's just all about here and now and next year is up to you. They should have been offered opportunities Queensland-wide. If QH is serious about keeping them, they need to make it clear about other opportunities after the end of the year. They are very skilled.

There would be value in having other processes in place that are more likely to make the next employment step a rural one. For example, when a rural job comes up somewhere in Queensland, send an EOI to those services with a current new grad in a rural placement to match employers with early career professionals with rural experience.

The incentives are great and I'm now a convert [to rural practice] but no-one is saying this is what we can organise for you.

I think if its achievable, it would be great if these positions were considered to directly transfer at level to HP3 vacancies in rural sites across QH. It is a high investment and staff will actively start looking for positions in August / September / October each year to secure their future.

The AHRGTP 'alumni' are a valuable resource that could be drawn on to build capacity in the AHRGTP, both in the local service through a facilitated handover, and in their subsequent roles.

3.7.6. EXPANDING CAPACITY THROUGH THE USE OF ALLIED HEALTH ASSISTANTS (AHA)

Several of the AHRGTP roles were implemented in conjunction with and supported by an AHA. AHAs were often key staff members in the service development aspect of the initiative, particularly with the implementation of telehealth. Having access to AHAs also increased the capacity to implement change.

In several projects, the incumbent was introduced concurrently with a new AHA role or employee and provided the training and support for the AHA. One incumbent, who had completed an AHA module at university and had previously worked with AHAs, was confident in her ability to work with them. However, several other incumbents reported that supporting and training AHAs detracted from their own clinical delivery capacity and slowed down project implementation. In one instance, a lack of clarity of the responsibilities of the incumbent resulted in a lack of delegation to the AHA. Delays in recruiting AHAs delayed project implementation. However, in most cases, the use of AHAs ultimately increased service capacity.

3.7.7. EXPANDING OUTREACH THROUGH TECHNOLOGY

Several service development initiatives centred on technology, particularly through either the introduction or expansion of telehealth. The use of new technology was seen as both a barrier and facilitator to project success. Positive experiences with technology, as happened in one site where the relieving professional staff and older clients successfully used the technology first with very positive experiences, meant the site came on board quickly.

However, several other projects found technical challenges with the implementation of videoconferencing (VC) and telehealth services, including:

- Difficulties scheduling VC appointments due to the accessibility of practitioner and patients at the other end
- Ensuring the AHA / person at the end of the telehealth intervention has the appropriate clinical and / or telehealth equipment to undertake the consultation
- Technology issues / room bookings / technology dropping out

The development of new service activities using technology had some other challenges as well. These included the need to avoid conflicting dates with other services (e.g. Royal Flying Doctor Service) and insufficient staff with skills to use the telehealth equipment at remote locations. Another concern was communities and patients becoming used to accessing VC and then the service ceasing at the conclusion of the AHRGTP.

4. DISCUSSION

This evaluation has examined, qualitatively, findings from the first 11 AHRGTP placements. The evaluation was performed at the end of the first year of the initiative, so there were several 'teething' difficulties that are likely to be addressed in subsequent iterations of the program.

The evaluation identified several key operational findings that need to be considered for the continued development of the AHRGTP, specifically:

1. There is a need to clearly communicate the strategic goals of an allied health rural generalist role and align these with the activities of the work teams;
2. The role needs to be supported by a rural generalist training pathway, including the required clinical and non-clinical service capabilities;
3. The length of the program needs to be reviewed to maximise outcomes. Most participants recommended two year appointments for the AHRGTP incumbent to support a longer development program and continuity of staffing;
4. Teams required greater support for the scoping and development of the service development projects, including access to project management, evaluation skills and data collection resources;
5. There was scope to optimise the benefits of the AHRGTP through facilitated handover and supporting future employment opportunities.

The evaluation found that other factors required to optimise the implementation of the AHRGTP were the introduction of timely and profession-tailored recruitment approaches and implementation of the role alongside strong models of supervision and support at professional, clinical and personal levels.

The key drivers for organisations participating in the AHRGTP were to create rural practitioners, promote rural recruitment and retention, and to meet service needs. The external factors that influenced the results (contexts) included the engagement of key stakeholders; ensuring access to adequate resources; minimising disruptions due to job vacancies in key positions; ensuring access to project management, evaluation and data collection; and working within networked support structures. The results are summarised into the logic model presented in Table 4.

Contexts that specifically supported the new role were the provision of practical support for living in a rural and remote area; access to protected time for PD; recognising interdisciplinary needs and differences.

The contexts that specifically supported service development had a focus on a clearly defined project with an emphasis on service development, and being able to create appropriate pathways to access new services where they had not previously existed.

The mechanisms associated with the successful implementation of the AHRGTP included: (a) timely and informative recruitment approaches; (b) development of generic and clinical competencies that support rural generalist practice and service development; (c) supervision and support at professional, clinical, and personal levels; (d) personal attributes consistent with the short term nature of the rural placement; (e) capturing the benefits of the AHRGTP through facilitated handover and supporting future employment opportunities; (f) expanding capacity through the use of AHAs; and (g) expanding outreach through technology.

There were several outcomes of the AHRGTP for the incumbents, their colleagues, and the service. From a service perspective, the AHRGTP was seen as a system disrupter which facilitated new discussions and enabled organisations to implement change. This was an important unintended outcome of the project and highlights the wider impact that a well-structured and supported graduate placement program can have. Other outcomes included increased staff

satisfaction, reduced travel times, building team and organisational capacity, the development of rural and remote practitioners, improved service integration, and increased service capacity and quality.

The AHRGTP combined an innovative model of supported graduate placement with a service development project to achieve the following aims:

- a) Increase employment opportunities for early career AHPs in rural and/or remote health services.
- b) Establish and evaluate a model for early career employment in rural and remote areas which includes addressing requirements for training, development, and ongoing support.
- c) Enhance opportunities for exposure to rural and/or remote service, incentivise rural and remote practice for early career professionals, and support sustainability of the rural and remote allied health workforce.
- d) Trial the rural and remote allied health generalist MoC in each AHRGTP site which may include implementation or expansion of telehealth services or other forms of service re-design, and/or workforce re-design including delegation and skill sharing/trans-disciplinary practice.

This qualitative evaluation suggests that the AHRGTP was successful in achieving all of these aims to at least varying degrees:

- a) Increased employment opportunities

While it is difficult for this small evaluation to quantify increased employment opportunities resulting from the AHRGTP, the evidence in support of this aim includes:

- Creation of 11 supernumerary positions
- Creation of new roles and new service capacity where gaps previously existed
- High levels of graduate demand for the majority of the positions
- Development of infrastructure to support new graduate roles in rural and remote areas
- Increased awareness of the contribution of AHPs in rural areas

In addition, several of the new AHRGTP roles were supported by the introduction of AHA roles, which further increased the service capacity of AHPs in those areas.

- b) Establish a model for early career employment in rural and remote areas including addressing requirements for training, development and ongoing support

The model of graduate support provided by the AHRGTP could be seen to reflect best practice, in that it addresses all of the issues identified by Moran et al (Moran, Coyle et al. 2014) in their review of mechanisms to support rural and remote practitioners. These are summarised in Table 5.

Table 5: The AHRGTP as a model of rural and remote supervision and support

<i>Mechanism</i>	<i>How addressed in this project</i>	<i>Additional implications / possibilities</i>
Needs analysis	Services identified unmet clinical and service needs. Developed innovative approaches to addressing these using the new graduate.	Services need to develop a clear implementation plan.
Marketing	Ensuring recruitment accurately reflects the content of the role. Timely recruitment processes.	Draw on alumni to help market the program. Advertise these positions as sought after training roles. Development of rural competencies and specific recognition of the rural generalist role in the allied health professions
External support, facilitation and coordination	External coordination by AHPOQ, establishment of supervision and support networks.	
Access to adequate resources	Additional professional development training; provision of technology. Some barriers to accessing transport and some technology.	
Leadership	Leadership for the new roles exhibited at level of AHPOQ, but also within services.	
Networking and supportive relationship	Personal, professional and clinical relationships; establishment of wider networks.	
Organisational commitment	Higher level organisational commitment and stakeholder engagement increased networked support, access to PD.	
Access to training / skills knowledge to perform supervision and or mentoring	Delegation training Use of the Calderdale Framework. Benefits of training skills. Need for staff to have supervision skills.	Potential to use the expertise of the program 'graduates' to build further capacity and support.
Regular feedback and evaluation opportunities	Need for data collection processes to inform service delivery and innovation.	

- c) Enhance opportunities for exposure to rural and / or remote service, incentivise rural and remote practice for early career professionals, and support sustainability of the rural and remote allied health workforce

There was evidence from respondents at all levels across every site that the AHRGTP provided a basis for creating rural AHPs who gained exposure to a wide range of profession-specific and generic learning. To realise the full extent of this aim, improved description and articulation of a framework for rural generalist roles and service models for the AHPs is required. It was evident from the project findings that this idea is still in a relatively early phase of development and there is currently not a shared understanding of the concept of allied health rural generalist

practice. Further work is required to progress this. The majority of incumbents across the posts were positive about their experiences, one describing it as a ‘privilege’. The majority of incumbents expressed a desire to remain in rural practice.

The two interrelated limitations of the approach were the length of the initiative, and the support for its graduates. There was a great deal of discussion about the length of the program. The high level of investment in developing the roles in conjunction with the introduction of the service development projects meant that some services perceived they were not receiving a ‘return on investment’ within the 12 month period. Several participants suggested increasing the length of the program to two years. The advantages and disadvantages of the two approaches are summarised in Table 6 below, based on feedback from respondents.

Table 6: Advantages and disadvantages of a 12 and 24 month AHRGTP

	<i>Advantages</i>	<i>Disadvantages</i>
12 month	<ul style="list-style-type: none"> • Builds more rural graduates more quickly – system capacity building • New opportunities for service development every twelve months • Learn from mistakes 	<ul style="list-style-type: none"> • High investment in role development from the service perspective • Unrealised opportunities for service and practitioner development at the end of the 12 months • No time for consolidation of service development or practitioner development • Time lost due to introduction and orientation of the new graduate • Lack of continuity of role • In very underserved areas, one year is only just long enough to get the role established • Time consuming to orientate staff and get them started
24 month	<ul style="list-style-type: none"> • Longer time for the service to achieve return on investment • Ability to consolidate the service development changes and the practitioner • First year professional development, second year consolidation • The service would like to keep the incumbent longer to benefit from the investment 	<ul style="list-style-type: none"> • Fewer new graduates developed

While it is important to reflect on these options, several of the challenges of the shorter program were attributable to the time invested in establishing a new program, initial teething problems, and the lack of succession planning for the graduates. As much of the infrastructure to develop the new roles has already been established, several of the disadvantages are likely to be minimised in future programs.

Secondly, the issues of succession and continuity of the roles could be addressed by establishing a program / support for the ‘alumni’ of the program to help relocate them in rural areas, and to use the skills and knowledge they have developed to build capacity in other rural and remote services. Further, it may be appropriate to consider this program as a pathway for development for a recognised speciality as an ‘Allied Health Rural Generalist’, building on the competencies and framework described below.

- d) Trial the rural and remote generalist MOC

The heterogeneity of the AHRGTP projects meant that the rural and remote generalist MoC was applied differently at each site. As one of the first projects to truly test this approach in practice, important learning arose from the way projects interpreted and implemented the approach. A contribution of this project was a stronger understanding of the repertoire of competencies that could form the basis of a rural and remote generalist, and secondly, the activities that form the rural generalist role.

The projects identified the following range of non-clinical, service-related competencies that enabled the graduate to optimise service development opportunities in a rural and remote area:

- a) Delegation skills
- b) Training skills
- c) Cultural competence
- d) Telehealth systems competence
- e) Evaluation skills
- f) Project management skills
- g) Skills assessing population health needs
- h) Health system orientation

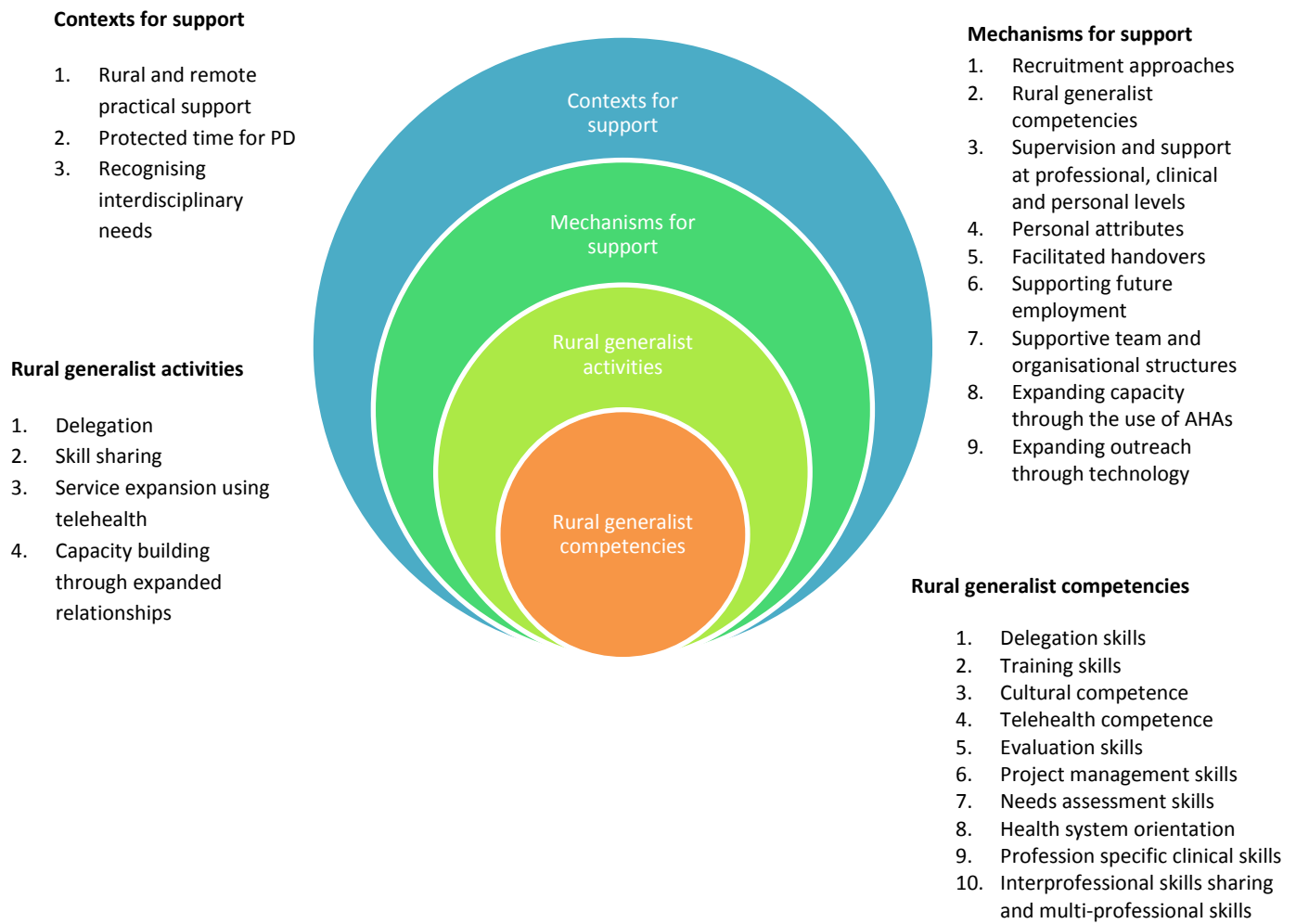
Development plans from each of the AHRGTP sites can contribute to the development of a clearer description of profession-specific and inter-professional clinical requirements for AHPs.

In addition, each of the AHRGTP projects applied the MoC using one or more of the following activities:

1. Delegation (vertical task substitution) to AHAs and other practitioners (e.g. radiographers training other licenced practitioners to perform x-rays);
2. Skill sharing (horizontal task substitution) between AHPs;
3. Service expansion using technology, including telehealth to deliver remote services; VC to deliver training; and use of integrated technology (e.g. iPads) to manage clinical notes and VC;
4. Capacity building through expanded relationships, new partnerships and inter-professional teamwork. These relationships occurred at several levels, resulting in expanded, networked, external support and training opportunities for the services as well as the development of new, local services.

Based on the findings above, and the contexts and mechanisms to support implementation, Figure 1 presents key components of a possible rural allied health generalist framework:

Figure 1: The key components of a possible rural allied health generalist framework



5. CONCLUSION

The AHRGTP specifically addressed most of the previously identified challenges associated with recruitment and retention of rural and remote AHPs. However these positions have done more than that. This initiative has shown that investing in the development of a high quality training and support model for early career professionals, that is linked to a service development project, can add significant benefits to the service, well beyond the additional service capacity created by the new role. There is learning here for the development and implementation of any new role.

The AHRGTP showed that a structured support program for new graduates can broker organisational change, for instance in the implementation of telehealth interventions and efficient use of AHAs. New graduates can build capacity in terms of training support and development for the whole team. The roles were also used to build relationships and establish networks (through their supervision relationships and through regional networking).

This project has implications, not only for the implementation of new rural and remote allied health roles, but for the training and role evolution of AHPs, and support for early career professionals generally.

A further point for consideration is the ongoing support of the incumbents. This project has shown that well developed rural and remote roles can be established as elite positions for AHPs. The roles and frameworks established through this project form a strong foundation for the development of the rural allied health generalist framework.

6. RECOMMENDATIONS

The recommendations arising from this project to promote effectiveness and sustainability for future programs are summarised as:

- Recommendation 1: Clarify and clearly articulate a rural allied health generalist training framework to participating services
- Recommendation 2: Facilitate early recruitment and clear marketing of positions
- Recommendation 3: Design rural generalist service development projects that are tightly focused, well scoped and realistic
- Recommendation 4: Operationalise the support processes required to support the role: distinct support and governance structures for the AHRGTP are implemented and monitored by the HHS sponsor and stakeholders, and by the funding provider
- Recommendation 5: Align the length of the AHRGTP with the goals of increasing exposure to rural practice while optimising capacity building
- Recommendation 6: Establish a formal training pathway that outlines the key skills and pathways required for rural practice

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APPENDIX A: QUEENSLAND HEALTH ALLIED HEALTH RURAL GENERALIST TRAINING POSITION: INTERVIEW AND SURVEY QUESTIONS

AHRGTP incumbents, Project Sponsors, Team Members:

1. Implementation of the AHRGTP position:

Briefly describe the model /approach you used to implement the AHRGTP in this site.

- Describe the profession chosen, and why this profession?
- Describe the location, and why this location?

What were the key drivers / rationale for the development / implementation of the AHRGTP in this location?

What factors have facilitated the implementation of the position?

What factors have been barriers to this implementation?

Did the implementation of the position go as planned or expected? If no, why not and what has differed?

What skills or resources have been required to implement the position?

What are the most important outcomes or impacts that have been achieved as a result of the implementation of the position?

Do you think the implementation of the position, and the initiative, have been successful?

Should this particular position be sustained in its current form? Please explain why or why not?

Should the overall RG training position initiative be sustained? Please explain why or why not?

2. Implementation of the service delivery strategies / projects associated with the AHRGTP :

Briefly describe the service developments or projects that have been associated with this position.

What were the key drivers / rationale for the development / implementation of these new services / projects?

What factors have been facilitators in these service developments?

What factors have been barriers to these service developments?

Have these service developments been implemented as planned or expected? If no, why not and what has differed?

What skills or resources, other than the AHRGTP, have been required to implement the service developments?

What are the most important outcomes or impacts that have been achieved as a result of these service developments?

Have there been any unintended outcomes, positive or negative?

Do you think these service developments have been successful?

Should these service developments be sustained?

Do you have any other comments you think may help our understanding of the outcomes or processes of implementing the AHRGTP (position or services developments) in your service.