

Queensland Health

**Rural and Remote Allied Health
Assistant Positions:
Evaluation of the development,
implementation and impacts in
Queensland Hospital and Health
Services**

Project Report

Rural and Remote Allied Health Assistant Positions: Evaluation of the development, implementation and impacts in Queensland Hospital and Health Services - Project Report

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For more information contact:

The Office of the Chief Allied Health Officer, Department of Health, Queensland Health, PO Box 2368, Fortitude Valley BC QLD 4006, email allied_health_advisory@health.qld.gov.au, phone (07) 3328 9298.

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Document authorship and history:

This report was prepared for Queensland Health by Kristine Battye Consulting Pty Ltd, P.O BOX 2428 Orange NSW 2800, manager@kbconsult.com.au.

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Summary

Allied health assistant (AHA) positions have been developed by health services in Queensland as a mechanism for improving access to allied health services in rural and remote communities.

AHAs work under the delegation of an allied health professional (AHP) and undertake a range of clinical and non-clinical tasks, delivering critical services to patients and enabling AHPs to focus on more complex clinical work. AHAs support the provision of allied health care delivered to individuals or through group sessions. They work in either a discipline specific (e.g., pharmacy assistant, podiatry assistant) or a multidisciplinary capacity.

In most Queensland Hospital and Health Services (HHS), the rural and remote allied health workforce is characterised by small, multi-professional teams located in rural or remote service hubs providing services across a large geographic area through outreach and telehealth. An AHA may be co-located with the allied health team or work in a satellite service facility, supported by supervision and task monitoring that is provided remotely (via telehealth), directly (during outreach visits) or in combination.

In recent years there has been a significant expansion in the number of AHA positions in rural and remote Queensland Health services. There is limited published information available to guide service leaders on the creation of these roles including workforce and service models, and impacts of rural and remote AHA positions.

Project Overview

The Office of the Chief Allied Health Officer (OACHO) engaged KBC Australia to undertake an analysis of the development and implementation of AHA roles in rural and remote HHSs and an investigation of their impact.

Method

A concurrent mixed methods evaluation was conducted between November 2021 and December 2022. Ethics approval was obtained through Darling Downs HHS Human Research Ethics Committee for the evaluation (HREC/2021/QTDD/78969). Site specific approvals (SSA) were obtained from nine HHSs.

Part 1 - Quantitative component to describe AHA workforce availability and allied health service activity trends. Data collected included a) retrospective AHA workforce and service data and b) point in time AHA and AHP survey data from the nine HHSs.

Five data sets were sourced from statewide data systems following approval of all relevant site specific assessment (SSA) applications:

- Queensland Health Decision Support System (DSS) payroll (de-identified):
 - Data set one: rural and remote allied health positions data 2014 – 2022
 - Data set two: rural and remote AHA position incumbent information (e.g., age, length of service, gender)
 - Data set three: longitudinal data for employees identified in data set two showing Queensland Health employment history (e.g., tenure, change in location / classification)

- Queensland Health Enterprise Reporting Service (QHERS) - Queensland Health non-Admitted Patient Data Collection:
 - Data set four: Service activity by location and mode
 - Data set five: Types of services provided by AHAs

Two online surveys were distributed via statewide and HHS allied health email distribution lists to all AHAs and AHPs in the nine HHSs in scope of the project. The AHA survey focussed on understanding the factors that influence their attraction and retention to the position and satisfaction in the role with consideration of training, supervision and recognition within the team. The AHP survey sought information on AHPs' understanding, experiences and views of working with AHAs.

Part 2 – Qualitative component involving a case study design to explore i) barriers and enablers to development, implementation, and impact of the AHA positions and ii) integration of AHA positions into the service model. Data collected consisted of interviews with AHAs, AHPs, managers, internal and external stakeholders, and consumers in five sites. Twenty-eight interviews were conducted via Microsoft Teams. Interview notes and reports were collated and thematically analysed site-by-site and then across sites to identify consistent and unique themes.

Data limitations

The project was conducted during the COVID-19 pandemic and as a result was hindered by several factors that limited the number of interviews conducted and reliability of survey data. The responses for the surveys were limited at 38 for the AHA survey and 66 for the AHP survey. Interviews were conducted with health service providers in five rural/remote communities. It is not possible to confidently extrapolate the findings to all other rural and remote settings; however several themes emerged consistently from the qualitative data indicating similarities across the study communities.

Results

Workforce Data

Growth in positions

In the eight-year period between July 2014 and April 2022, occupied full-time equivalent (FTE) staffing of AHA positions in Modified Monash Model (MMM) level 4 to 7 locations in Queensland (excluding locations in North West HHS that was out of scope for this project) have approximately doubled from 37.02 FTE to 75.11 FTE. The majority (72%) of these positions were multidisciplinary AHAs, 23% were pharmacy assistants and fewer than ten percent were other discipline-specific positions. Nearly half (48%) the AHA positions were in MMM4 locations.

Profile of AHA employment

Based on snapshot data at April 2022, the workforce is highly feminised (92%) and 42% are aged 50 years or older. More than half (53%) of the AHA workforce has been employed with Queensland Health for six or more years.

AHA survey respondents had a wide variety of backgrounds prior to becoming an AHA. Many AHA survey respondents have previously worked in the health industry and/or in aged or disability care. Others have worked in industries such as hospitality, retail and education.

Workforce turnover and retention

Results from longitudinal tracking of AHA employees in the payroll system demonstrates that in the nine rural and remote HHSs in the study the AHA workforce is relatively stable. Of the 57 AHAs employed in

these HHSs in January 2015, half (29) remained in Queensland Health employment seven years later. Overall, AHAs had a median length of service of 2.23 years in a rural or remote location.

Case Sites

A variety of AHA-supported models of care have emerged in rural and remote Queensland Health services. The five case sites in this study were purposively selected to reflect the diversity of AHA-supported service models and settings in which AHAs work. Two sites had AHAs based in small rural health facilities with visiting AHP services from a larger hub site. Two sites had co-located AHAs and AHPs with the teams also providing outreach services to other locations. The fifth site was a rehabilitation and recovery service providing multidisciplinary care to inpatients in an extended care unit and acute mental health unit in a regional centre, with a service footprint that included rural communities.

Factors supporting growth of AHA positions

Establishment of new positions has occurred predominantly through the allocation of short-term funding such as vacancy savings and/or workforce redesign within the team, although the study included examples of AHA positions created through growth funding and grant programs. Investment in AHA roles recognised the potential value of AHA-supported service models in rural and remote communities and the motivation of service leaders to trial new strategies to deliver care.

To some extent the growth in rural positions also mirrors the development of telehealth. Telehealth has enabled opportunities for providing allied health services where there is not a resident AHP workforce and strengthened delegation, task monitoring and supervision in AHA-delivered services.

Benefits of AHA-supported service models

Benefits for communities and individual patients of AHA-supported services identified by study participants included: improved access to a wider range of services; reduced travel time for patients to attend appointments in larger centres; the potential for earlier discharge from hospital through access to services closer to home; and familiarity with and consistency of the local allied health service provider.

Benefits for health services were identified by study participants as: increased allied health service capacity; improved efficiency enabling AHPs to focus on more complex clinical demands; maintaining service frequency when AHP outreach is limited (e.g., wet season) and/or during periods of vacancy (with delegation and supervision provided from larger centres); and the capacity to deliver greater service volume and frequency using telehealth through patient-end clinical support provided by the AHA.

Implementation challenges

Study participants identified several key challenges in the development and implementation of AHA-supported service models including: supervision and clinical governance where supervisors and AHAs are based in different locations; ensuring the currency of training in delegation practice for both AHAs and AHPs, particularly where there is a high turnover of AHPs and significant use of locum AHP workforce; and workload management for AHAs working in multidisciplinary models.

Implementation Enablers

Several common factors were identified across study sites that have enabled the implementation of AHA-supported models of care. Access to dedicated position funding has been advantageous for the development of new models, with recurrent funding facilitating the creation of permanent positions, which enables effective recruitment and retention.

Rural and remote services noted the benefits of recruiting AHAs from the local community due to their commitment to and understanding of those communities and the perceived likelihood of retention. For Queensland Health AHA positions at Clinical Assistant Level 3 (CA3) there is no mandatory qualification, allowing for open and flexible recruitment processes that emphasised transferable skills and attributes of the candidate. Attributes of successful AHAs were identified as compassion and empathy, interest in working with people, strong communication skills, and flexibility.

AHAs would generally be expected to undertake vocational training after commencing employment (unless they have previously completed the Certificate IV in Allied Health Assistance or other relevant qualification). In the case sites, a formal clinical supervision model for AHAs was found to provide additional educational support and facilitate on-the-job training to complement and reinforce course/qualification requirements.

Stakeholders identified that all participants in the service model need a clear understanding of the role of the AHA and the delegation model, as well as clinical and operational supervision arrangements. In models where AHAs are working remotely from their line managers and clinical supervisors, it is important for staff who are co-located with the AHA but external to the allied health team (e.g., nurses, doctors, operational staff) to be orientated to the role. A clearly documented delegation model assists this process.

The availability of education and training resources, such as Clinical Task Instructions and online delegation training package, developed centrally by Queensland Health has been crucial for rural and remote teams that lack the capacity to develop foundation resources internally. While training needs to be contextualised to individual sites, study participants noted the value and efficiency of organisation-wide resources.

As noted, study sites demonstrated that AHAs often work at different sites from their delegating AHPs and team leaders, either as their permanent base or on outreach. Study participants highlighted the importance of good communication and high levels of trust between AHAs and AHPs to support the effective and efficient functioning of dispersed teams. Further, it was noted that active fostering of relationships between remotely-located AHAs and their local colleagues in the multi-disciplinary team was important, as was regular face to face connection with their allied health team.

Conclusion

There has been significant growth in rural and remote AHA positions in Queensland Health since 2014. While the service models in which AHAs are working differ, factors contributing to the development and stability of AHA-supported service delivery in rural and remote communities were commonly found to include local recruitment, access to high quality education and training resources, and clearly defined and documented clinical governance and operational processes. Stakeholders identified that the AHA workforce supports the sustainability of allied health service delivery in rural and remote communities.

1 Introduction

1.1 Allied Health Assistants – an emerging workforce in rural and remote areas

Allied health assistant (AHA) positions have been developed by regional, rural and remote health services as a mechanism to improve access to allied health services in a range of service settings (National Rural Health Commissioner 2020). Working under the delegated authority of allied health professionals (Queensland Health 2017), allied health assistants undertake clinical activities and provide support functions for allied health teams in public and private settings. AHAs may work with a single allied health profession or multiple professions and may work across a range of setting e.g., hospital, aged care, community (Somerville, Davis et al. 2018, National Rural Health Commissioner 2020).

As part of the allied health team, the AHA role is guided by the needs of the service and community, and influenced by the purpose, scope and objectives of the health service (Schwarz, Ward et al. 2020, Cairns, Geia et al. 2021). The scope of the position is also influenced by the profession and skill mix of the allied health team. AHA functions include delivering clinical care prescribed by the allied health professional (e.g., therapy, interventions, administering standardised tests, providing standard patient education) and providing non-clinical support activities (e.g., maintenance of equipment/stock management) (Snowdon, Storr et al. 2020). AHAs who identify as Aboriginal and Torres Strait Islander may also be a cultural broker, most commonly in remote Aboriginal and Torres Strait Islander communities, taking a lead role in enabling a culturally safe space for both the service providers and the service recipients (Cairns, Geia et al. 2021).

Over the last decade, there has been considerable growth in the number of AHA positions implemented by rural and remote health services. Training for AHAs was formalised in the mid-late 2000s with the development of the Certificate III and IV in Allied Health Assistance (National Rural Health Commissioner 2020). AHA training generally includes the Certificate IV in Allied Health Assistance delivered by a Vocational Education and Training (VET) provider along with work-based experiential development and competency-based training (e.g., Clinical Task Instructions). AHAs' practice is supported by local delegation processes, including delegation instructions, task monitoring and reviews by delegating health professionals, and by clinical supervision that supports AHA capabilities and clinical quality (Queensland Health 2018). Historically, less attention has been given to the knowledge, skills, and training requirements of allied health professionals in relation to delegation practice (Stute, Hurwood et al. 2014, Brown, Fitzpatrick et al. 2020), but this is an increasing focus for healthcare organisations, such as the implementation of the Queensland Health *Training in Delegation Practices* online training program in 2022.

Currently in Australia AHAs are not a regulated workforce, and as such their role, scope of practice, delegation model, training requirements, allocation of AHA positions and career pathways have not been standardised across disciplines or private and public sectors (Stute, Hurwood et al. 2014, Somerville, Davis et al. 2015, Sarigiovannis, Jowett et al. 2020). Furthermore, there has only been preliminary evidence of the impact of AHA-supported services on the service recipients' experience of care (Gallego, Dew et al. 2018) and outcomes (Rushton, Edwards et al. 2021), or healthcare organisation outcomes (Hall, Maxwell et al. 2020, Schwarz, Ward et al. 2020) including cost-effectiveness (Sarigiovannis, Jowett et al. 2020; Snowdon, Storr et al. 2020).

1.2 Role of Allied Health Assistants in Queensland Health

The development of the AHA workforce in Queensland Health has been supported by the Allied Health Assistant Framework, originally published in 2015 (Queensland Health 2022). The framework aims to:

- support the development, implementation and evaluation of safe and effective delegation and optimise the effective use of the allied health assistant workforce in allied health services, and
- assist allied health assistants, allied health professionals and service managers to understand the roles and scope of practice of the allied health assistant workforce.

AHAs work under the delegation of allied health professionals (AHP) and undertake a range of clinical and non-clinical tasks that support the provision of services to clients and the community, and assist the team to achieve service targets and outcomes. AHAs can deliver delegated clinical activities to individuals or through group sessions.

In Queensland Health, AHA positions meet the definition of 'Clinical Assistant' in Schedule 5 of the Health Practitioners and Dental Officers (Queensland Health) Certified Agreement (No. 4) 2022. In summary, an AHA undertakes delegated clinical tasks related to the direct examination and/or treatment of patients, and/or health protection and promotion to the community that are within the professional scope of practice of allied health professions. Although there are more than 25 professions recognised in the 'allied health' grouping in Queensland Health, the following are the main professions located in rural and remote teams:

- Audiology
- Clinical measurement science
- Dietetics/nutrition
- Exercise physiology
- Occupational therapy
- Pharmacy
- Physiotherapy
- Podiatry
- Psychology
- Radiography and sonography
- Social work
- Speech pathology

AHAs work in either a profession-specific (e.g., physiotherapy assistant, pharmacy assistant) or multidisciplinary capacity. In most rural and remote HHSs, the allied health workforce is characterised by small, multi-professional teams located in rural or remote service hubs providing services across a large geographic area through outreach and telehealth. An AHA may be co-located with the team or work in a satellite service centre, supported by delegation, task monitoring and supervision that is provided remotely (via telehealth), directly (during outreach visits) or in combination. The development of some rural and remote AHA roles has established a resident allied health workforce in small communities that could not support a multi-professional allied health team. The aim has been to increase the range of allied health services available locally, improve the timeliness of allied health service provision, and increase service frequency to support clients and carers to implement therapeutic programs.

The majority of AHA roles in regional, rural, and remote health services are Clinical Assistant Level 3 (CA3) or Clinical Assistant Level 4 (CA4). Most CA3 roles provide a wide range of clinical and non-

clinical activities that support the allied health team. CA3 positions do not have a mandatory qualification, although a Certificate IV relevant to the role is desirable. CA4 roles have a mandatory Certificate IV qualification, and generally can undertake tasks with greater technical or procedural complexity than CA3 roles. There are a limited number of CA5 roles in regional or large rural services, which generally have operational management responsibilities for an AHA team.

The scope of AHA roles vary by service model/model of care, setting, the type of services delivered, the composition of the allied health team and other factors. Examples of AHA roles are outlined in the Queensland Health allied health assistant orientation workbook (2022) Table 1 (reproduced below).

Table 1. AHA roles / duties

Direct patient care	Indirect patient care
Implementing and facilitating therapy / treatment programs designed by professionals	Ordering stock
Assisting AHPs in the safe use of equipment	Assisting and coordinating services
Supporting and supervising clients with exercise programs – individually or in groups	Preparing and/or maintaining a safe clinical environment
Working with patients on treatment goals	Cleaning and maintenance of equipment
Assisting with mobility, gait, and transfers	Recording activities and service statistics
Gathering and documenting objective and subjective patient information for AHP assessment, diagnosis, care planning or evaluation of interventions	Maintaining records of work undertaken with patients
Provision, fitting, and training in the use of equipment	

Reference: Queensland Health, 2022a p5 (adapted from Victorian Department of Health, 2012)

1.3 Development of AHA positions in rural and remote hospital and health services

Queensland Health has invested in developing allied health teams in rural and remote areas. This has included the development of the Allied Health Rural Generalist Pathway and Allied Health Rural Generalist Training Positions that commenced in 2014 (Queensland Health, 2023). A key element of rural generalist practice is working with AHAs as a mechanism for service development and enhancement in rural and remote areas.

The strategic importance of the AHA roles for rural and remote service capacity is evidenced by Queensland Health's investment in governance and training resources and the transition of AHAs (Clinical Assistants) from the Operational Stream to the HPDO3 Certified Agreement 2019.

1.4 Training pathways

1.4.1 Allied Health Assistants (except Pharmacy Assistants)

The Certificate IV in Allied Health Assistance (Australian Government, 2022a) has been identified as the qualification best aligned to allied health assistant roles within Queensland Health. This qualification is designed for workers who provide therapeutic and program-related support to allied health professionals under direct, indirect, or remote supervision.

Candidates for the Certificate IV in Allied Health Assistance (HLT43015)¹ must complete seven core units and nine elective units. Core units are:

- Communicate and work in health or community services
- Work with diverse people
- Manage legal and ethical compliance
- Recognise health body systems
- Confirm physical health status
- Follow safe work practices for direct client care
- Interpret and apply medical terminology appropriately
- Candidates are also required to complete at least 120 hours of clinical placement.

AHAs can commence in CA3 roles in Queensland Health without having completed the Certificate IV in Allied Health Assistance but most health services expect and support AHAs to commence / continue training following appointment.

The My Skills website (Australian Government) listed 18 training providers in Queensland at October 2022 that offered the Certificate IV in Allied Health Assistance (HLT43015). However, stakeholders engaged through this project suggested that fewer training providers actively offer the program, and providers take the program on and off scope frequently. Stakeholder feedback also indicated that the capacity of training providers to provide high quality education for remote learners varies. The national average course fee was \$638 - \$17,040, with funding programs available to some learners.

1.4.2 Pharmacy Assistants

When this project was undertaken in 2021/22, pharmacy assistants in Queensland Health often possessed a Certificate III or IV in Hospital/Health Services Pharmacy Support² (Australian Government, 2022b) or equivalent training and experience. The Certificate IV Hospital/Health Services Pharmacy Support qualification requires skilled pharmacy technicians working on a regular basis under the supervision of a pharmacist in a hospital or community setting to support the qualified pharmacist in dispensing, compounding, and labelling a range of prescription medications. The course delivers a range of team leadership, communication and supervisory skills as well as coordinating the work of pharmacy assistants. Since the completion of this project, work has been undertaken in Queensland Health to progress the training requirements to mandatory Certificate III for CA3 roles, and Certificate IV for CA4 roles.

¹ Certificate IV in Allied Health Assistance (HLT43015) was superseded in November 2022 by Certificate IV in Allied Health Assistance (HLT43021), with updated provider and course information available on the Australian Government Your Career website at <https://www.yourcareer.gov.au/learn-and-train/courses/HLT43021>

² Certificate IV in Hospital/Health Services Pharmacy Support (HLT47115) was superseded in November 2022 by Certificate IV in Hospital or Health Services Pharmacy Support (HLT47121), with updated provider and course information available on the Australian Government Your Career website at <https://www.yourcareer.gov.au/learn-and-train/courses/HLT47121>.

2 Project overview

The OCAHO engaged KBC Australia to undertake an analysis of the development and implementation of AHA roles in rural and remote HHSs and an investigation of their impact.

2.1 Purpose and scope

The purpose of the project was to increase the evidence available to Queensland Health and other stakeholders to inform allied health service and workforce planning and resourcing decisions in rural and remote health services.

The scope of the project was an investigation of development and changes to the rural and remote AHA workforce in Queensland HHSs since 2014. 'Rural and remote' was defined as Modified Monash Model Level 4 - 7, but for operational reasons excluded all sites in North West HHS (see section 3.2.2). Pharmacy was not in scope of qualitative component of the project (case sites) due to concurrent statewide pharmacy workforce planning activities at the time of the project. However, pharmacy assistants were included in the quantitative component (workforce data analysis).

2.2 Methods

A concurrent mixed methods evaluation was conducted between November 2021 and December 2022.

Part 1 - Quantitative component to describe AHA workforce availability and allied health service activity trends. Data collected included a) retrospective AHA workforce and service data and b) point in time AHA and AHP survey data from nine HHSs.

Part 2 – Qualitative component involving a case study design to explore i) barriers and enablers to development, implementation, and impact of the AHA positions and ii) integration of AHA positions into the service model. Data collected consisted of interviews at five sites with AHAs, AHPs, managers, internal and external stakeholders, and consumers.

The Project had seven key stages:

- A) Project establishment
- B) Project scoping
- C) Development of the evaluation framework and research protocol
- D) Ethics approval
- E) Data collection
- F) Data analysis
- G) Reporting

2.2.1 Project scoping

The purpose of the project scoping phase was to develop a detailed understanding of the rationale for AHA positions in rural and remote health services to inform the evaluation framework and research protocol.

A brief literature scan was undertaken to develop a preliminary evidence base for AHA positions in rural and remote areas, drawing on published and grey literature from Australia and internationally. A range

of Queensland Health rural allied health workforce policy documents and resources were also reviewed to inform the development of the evaluation framework and research protocol.

An evaluation framework was developed in consultation with the OCAHO to assist and guide the scope of the evaluation, key elements to be investigated and the development of evaluation questions.

2.2.2 Ethics approval

Ethics approval was obtained through Darling Downs HHS Human Research Ethics Committee as a Lead Committee for multi-site research for the evaluation (HREC/2021/QTDD/78969). Site specific assessment (SSA) approvals were obtained from nine HHSs to undertake the study including:

- Cairns and Hinterland HHS
- Central Queensland HHS
- Central West HHS
- Darling Downs HHS
- Mackay HHS
- South West HHS
- Torres and Cape HHS
- Townsville HHS
- Wide Bay HHS

The nine HHSs cover the rural and remote allied health workforce in Queensland, excepting far north western Queensland. North West HHS was invited to participate in the evaluation, but an extended delay in processing of the SSA led to withdrawal of the health service from the scope of the study, with agreement of the OCAHO.

2.2.3 Workforce and service data

Five data sets were sourced from statewide data systems through liaison with the data custodian and following approval of all relevant SSAs.

Queensland Health Decision Support System (DSS) payroll (de-identified):

- Data set one: rural and remote AHA positions data 2014-22 (e.g., location, occupied full-time equivalent positions)
- Data set two: rural and remote AHA position incumbent information (e.g., age, length of service, gender) for all employees in positions identified in data set one
- Data set three: longitudinal tracking in Queensland Health employment for all employees identified in data set two (e.g., tenure, change in location / classification)

These data were sourced for the first pay period in each quarter of the data collection period.

Queensland Health Enterprise Reporting Service (QHERS) - Queensland Health non-Admitted Patient Data Collection

- Data set four: AHA service activity by location and mode
- Data set five: Types of services provided by AHAs in all eligible rural/remote locations statewide

2.2.4 Surveys

Two surveys were conducted with the following groups:

1. AHAs working in the nine HHSs in scope of the project (all locations in the HHS including regional centres, rural and remote communities)
2. AHPs working in the nine HHSs in scope of the project

The AHA survey focused on understanding the factors that influence their attraction and retention to the positions, satisfaction in the role with consideration of training, supervision, and recognition within the team. The AHP survey sought information on AHPs' understanding, experiences and views of working with AHAs.

Surveys were completed online on the Qualtrics platform. An invitation to participate in the surveys was distributed electronically by OCAHO through usual allied health email distribution channels in each of the nine HHSs, including contact lists for Directors of Allied Health, rural allied health team leaders, HHS Directors of Medical Imaging and Pharmacy, and the Statewide Mental Health Allied Health Advisory Group that included Directors and team leaders of allied health mental health services. Recipients were requested to forward the email to all AHPs and AHAs in their HHSs through established communications networks.

Both surveys were open for four weeks, with at least one additional release and reminder sent by OCAHO during that period. There was no mechanism for tracking the extent of dissemination of the survey link beyond its distribution to HHS contacts by OCAHO.

2.2.5 Interviews

Five case sites were identified for participation in the interview consultations. Sites were selected to reflect a mix of service setting and models of care that influence AHA roles.

Potential participants were selected through consultation between the evaluators and the site contact person, usually the Director or Manager of Allied Health. Sampling was purposive to represent the participant groups and to gain a variety of perspectives within and across different study sites. Invitations to participate in interviews were made by the respective contact persons in each of the study sites.

Interviews were conducted with stakeholders using remote methods, predominantly Microsoft Teams. Attempts were made to interview a range of stakeholders in each of the nominated sites including: AHAs, AHPs who were responsible for delegation to AHAs, team leaders, allied health service managers, other health staff working with AHAs, and clients.

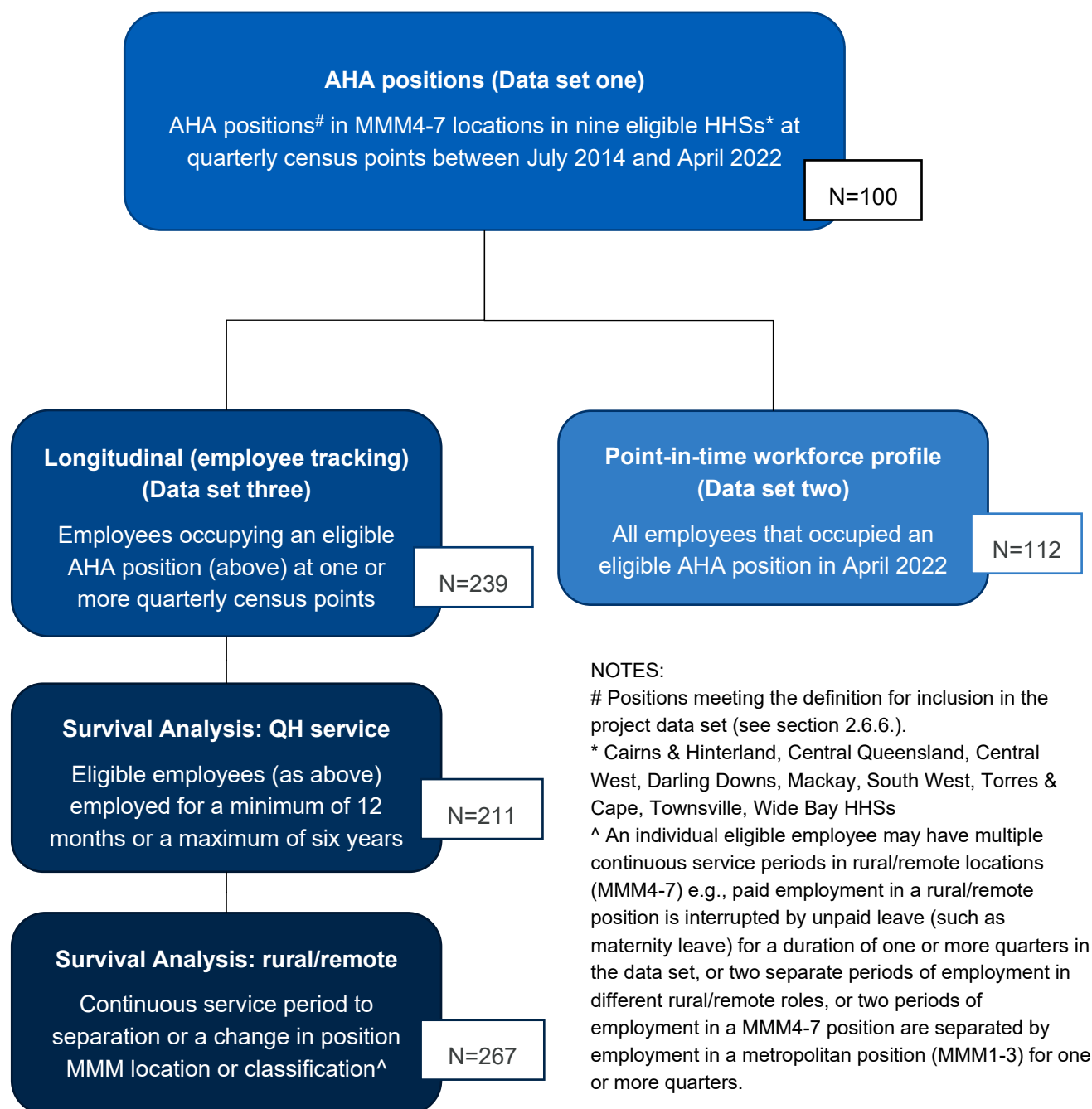
Case sites provided various documentation to the evaluators to inform the evaluation including: business cases to establish the AHA position, Clinical Task Instructions (task competency documents) developed by the team or HHS, AHA scheduling, handover or other communication tools, and professional conference / meeting presentations on the AHA position implementation.

2.2.6 Data Analysis

Workforce data

Three data sets were drawn from the Queensland Health payroll system to examine workforce metrics including recruitment and retention in the period 2014 – 2022. A summary of the positions / employees included in each data set and the relationship to the analyses is shown in Figure 1.

Figure 1. Summary: position and employee data sets for analysis



Data set one (positions):

Occupied rural or remote positions that were on HHS establishment at the first pay run of each financial quarter between July 2014 and April 2022 were captured. Positions were identified as AHA roles eligible for this study if the position:

- discipline classification in the payroll system was 'Allied Health - Assistant/Aide', 'Therapy - Assistant/Aide' or a profession-specific category such as 'Pharmacists and Technicians - Assistant/Aide' or 'Social Workers - Assistant/Aide', and
- base location was in a Modified Monash Model (MMM) 4-7 location (excluding North West HHS), and

- was Operational Officer (OO) Level 3, 4 or 5 or Clinical Assistant (CA) Level 3, 4 or 5, and
- had a unique position identification reference number (position ID), and
- was occupied by an employee for at least one quarter in the data collection period July 2014 – April 2022.

The extraction criteria may have included positions that had been redesigned and allocated a new position ID e.g. a profession-specific position redesigned as a multi-disciplinary position with a new role description and position ID, with both positions being captured separately in the data set, despite no change in overall AHA establishment for the team. It also may include positions that were created or disestablished during the data collection period, and positions that were established with zero occupied full-time equivalent (FTE) staff employed against them for a portion of the data collection period. Consequently, the total number of positions in Data set one (n=100) differs from the total FTE positions at any point in time during the data collection period (maximum point-in-time FTE=79).

Descriptive information for each eligible position was captured e.g., location recorded as MMM classification, full-time/part-time, OO/CA level, substantive/acting incumbent. Summary statistics for all positions in the data set were produced through descriptive analysis of the data.

Data set two and three (employees):

Employees that were incumbents in a position identified in Data set one for at least one quarterly data census point were included in the workforce analysis. All employee data was deidentified by Queensland Health including use of randomly-generated unique identifier codes for individual employees, specific practice locations replaced by MMM classifications, and ordinal Queensland Health service and age data replaced by broad categories (ranges). Participants who worked in multiple roles within a quarter were coded to the position and location of the largest fractional role. As the data was drawn from the payroll system, employees that remained incumbents in a position, but were on unpaid leave for a quarter (e.g., maternity leave) were not captured in the data for that period.

The workforce analysis included a point-in-time workforce profile (Data set two) and a longitudinal tracking analysis (Data set three).

Point-in-time descriptive analysis was undertaken at the most recent time point in the data set (April 2022) to produce a current profile of the AHA workforce. This included analysis of categorical data for sex, age group, Queensland Health service duration, base location by MMM classification and role type.

For the longitudinal (employee tracking) analysis, employee data was recorded at the start of each quarter from an individual's initial appearance in an eligible rural or remote AHA role, through to separation from Queensland Health / cessation of Queensland Health paid employment or the end of the data collection period.

Crude turnover rate was defined as the total number of leavers in a calendar year divided by the average number of employees within the same calendar year. The annual retention rate was defined as the number of employees at the start of a (calendar) year who were still employed at the end of the year divided by the number of employees at the start of the year.

Participants who had worked a minimum of 12 months or a maximum of six years were included in the survival (or retention) analysis. The outcomes of the survival analysis were:

- A) Time to leaving Queensland Health paid employment as an AHA, and
- B) Time to leaving a position in a rural or remote (MMM4-7) location or a transfer to a different position (whether in the same location or different).

For both survival analyses, service time commenced when an eligible employee appeared in the data for a minimum of 12 months (four quarters), and ended when the individual appeared in the data for six continuous years, the data collection period ended or there was a separation event.

For analysis A, a separation event occurred at the final quarter before which the employee ceased to be represented in the data in any work role or location i.e. any Queensland Health paid employment. If the employee subsequently re-entered the data in an eligible rural or remote position, this was considered a new period of service, rather than a continuation of previous service time. This may include a small number of employees that maintained 'ownership' of a position but had an extended period of unpaid leave e.g. maternity leave. A total of 16 out of 239 employees (6.7%) in Data set three had a break in service of between one and four quarters who returned to a position in the same MMM location. Consequently, the potential impact of maternity leave and similar longer-term unpaid leave is likely to be small but not negligible in this analysis.

For analysis B, a separation event included an end or break in paid employment (as per analysis A), or a change to the MMM classification of the position base location or position OO/CA classification. For example, an individual whose service in one eligible position in a MMM4 location that was subsequently followed in the data with commencement in an eligible position in a MMM7 location would have two periods of service appear in the analysis. This was used as a proxy for employee retention in an AHA position in a rural or remote location. An employee that changed location but remained in the same OO/CA level and MMM classification, such as an employee moving from a CA3 position in Atherton (MMM4) to a CA3 position in Biloela (MMM4), would not have been detected in the analysis, but this not likely to be common so the effect is assumed to be negligible.

Survival probabilities were calculated for all Allied Health Assistants and then separately for Pharmacy Assistants and all other Allied Health Assistants. A Cox Proportional Model was built to compare the retention differences between Modified Monash Model locations and employment levels. Correlation resulting from participants who were employed at multiple MMM locations over the study period was controlled for by including a random effect term and applying robust standard errors. The proportion hazards assumption was met ($p=0.56$) in the Cox Proportional model.

Surveys

Survey data were collated in Excel using Qualtrics and exported for analysis using the STATA 15 statistical package. Data analysis techniques included the presentation of descriptive statistics, cross-tabulations, analysis of differences in means.

Interviews and source documents

Interview notes and reports were collated and thematically analysed site-by-site and then across sites to identify consistent and unique themes.

2.2.7 Reporting

A Draft Final Report was provided to the Project Governance Group for review in November 2022. The Final Report was provided to OCAHO in December 2022.

2.3 Results

The findings of the evaluation are drawn from information collected through quantitative and qualitative methods.

2.3.1 Interviews

Table 2 shows the number of people interviewed across all five case sites in each participant category.

Table 2. Interview participants by group

Participant group	Interviews
Allied Health Assistant	6
Allied Health Professional	15
Allied Health Service Manager or Team Leader	4
Director of Nursing (DON)/Nurse Unit Manager (NUM)	1
Consumer / client	2
Total	28

2.3.2 Overview of survey respondents

AHA Survey

Thirty-five (35) valid survey responses were received (39 registered responses, four incomplete). Fifteen respondents were working in a regional location, 20 in rural and none in remote locations. Table 3 provides an overview of survey respondent demographics. Note: some demographic questions were optional so data may not tally equally in each category.

Table 3. Demographics of AHA survey respondents

Demographic criteria	Respondents
Sex	
Female	32
Male	2
Prefer not to say	1
Age	
20-24	4
25-40	4
41-59	20
60+	7

Demographic criteria	Respondents
First Nations status	
Aboriginal or Torres Strait Islander	0
Neither Aboriginal nor Torres Strait Islander	33
Prefer not to say	2
Location	
Remote	0
Rural	20
Regional	25

AHP Survey

Sixty-two (62) valid responses were received (65 registered responses, two incomplete, one non-AHP). Table 4 provides a summary of respondent demographics. Twenty-three (23) respondents were working in a regional location, 30 in rural and 10 in remote. Note: some demographic questions were optional so data may not tally equally in each category.

Table 4. Demographics of AHP survey respondents

Demographic criteria	Respondents
Sex	
Female	58
Male	5
Prefer not to say	0
Age	
20-24	1
25-40	37
41-59	26
60+	1
First Nations status	
Aboriginal or Torres Strait Islander	0
Neither Aboriginal nor Torres Strait Islander	62
Prefer not to say	0

Demographic criteria	Respondents
Location	
Remote	10
Rural	30
Regional	23

Table 5. Professions of AHP survey respondents

Profession	Respondents
Dietitian/ Nutritionist	13
Occupational therapist	9
Physiotherapist	12
Podiatrist	3
Social worker	5
Speech pathologist	5
Radiographer	9
Pharmacist	1
Other allied health profession	5

2.4 Data limitations

The project was hindered by several factors, which impacted the scope of the consultation process and the reliability of the survey data.

Delays were experienced with processing of some SSAs. North West HHS had a processing delay of six months that was unable to be resolved by KBC or the project sponsor and posed a risk to the overall project timeline. The HHS was excluded from the data collection.

A COVID-19 outbreak in Queensland from early 2022 resulted in all HHSs placing a hold on research activities. When research activities re-commenced, recruitment of participants for interviews was difficult despite a number of strategies to promote engagement including the project sponsor raising awareness of the project with allied health leaders at meetings and other forums. KBC also made repeated attempts to engage participants across all sites through follow up emails and phone calls. The planned six case sites were reduced to five to accommodate reduced access to clinical teams.

Although the surveys were widely distributed by the project sponsor and reminders sent, the response rates were very low. To accommodate the low survey response rate, the findings presented in this report relate primarily to the analysis of workforce data and interviews, with survey data supporting or expanding identified themes.

In case sites the majority of participants interviewed were AHPs and team leaders. In some sites no AHAs were available to participate in interviews, which is a notable limitation and potentially skews the findings towards the views and experience of other members of allied health teams rather than AHAs.

3 Case sites

This section describes the five case sites selected to examine the role of AHAs in various service settings and to investigate drivers, enablers and challenges of AHA position implementation.

3.1 Case site A

The HHS encompasses both coastal and inland areas in a region of approximately 48,597 km². The region's population is estimated at 215,00 and is expected to grow by approximately 1% per annum to 2031. The First Nations population is approximately 4.2%. The region has a range of industries, including tourism, agriculture, forestry, fishery, mining, and manufacturing. Economic indicators highlight key challenges of unemployment, workforce participation, and an ageing population.

The rural allied health team operates out of small hospitals and Multi-Purpose Health Services (MPHS) across seven inland communities. AHAs are based in each of the seven sites, with some outreach into the community. All seven locations are classified as MMM5.

3.1.1 Service Description

There are currently seven AHA positions in the allied health team. All are CA3 level, and all are part-time. All AHAs have completed or are undertaking the Certificate IV in Allied Health Assistance. It is not a prerequisite for the positions, but it is a local organisational expectation that a successful applicant will complete the Certificate IV within the first 18 months in the position. AHAs have previously been supported through payment of course fees as well as through access to study leave to complete the Certificate IV training.

Seven allied health professionals delegate tasks to the AHAs. The psychologist does not delegate tasks to the AHAs. See Table 6 for team composition.

Table 6. Case A allied health team composition

Positions	Headcount	Level
Dietitian	1	HP4
Speech pathologist	1	HP4
Podiatrist	1	HP4
Exercise physiologist	1	HP4
Psychologist	1	HP4
Social worker	2	1xHP3; 1xHP4
Physiotherapist	3	2xHP3; 1xHP4
Occupational therapist	2	1xHP3; 1xHP4
Allied Health Assistant	7	CA3

3.1.2 Overview of the Model of Care

The allied health model of care encompasses inpatient, outpatient and community-based services as well as services to aged care residents in MPHSSs. Services and programs in which AHAs work are shown in Table 7.

Table 7. Tasks commonly delivered by AHAs - Case A

Commonly delegated tasks
• Cardiac rehabilitation (individual and group) • Pulmonary rehabilitation (single session and group) • Chronic disease self-management (individual or 6-week group program) • Chronic pain self-management group • Falls and balance program (individual or group) • Healthy eating group • Rolling rehabilitation programs (individual or group) • Pre-admission clinic Note: AHA functions in groups can include supervision and facilitation of the program and patient-end support of AHP-delivered group interventions via telehealth.

AHPs based in the service hub conduct outreach visits to the other sites on a weekly or fortnightly basis (frequency varies by profession and is influenced by occupied FTE and service demand). Outreach visits include face to face services to patients, predominantly at the local hospital/MPHS sites, with some home visits. AHAs work with the AHPs while on site and plan and discuss the care plans and delegated tasks, including session frequency, to be implemented between AHP visits.

AHPs also provide telehealth-supported services from their base location with AHAs facilitating patient-end support at their site. Regular telehealth-supported services include falls and balance, rehabilitation, and pre-admission clinics. For group sessions like falls and balance, the AHP can run the session with patients across multiple sites with patient-end support of the AHAs. Telehealth can also be used for individual consultations, for example to review a patient as part of care planning for discharge. This timely care avoids waiting for the next scheduled AHP outreach visit which may not occur for some days. The AHA supports the operational arrangements, delegated clinical tasks that are within their scope, and patient safety and engagement with the AHP telehealth consultation.

The allied health team has a multidisciplinary team meeting each Monday morning to discuss inpatients at each of the sites. This meeting is attended by all AHPs and AHAs. Some specific task delegation occurs at that meeting. Following the meeting, additional delegation is done via email or phone call between AHPs and AHAs.

3.1.3 Establishment of AHA positions

The current AHA model has grown from an initial trial in one or two sites. The allied health team experienced the benefits of having a locally-based team member in smaller communities to support the outreach model of service delivery where AHPs only had the capacity to visit outlying sites once per week or fortnight. Once the model had been trialled, the team was ready to implement it on a wider scale when funding became available through the HHS, initially using non-recurrent funding for two to three years before the positions were permanently established. The current model commenced in 2014 in seven sites. Initially positions were 0.4FTE (4 hours per day, 4 days per week). That has since increased to 0.8FTE (four full days per week) at most sites as funding and workforce redesign opportunities have emerged.

The drivers for progressive trialling, development and embedding of AHA positions included:

- Improving access to allied health care by:
 - reducing travel requirements for patients and AHPs that were inherent in the outreach model
 - improving timeliness of care, given the feasible frequency of outreach AHPs visits
 - improving the frequency/intensity of therapy services
- Providing a sustainable local workforce, particularly in communities that are too small to sustain a multi-professional team of allied health practitioners
- Improving efficiency through implementing group-based care where appropriate and clinically indicated
- Addressing challenges in the existing model of outreach service delivery.

3.2 Case site B

The HHS encompasses a region of approximately 130,238km². The region's population is estimated at 26,966. The First Nations population is approximately 65%. The largest employer is the public sector, and the main private industry is mining. There is a growing tourism industry. Across the HHS there are four hospitals, two of which integrate MPHS/residential aged care services, and 31 primary health care centres.

Case site B is a remote (MMM6) coastal community with a service catchment population of approximately 4,500, of whom approximately 2,800 live in the main town. The First Nations population is approximately 21.9%. Key challenges for the region include an ageing population and high levels of socio-economic disadvantage.

The allied health team are based in a 28 bed MPHS and provide outreach services to several smaller communities.

3.2.1 Service Description

The rural allied health team in Case site B includes six allied health professions as shown in Table 8.

There are currently two AHA positions aligned to the Healthcare in the Home (HiTH) program. Both are full time positions at CA3 level, and both are Aboriginal and Torres Strait Islander identified positions. The current AHAs are undertaking the Certificate IV in Allied Health Assistance. It is not a prerequisite for the positions, but it is an HHS expectation that all AHAs will complete the Certificate IV within the first 18 months in the position. AHAs are supported to complete their Certificate IV through team support and study leave. The HHS paid for the training for the first group of AHAs recruited across the HHS.

Table 8. Case B allied health team composition

Positions	Headcount (FTE)	Level
Dietitian	1 (1 FTE)	HP4
Speech pathologist	1 (0.8 FTE)	HP4
Podiatrist	1 (1 FTE)	HP4
Social worker	1 (0.8 FTE)	HP4

Positions	Headcount (FTE)	Level
Physiotherapist	2 (1.6 FTE)	HP4
Occupational therapist	1 (0.8 FTE)	HP4
Allied Health Assistant	2 (2 FTE)	CA3

Tasks commonly undertaken by the AHAs are shown in Table 9.

Table 9. Tasks commonly delegated to AHAs (by profession reporting the task) - Case B

Profession reporting task	Commonly delegated tasks
Occupational Therapy	• Rowland Universal Dementia Assessment Scale • Standardised mini mental state examination • Montreal Cognitive Assessment
Podiatry	• Foot screening • Foot care advice
Dietetics	• Malnutrition screening tool
Physiotherapy	• 6 min walk test • Standing balance retraining • Timed up and go • Standing transfer and walking • Knee strengthening exercises
Multiple professions	• Blood pressure measuring • Heart rate measuring • Pulse oximetry recording

3.2.2 Overview of the Model of Care

The HiTH model focusses on preventing hospital admissions for vulnerable members of the community. Referrals are received from the community nurse and/or AHPs. An initial multi-professional team assessment is conducted including diet, weight loss, psychosocial wellbeing, personal care activities and falls risk. Following the assessment, a holistic view of the person's current function and wellbeing is developed. The occupational therapist or physiotherapist supports the client to set goals in relation to the HiTH service with a focus on maximising function and the client's ability to remain safe and independent in their home. Referrals may also be generated to other team members including the diabetes educator, other allied health professions or the Community Health team.

A program is developed by the relevant AHP/s to meet the person's goals. Relevant tasks are delegated and the AHA conducts weekly home visits to assist the client to implement the program. The programs are generally focussed on functional retraining including activities of daily living and mobility, and target people assessed as being at high risk of hospital admission or readmission, those with co-morbidities affecting function or who are at high risk of a fall. Programs are generally implemented for six to eight weeks, with periodic team review and evaluation against goals. Some clients will engage with HiTH more than once.

The team has a multidisciplinary meeting each Monday morning attended by AHPs and AHAs to discuss clients' progress and facilitate the delegation of tasks for each client.

3.2.3 Establishment of AHA positions

The development of the HiTH program, including the AHA positions, was driven by an identified need to increase access to services and prevent hospital admissions for vulnerable clients in the community. The program brings together funding sources to meet that need.

The initial funding came from: Care in the Right Setting (CaRS) \$830,000 over 2 years, First Nations health strategy \$300,000, and the Indigenous Training initiative \$58,000. The program has now secured recurrent funding through the HHS.

3.3 Case site C

The HHS covers an area of 88,650 km² and includes a large regional centre, rural towns, and small rural communities. The population is estimated at 280,000. The First Nations population is approximately 5%.

Case site C is a Rehabilitation and Recovery Service located in the regional centre providing multidisciplinary care to inpatients in an Acute Mental Health Unit and extended care unit (located in the regional hospital) as well as care for people with an Acquired Brain Injury. The services provide care for a large catchment area that includes regional and rural communities.

3.3.1 Service Description

The composition of the allied health team is shown in Table 10. Under the Rehabilitation and Recovery model, AHAs receive delegated tasks from all allied health professions except for psychology.

Table 10. Case C mental health allied health team composition

Positions	Headcount (FTE)	Level
Exercise Physiologist	1 (1 FTE)	HP4
Physiotherapist	1 (1 FTE)	HP4
Dietitian	1 (0.61 FTE)	
Social worker	3	1xHP5; 1xHP4; 1xHP3
Speech Pathologist	1 (1 FTE)	
Occupational therapist	3 (3 FTE)	Director; 1xHP4; 1x HP3
Psychologists	3	Director; 1xHP4; 1x HP3
Allied Health Assistants	3 (1.9 FTE)	CA3
Recreation officer	1 (1 FTE)	
Note: Peer support workers also work with the team		

3.3.2 Overview of the Model of Care

The AHAs have a wide range of tasks they can undertake under delegation from six allied health professions as shown in Table 11.

Table 11. Tasks commonly delegated to AHAs (by profession reporting the task) - Case C

Profession reporting task	Commonly delegated tasks
Exercise physiology	• Co-facilitation of group exercise sessions with exercise physiologist • Tasks in care plans identified as appropriate for delegation by Exercise Physiologist
Occupational therapy	• Facilitating breakfast group • Supervising meal planning and preparation therapy activities • Facilitating kitchen safety for meal preparation therapy tasks • Reinforcing activities of daily living therapy goals • Reinforcing and practicing pedestrian skills/ road safety • Co-facilitating sensory modulation group with occupational therapist • Bringing consumers to group • Supporting safety in showering goals (e.g., shower chair use) • Managing occupational therapy equipment including maintenance and replacement management
Dietetics	• Implement malnutrition screening tools with clients • Data collection on consumer weight status, food intake, relevant lab values and modes of feeding • Providing individual and group consumer education on diet and nutrition using standardised resources.
Social work	• Operational coordination and supporting consumer referrals and documentation for weekly Centrelink Outreach Worker clinic • Supporting consumers and families to complete processes required for aged care accommodation options e.g., monitoring vacancies and completing applications • Coordinating and supporting consumers for practical aspects of arranging accommodation options e.g., completing public housing applications, viewing potential properties. • Supporting consumers to complete non-clinical documentation impacting on discharge progress e.g., Medicare/health care card renewal, Centrelink payment applications. • Supporting consumers and carers to coordinate travel arrangements • Supporting consumers to coordinate practical home management tasks while an inpatient e.g., mail and bill management, care of pets.
Speech pathology	• Support practice with communication devices
Physiotherapy	• Functional exercise programs e.g., stepping, stairs, getting out of bed, walking program, balance-related exercises • 'Spotter' in the pool for hydrotherapy exercises • Providing support for group-based programs delivered by the physiotherapist

AHPs delegate tasks directly to AHAs. Tasks are documented and include details specific to the client and clinical task e.g., physiotherapist documents the exercise including the number of sets and repetitions.

The AHPs and AHAs work across the extended care centre and Acute Mental Health Unit. The senior AHPs and AHAs hold monthly collaboration meetings to plan the monthly timetable of group programs, individual care plans and prioritise activities. For variation of planned programs or new/amended delegation each day, the team has developed a timetable for tasks required to conduct group programs and implement care plans for individual consumers. The team has also developed a feedback template for the AHA to document the tasks completed and any relevant information for each group or individual on that day.

The balance of delegation varies by profession and by site. Social worker delegation predominantly occurs for patients in the Acute Mental Health Unit to prepare clients for discharge. Clients in the extended care centre generally have a focus on building capacity in activities of daily living. Client support to practise these activities is often delivered by AHAs in a group setting. In the extended care centre, most delegated tasks are from occupational therapists, exercise physiologists and physiotherapists.

3.3.3 Establishment of AHA positions

Historically the Rehabilitation and Recovery Team had a Physiotherapy Assistant. Two years ago the team re-focussed the position to work across multiple professions. The rationale for the change included increasing the capacity and efficiency across the team, enabling more AHPs to practice to their full scope and to improve the team's responsiveness to referrals for assessment, intervention and discharge planning.

Funding for increasing AHA establishment became available through:

- Conversion of a OO3 Recreation Officer role to an AHA position in response to increasing demand for social work tasks in the Acute Mental Health Unit
- Conversion of a Nutrition Assistant position to increase the AHA dietetics scope and additional multidisciplinary AHA capacity.

3.4 Case site D

The HHS covers an area of approximately 148,00 km². The area has a population of approximately 258,000. The First Nations population is approximately 8%, with some areas significantly higher at 13%. There is a large regional city and many smaller rural and remote communities.

The Case site D rural allied health team service catchment includes a rural town and two smaller remote communities and surrounding areas. Service centres in the rural town are a rural hospital and an HHS-managed residential aged care facility (RACF). The two remote communities have MPHSSs.

3.4.1 Service Description

The rural allied health team is now part of the HHS Allied Health Services Division, having recently moved from the HHS Rural Service Group. The AHAs report to the HHS Rural Allied Health Manager. Reporting was recently changed as part of the organisational structure changes and had previously been operationally to the Director of Nursing (DON) in the remote facilities in which the AHA positions are based.

AHPs are based in the rural hub site and conduct outreach visits to remote sites, either on a regular schedule (e.g., once per month) or as service demand and referrals require.

3.4.2 Overview of the Model of Care

AHAs in the two remote sites attend the Rapid Round meeting in their facility. If the medical or nursing team identify that a patient/resident needs intervention from allied health, the AHA will record relevant information and coordinate communication of the request to the AHP/s. If relevant and appropriate, the AHP will delegate screening and intervention tasks to the AHA, facilitated by telehealth.

Routine (scheduled) low risk foot care for podiatry in the RACFs is undertaken by the AHA through a protocol. The protocol defines the scope of the activities undertaken by the AHA, including processes, indications and limitations. The protocol is managed and monitored by the HHS podiatry service.

Examples of tasks undertaken by AHAs are shown in Table 12.

Table 12. Tasks commonly delegated to AHAs (by function) - Case D

Functions	Commonly delegated tasks
Clinical	Inpatients/residents • Complete screening tasks (direct delegation or protocol-driven) and outcomes reported to AHPs and local team • Facilitate client-end requirements for AHP triage and reviews e.g., set up telehealth equipment and prepares client, support clinical activities and patient safety MPHS Residents • Complete delegated tasks daily as per care plan and delegation instructions • Co-facilitation of group exercise sessions • Participate in fortnightly review with rural allied health team of the care plan and delegated tasks • Facilitate mobility / recreation participation Community Rehabilitation clients • Through an inter-agency collaborative care model, deliver delegated community rehabilitation activities, including working with AHPs from the non-government service provider who are engaged in client care • Complete home visits / therapy sessions as delegated
Administrative	• Patient bookings, vehicle bookings, outreach support • Patient data / information collection/ entry
Operational	• Stock control and ordering • Patient equipment audits, cleaning and basic maintenance
Licensed Operator	• In two locations AHAs complete the required training to obtain an X-Ray operator use license. These employees deliver after hours / weekend on-call X-ray services as a licensed X-ray operator (separately to their AHA role). This provides operational flexibility and capacity for the service and additional income options for the employees.

3.4.3 Establishment of AHA positions

Positions were funded recurrently from 2016 through a successful application to the Queensland Government Rural Revitalisation Funding Program. Needs identified in the funding grant application and implementation plan were a planned transition of health care facilities in two satellite communities to MPHSs with ten aged care beds across the sites, and no resident AHP workforce. In 2018 a multi-agency service model was developed to support increased access to allied health workforce in the communities. Agencies included the HHS, a community-based rehabilitation provider and the local PHN-funded Integrated Chronic Care (ICC) / Outreach Allied Health Services (OAHS) provider.

During the development and implementation of the allied health roles, the allied health team based in the rural service hub and the local Community Advisory Network (CAN) identified gaps between AHP outreach visits to smaller communities of between three and ten weeks, and that AHAs were well placed to increase the frequency of intervention and improve equitable access to allied health services. The idea of an inter-agency shared AHA model was developed as a collaboration between the three agencies, with local service managers responsible for the ongoing support and governance of the model. AHAs are employed by the HHS, with in-kind contributions from external agencies for operational matters such as fleet vehicle use. The overall goal was to increase equity of service access for rural consumers and optimise the functions and outcomes of the newly established AHA roles. A shared training model was agreed, with each agency contributing to the training of relevant competencies related to their respective workloads and clients. Monthly meetings were established to monitor workloads and manage emergent issues, as well as provide opportunities for expansion or improvement. One barrier that has remained constant was the ability to share clinical information between organisations, sometimes impacting on transitions of care between outreaching teams. In the development of the model, it was highlighted that each agency had a separate funding stream and client group. However, in order to provide clarity to the HHS AHA workforce, the scope of the service was clearly defined to ensure alignment to existing publicly funded service offerings. Exclusion criteria were developed to assist screening and management of publicly funded clients to limit the potential for conflict.

3.5 Case site E

The HHS covers an area of 319,000 km². The population is around 26,000, which is spread across six local government areas. The First Nations population is approximately 13%.

Health services are delivered from three hospitals and eight MPHSs. Allied health teams are based at each of the hospitals and provide outreach to the smaller sites.

Note: information collection for this case site related primarily to the allied health team at the largest hospital facility, with a particular focus on podiatry services. The allied health team composition in this hospital is shown in Table 13.

Table 13. Case E allied health team composition

Positions	Headcount	Level
Podiatrist	2	1xHP3; 1xHP4
Physiotherapist	2	2xHP3; 2xHP4
Occupational therapist	3	2xHP3; 1xHP4
Speech pathologist	2	1xHP3; 1xHP4

Positions	Headcount	Level
Social worker	2	1xHP3; 1xHP4
Dietitian	2	1xHP3; 1xHP4
Exercise physiologist	1	HP3
Advanced AHA	1	CA4
AHA	2	CA3
Aboriginal liaison officers	3	3xAO4

3.5.1 Overview of the Model of Care

The model of care for podiatry services encompasses inpatient, outpatient and community-based services as well as services to aged care residents in MPHS sites. The team provides outreach services to several smaller communities.

The HHS podiatry service is focussed on high-risk foot services. One Advanced AHA (CA4) in the team focuses on the podiatry case load and has received formal and work-based training in this area.

Patients are initially assessed by the podiatrist and low risk care is delegated to the AHA if appropriate.

Patients are reviewed by the podiatrist at least every 12 months, or a review can be initiated earlier if the patient's risk profile changes as assessed on a formal screening tool that the Advanced AHA has been trained to administer. The AHA visits smaller communities to provide routine low risk nail care clinics in the HHS-operated MPHSs and RACFs. Low risk nail care is delivered under a protocol that includes risk assessment tools.

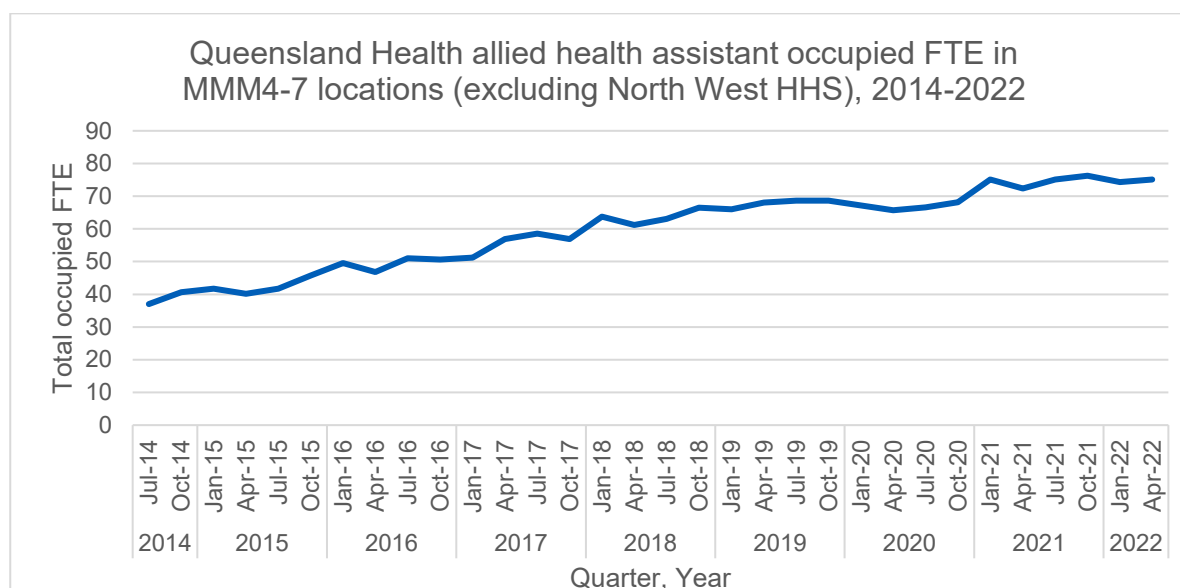
4 Findings: workforce and service data

Data presented in this section includes all MMM4-7 areas of Queensland with the exception of the North West HHS.

4.1 Profile of AHA positions in rural and remote services

In the nearly eight-year period July 2014 to April 2022, occupied FTE AHA positions in MMM4-7 locations in Queensland (excluding North West HHS) more than doubled from 37.02 FTE to 75.11 FTE (Figure 2).

Figure 2. Occupied FTE AHA positions in MMM4-7 areas in Queensland (excluding North West HHS), July 2014 to April 2022



Nearly half (48%) the AHA positions in the period July 2014 to April 2022 were located in MMM4 (medium rural town) locations. The majority of AHA positions are multidisciplinary positions (nearly 75%) and almost one quarter (23%) were pharmacy assistants (Table 14). There were a small number of profession-specific roles other than pharmacy. It should be noted that these data include the 100 total positions implemented in this entire time period, although at no time was there greater than 79 FTE occupied AHA positions. The data include positions that were established/disestablished during the time period or were transitioned between locations or discipline classifications.

Table 14. Description of Queensland Health AHA positions in MMM4-7 areas (excluding North West HHS), July 2014-April 2022

Description of AHA positions		No. of positions (n=100)
Location	MMM4	48
	MMM5	21
	MMM6	9
	MMM7	22
Classification*	Allied Health Assistant	72
	Nutritionist Assistant	<5
	Pharmacy Assistant	23
	Social Worker Assistant	<5
	Therapy Assistant	<5

* Queensland Health payroll system classification - may not reflect the position title or scope of the role

4.1.1 Profile of AHA workforce in MMM4-7 locations

The AHA workforce employed at April 2022 is highly feminised (92%) and 42% of employees are aged 50 years or older (Table 15). More than half (53%) of the AHA workforce has been employed with Queensland Health for six or more years.

Table 15. Description of AHA employees in MMM4-7 areas in Queensland (excluding North West HHS), April 2022

Description of AHA employees		No. of employees (n=112)
Sex	Female	103 (92%)
	Male	8 (7%)
	Other	<5 (<1%)
Age group	20-24 years	9 (8%)
	25-29 years	14 (13%)
	30-34 years	10 (9%)
	35-39 years	5 (4%)
	40-49 years	27 (24%)
	50+ years	47 (42%)
Length of service in Queensland Health (in any role)	0-2 years	34 (30%)
	3-5 years	19 (17%)
	6-10 years	32 (29%)
	11-20 years	17 (15%)
	>20 years	10 (9%)

4.1.2 Profile of AHA background and training

Nine AHA survey respondents had no formal qualifications prior to commencing in the role. Five had a bachelor degree (i.e., non-clinical field of education), while others had a range of qualifications including Certificate III or IV and Associate, Advanced or Graduate Diplomas. About one third of survey respondents indicated they had not completed and were not currently undertaking the Certificate IV in Allied Health Assistance. Of the 22 survey respondents who had either completed the Certificate IV Allied Health Assistance training or were currently studying, ten had self-funded the training (either while working for Queensland Health or previously), nine were funded through Queensland Health and three had partial support through government scholarships or subsidies.

Survey respondents had a wide variety of backgrounds prior to becoming an AHA. Many AHA survey respondents had previously worked in the health sector and/or in aged or disability care. Others had worked in industries such as hospitality, retail and education.

4.1.3 Workforce turnover and retention

Results from longitudinal tracking of AHAs in the Queensland health payroll data demonstrates that in rural and remote services this is a relatively stable workforce.

Turnover / stability

Table 16 shows the proportion of the AHAs who exited Queensland Health employment (permanent separation or extended period of unpaid leave in advance of the end of the data collection period) by calendar year. Between 2015 and 2021 the crude annual turnover was lowest in 2019 at 11.4% and highest in 2021 at 20.2%. The increased turnover in the last two years of data collection may be influenced by transient impacts of the COVID-19 pandemic or may be a more sustained trend. This would be worth subsequent evaluation in future years.

Table 16. Crude annual turnover (separation) rate of AHAs in MMM4-7 locations (excluding North West HHS), 2015 to 2021

Year	Number of exits	Average number employed in year	Crude annual turnover (%)
2015	10	59.8	16.7
2016	8	68.5	11.7
2017	13	78.8	16.5
2018	13	90.5	14.4
2019	11	96.3	11.4
2020	18	99.8	18.0
2021	22	109.0	20.2

Stability rates measure the proportion of an original workforce cohort that remains employed by the organisation. Table 17 shows that of the 57 AHAs employed in January 2015, approximately half (29 AHAs) remained employed as an AHA in a MMM4-7 location in Queensland Health seven years later. The proportions recorded in bold font and darker shaded cells are the stability rates after two years for each successive cohort. Each cohort is formed by tracking all employees in an eligible AHA roles in the January pay runs of each successive year. Between cohorts the two-year retention (stability rate) ranged between 70.8% and 81.8%.

Table 17. Stability rates of AHAs in MMM 4-7 locations (except North West HHS), 2015 to 2022

Cohort of employees in AHA roles: number employed at annual census (%)							
Census date	Jan 2015	Jan 2016	Jan 2017	Jan 2018	Jan 2019	Jan 2020	Jan 2021
Jan 2015	57 (100.0)						
Jan 2016	44 (77.2)	66 (100.0)					
Jan 2017	41 (71.9)	60 (90.9)	74 (100.0)				
Jan 2018	39 (68.4)	54 (81.8)	64 (86.5)	89 (100.0)			
Jan 2019	36 (63.2)	48 (72.7)	56 (75.7)	74 (83.1)	94 (100.0)		
Jan 2020	35 (61.4)	47 (71.2)	55 (74.3)	69 (77.5)	79 (84.0)	96 (100.0)	
Jan 2021	30 (52.6)	41 (62.1)	48 (64.9)	61 (68.5)	72 (76.6)	79 (82.3)	109 (100.0)
Jan 2022	29 (50.9)	39 (59.1)	46 (62.2)	55 (61.2)	62 (66.0)	68 (70.8)	86 (78.9)

Survival Analysis

Queensland Health employment

Table 18 shows the survival (i.e., retention) probabilities in Queensland Health employment for AHAs who accrued a minimum of 12 months and maximum of six years' service following commencement in an eligible rural or remote position. The minimum retention time in the eligibility criteria accommodates short-term (locum) appointments and fixed-term cover for maternity leave, that has been shown in previous OCAHO workforce studies to be a confounder for rural/remote workforce retention studies.

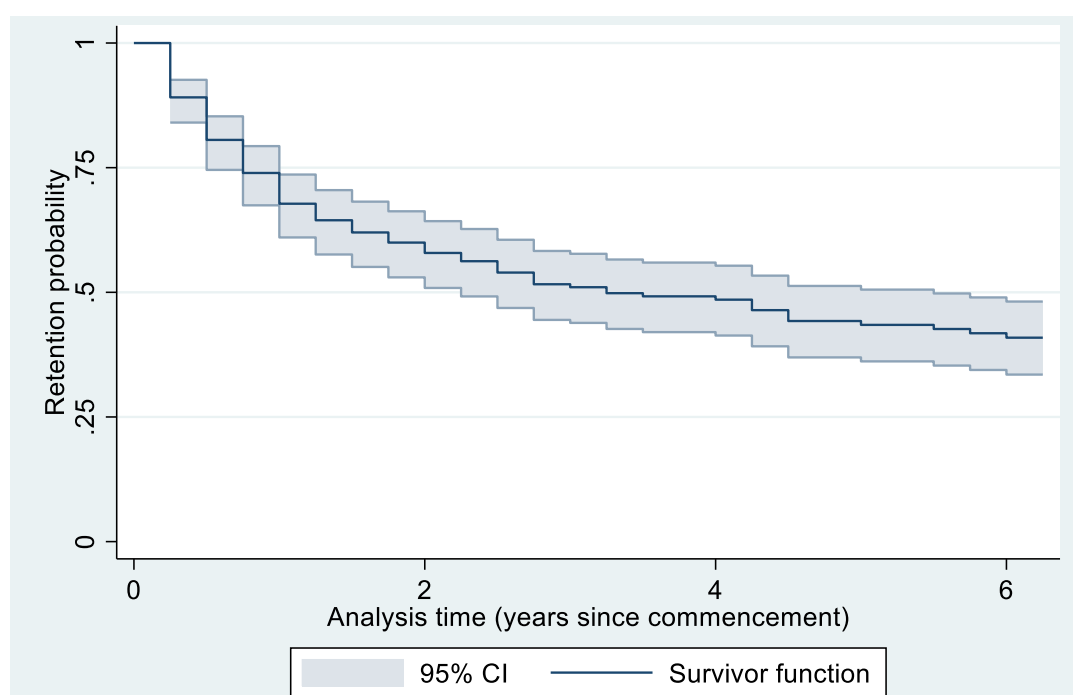
The survival probability for Pharmacy Assistants is greater than for non-pharmacy AHAs. For example, after six months of employment, pharmacy AHAs had a 91% (95% Confidence Interval [95% CI]: 79% to 96%) retention probability compared to 78% (95% CI: 70% to 83%) of non-pharmacy AHAs. After the third year of employment the retention probability of pharmacy AHAs dropped to 63% (95% CI: 48% to 74%) and for non-pharmacy AHAs it dropped to 47% (95% CI: 39% to 55%). The Kaplan-Meier survival curve for employment with Queensland Health of the eligible employees in this data set is shown in Figure 3.

Table 18. Survival probabilities and median survival time of employment with Queensland Health for eligible AHAs

	Allied Health Assistants (except pharmacy) (n=158)	Pharmacy Assistants (n=53)	All assistants (n=211)
Survival probability after 6 months	78% (70%-83%)	91% (79%-96%)	81% (75%-86%)
Survival probability after first year	64% (56%-71%)	80% (66%-88%)	68% (62%-74%)
Survival probability after second year	55% (47%-63%)	67% (52%-78%)	58% (51%-65%)
Survival probability after third year	47% (39%-55%)	63% (48%-74%)	51% (44%-58%)
Median survival	2.75 (1.75-4.25)	-	3.25 (2.25-5.5)

Note: Median survival for pharmacy could not be estimated due to a low number of events

Figure 3. Kaplan-Meier survival curve for employment with Queensland Health of eligible AHA employees



Time to leave employment in a rural or remote position

Table 19 shows the survival probabilities of employment in a Queensland Health rural or remote position for AHAs who accrued a minimum of 12 months and maximum of six years' service in an eligible role. Overall, AHAs had a median length of service of 2.25 years in a position located in a rural or remote (MMM4-7) area prior to either changing OO/CA role classification, MMM location classification or separating from Queensland Health. This outcome is indicative of the time from commencement to change in employment circumstance including separation, transfer to a different MMM location or promotion. It is a proxy for retention time in a specific location/position, and therefore a rough indication of recruitment demands for the service. It should be noted that the data will include

some changes that are administrative in nature e.g., reclassification of a role in the HR system. This is likely to have produced a minor underestimation of retention time.

After six months the employee retention probability was 78% (95% CI: 73% to 83%) and dropped to 44% (95% CI: 37% to 50%) after the third year (Table 19). The Kaplan-Meier survival curve is shown in Figure 4.

Table 19. Survival probabilities and median survival (continuous employment) with Queensland Health in a rural or remote location (MMM4-7 except North West HHS)

	Allied Health Assistants (except pharmacy) (n=197)	Pharmacy Assistants (n=70)	All assistants (n=267)
Survival probability after 6 months	80% (73%-86%)	87% (75%-94%)	78% (73%-83%)
Survival probability after first year	66% (58%-73%)	71% (58%-80%)	64% (58%-70%)
Survival probability after second year	54% (46%-62%)	59% (46%-70%)	52% (45%-58%)
Survival probability after third year	43% (35%-52%)	57% (44%-69%)	44% (37%-50%)
Median survival	2 (1.5-2.75)	-	2.25 (1.75-3.25)

Note: Median survival for pharmacy could not be estimated due to a low number of events

Figure 3. Kaplan-Meier survival curve for continuous employment with Queensland Health in a rural or remote location (MMM4-7 except North West HHS) for eligible employees with subgroups defined as non-Pharmacy AHAs and Pharmacy AHAs

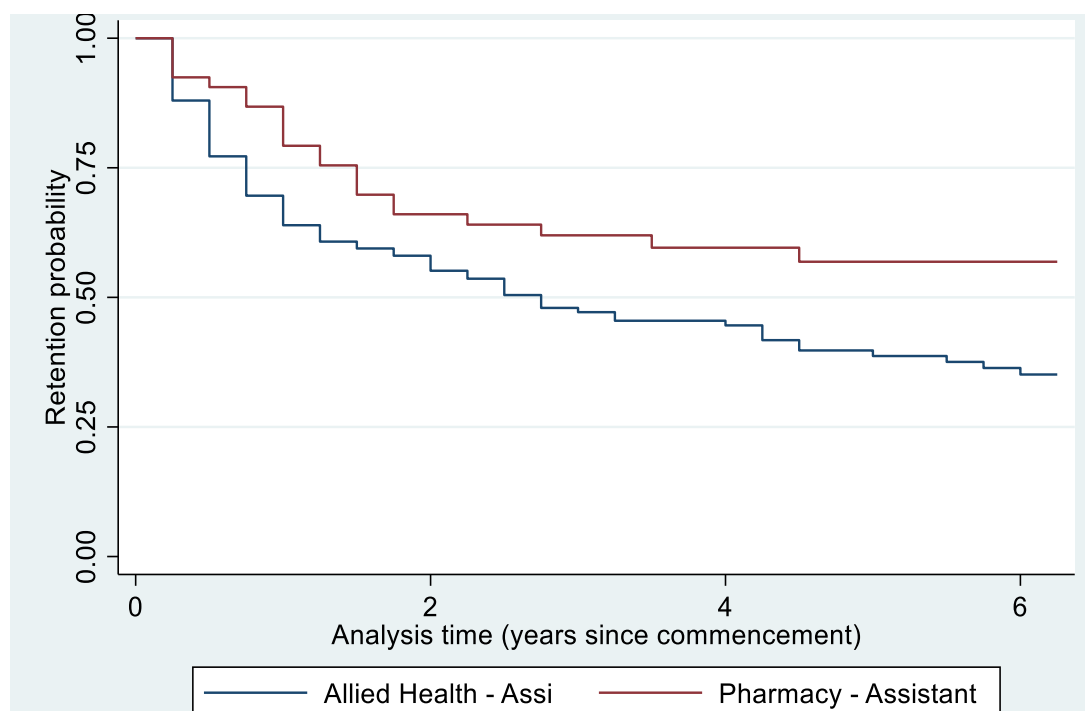


Table 20 shows that the hazard of exiting Queensland Health employment was 30% higher (HR 1.30; 95% CI: 0.87 to 1.95) for AHA employees in remote locations compared to rural locations. Whilst there was no statistical difference in the length of time employed in Queensland Health by location nor clinical level, the lack of statistical significance may be a result of study power (i.e., small number of participants) rather than a true lack of difference between variables.

Table 20. Cox proportional hazard ratio model estimates of time to leaving Queensland Health employment

		Hazard ratio (HR) (95% CI)	P value
Location (Modified Monash Model classification)	MMM4 & MMM5 (rural)	1.00	0.19
	MMM6 & MMM7 (remote)	1.30 (0.87 to 1.95)	
Clinical Level (OO/CA)	3	1.00	0.86
	4	0.95 (0.51 to 1.74)	

The median length of employment for AHAs in remote (MMM6-7) areas was more than a year shorter than employees in rural locations (MMM4-5) (Table 21). Between clinical levels there was minimal difference in the median length of service (2.25 years verses 2.27 years).

Table 21. Median length of Queensland Health employment within a rural vs remote location

		Number of employees	Median length of service (95% CI)	P value†
Location (Modified Monash Model classification)	MMM4 & MMM5 (rural)	178	2.75 (2 to 4.5)	0.19
	MMM6 & MMM7 (remote)	51	1.5 (0.75 to 3.25)	
Clinical Level (OO/CA)	3	249	2.25 (1.75 to 3.25)	0.95
	4	26	2.27 (0.75 to -)	

† Log rank test

4.2 Service data

Table 22 shows the number of reported non-admitted patient service events provided by positions classified as AHAs, Therapy Assistants and Therapy Aides in rural and remote HHSs in the period 2016/17 to 2020/2021 financial years. The total number of services increased between 2016/17 and 2018/19, with a slight reduction in the following two years. The Non-admitted Patient data set is used for the purpose of funding and performance reporting, so the decrease may be indicative of either decreasing activity, or decreased reporting of activity (or both). The impact of the COVID-19 pandemic on service activity needs to be considered when interpreting the data.

The analysis was limited to high-level service data only i.e., data rolled up for all MMM4-7 locations rather than reported separately by MMM levels, HHSs or facility types; data presented for entire

financial years rather than quarters / months; no disaggregation of data by CA/OO level or clinic type that would indicate relative focus of rural AHA positions on specific areas of practice. Despite data being non-identifiable (i.e., no patient level identification possible in the data set), the risk of re-identification of any further disaggregation was cited as a concern by Queensland Health service informatics unit. The level of aggregation of the data limits its value for this study of the Queensland Health AHA workforce.

Table 22. Non-admitted patient service events provided by Allied Health Assistants/Therapy Assistant/ Therapy Aides, MMM4-7 locations (except North West HHS) 2016/17 to 2020/21

Delivery mode	2016/2017	2017/2018	2018/2019	2019/2020	2020/2021
In person	1,339	2,713	5,226	4,318	4,060
Telephone	245	61	72	250	197
Electronic mail	2	6	1	-	2
Telehealth - provider	4	-	2	17	19
Telehealth - recipient	253	211	322	243	203
Postal/courier service	2	-	-	-	-
Total	1,845	2,991	5,623	4,828	4,481

5 Findings: implementation of AHA positions

The findings presented in this section are based on the survey data and interviews in the Case sites. As noted previously, the response rate to the survey was very low and fewer interviews were conducted than originally intended. Therefore, while the findings reflect participants' views, they may not be generalisable to all other health services and locations.

5.1 Attraction, recruitment and retention

HHSs use a variety of methods for recruitment of AHAs and face a range of challenges in the recruitment and retention of an AHA workforce. In addition to 'normal' advertising such as Queensland Government Smartjobs and seek.com.au, rural sites reported focussing their recruitment on local communities in which positions are based.

In the small community of Case site B, on-line advertising for the Aboriginal and Torres Strait Islander identified AHA positions has been supplemented with a more localised approach, including placing ads on local community noticeboards, through local Aboriginal and Torres Strait Islander organisations and using "word on the streets".

A key enabler identified for recruitment of AHAs in rural and remote communities is employment of local people. People who have existing ties and knowledge of the communities in which they work provide valuable insight into those communities that can be shared with other allied health team members. This can range from helping a visiting AHP to “find the best coffee” to providing advice about local services and acting as a liaison between community members and health services. Further, local recruits often have a passion for assisting their own community and, as demonstrated in the workforce data, can be long term employees, reducing retention challenges.

Involving local health service managers (e.g., Directors or Nursing [DONs]) in the recruitment process can be beneficial for identifying and engaging suitable local candidates, and in the longer term can also assist in creating positive working environments for AHAs, particularly where they are situated remotely from their operational manager and clinical supervisor.

In Case site D local recruitment has proven the most effective strategy so far. Successful candidates did not have AHA qualifications or previous experience but lived locally and knew the context of their communities. The HHS has supported AHAs to complete their Certificate IV in Allied Health Assistance.

In Case site A recruitment to AHA positions was focussed on attracting local candidates who were already embedded in their communities. The local Director of Nursing was part of the recruitment panel and was often a useful resource for identifying potential candidates, either internally within the health service or the wider community. A number of AHAs have been recruited from operational streams within the local health services. This approach was seen to have advantages for retention. By targeting recruitment to people with ties to the communities, they may be more likely to stay for a longer period.

Understanding the type of people interested in AHA roles is also relevant for attraction and recruitment. In the survey, the three most commonly cited reasons for choosing to become an AHA were:

- interest in working with people,
- interest in the health care sector, and
- type of work activities.

Retention challenges vary in different places. In larger centres there are more jobs available, such as roles in disability support or aged care, both within and external to the HHS. In these settings the AHA workforce may be more mobile, and services may face greater challenges in retaining AHAs than in smaller communities where there are fewer alternative employment options.

Several participants identified that the salary for AHAs has historically been lower than administrative positions. A number of examples were cited where AHAs had moved into administrative or other HHS roles because the remuneration was higher. Salary differences were noted to have reduced since migration of AHAs to the clinical assistant (CA) stream in HPDO3.

Frequently AHPs and other health professionals are offered accommodation or accommodation allowances, particularly in more remote locations. While it was noted in the case sites that recruitment often focusses on attracting local people to the AHA roles, participants noted that accommodation support is not available to AHAs and is a potential barrier to recruiting suitable candidates from outside the local area. A number of AHPs and other professionals felt this is unfair given they are all members of the same teams and have the same costs of living in these communities.

5.2 Line management and clinical governance

In all the case sites, line management (including administration and human resources functions) of AHAs is undertaken by the team leader, manager, or director of the allied health team. No specific issues with this approach were identified in the interviews, with one team leader noting that “it is just like any other team, there is nothing specific to the AHA role that impacts on how line management occurs or the issues that arise from time to time in any team”.

There was more variation between case sites in the way clinical supervision of AHAs is provided. Clinical supervision is ‘a formal working alliance between an allied health assistant and allied health professional, with the primary intention to ensure alignment of practice capabilities to the supervisee’s role and setting and to enhance the knowledge, skills and attitudes of the supervisee’ (Queensland Health 2022b, p5). This is distinct from ‘task monitoring’ that is part of the delegation process and ensures safety and quality of the delegated tasks. The approaches to clinical supervision in case sites ranged from limited formal clinical supervision to a structured approach modelled on the way AHPs have clinical supervision in the team. The majority of AHA survey respondents (27/35, 77%) indicated they have access to regular clinical supervision. Maintaining clinical supervision arrangements was reported to be challenging in situations where there is high AHP turnover, which is common in rural and remote settings.

In Case site C each AHA is paired with an AHP for clinical supervision. Where possible, an AHP external to the team also provides supervision to enable support for operational and team dynamic matters, e.g., issues that arise with clinical prioritisation and expectation management, in situations where there are multiple AHPs delegating to the AHA.

In Case site A each AHA is allocated an AHP as their “lead clinical supervisor” who is responsible for providing clinical supervision. This mirrored clinical governance arrangements for AHPs. Time is quarantined in both AHA and AHP calendars for supervision to ensure it is not “bumped” by other tasks. Clinical supervision includes mentoring, advice, and guidance about clinical tasks and, where appropriate, support for completing Certificate IV training. Initially supervision is provided weekly then moved to fortnightly or monthly as the AHA becomes more experienced in their role. A group-based peer supervision model is in place for AHAs who have over five years’ experience. Some experienced AHAs access both individual and peer group supervision arrangements.

In Case site E a rotational supervision model across the AHP staffing has proven to be most effective. It increases the inter-professional supervision experiences, which is valuable, whilst distributing the responsibilities and time allocation for supervision across AHPs. Depending on the available workforce and skillset at the time, the service aims to ensure each AHA has a different supervisor for education and development activities.

Some rural and remote AHAs in case sites work in situations where they are not physically located with their line manager and/or their clinical supervisor. These AHAs work within a team in a small healthcare facility that has a separate management and governance structure. While this was reported to work well in many situations, case site interviewees identified that it can also pose challenges if the role of the AHA is not clearly understood by the local healthcare team.

Nearly half of AHA survey respondents said they felt isolated in their role, despite most being located in regional or larger rural centres and most being co-located with their primary clinical supervisor.

Case site A stakeholders noted the importance of engagement between the allied health team and the local facilities in which AHAs are based. The allied health team has undertaken inservice training with staff in local facilities (predominantly nurses) including information on the AHA's scope. This clarity of role and functions was seen as important for AHA employees and the quality and safety of the service.

AHAs can be well supported in off-site or remote environments when the local managers see them as part of the team and establish effective communication and support mechanisms with other team members (primarily nurses, doctors, and operational staff) in the local facility. One local service manager in a case site emphasised the importance of their role in encouraging and supporting AHAs as well as providing AHAs with advice and feedback when they perform well and including them in local team activities and meetings.

5.3 Networks

Approximately half of AHA survey respondents said they were part of at least one peer network or community of practice. About a third reported were part of a Queensland Health statewide network and/or a HHS AHA network.

The Case site A AHAs have a peer support network that meets once a month and includes all AHAs across the seven rural sites of the HHS. This network is also used for peer supervision by more experienced AHAs.

5.4 Training

5.4.1 Vocational Training

The majority of AHAs in case sites have completed or are currently undertaking a Certificate IV in Allied Health Assistance. The AHA survey identified the most common enablers for completing the Certificate IV training included:

- the availability of the course online,
- support from clinical supervisors and/or team members,
- the ability to gain recognition for prior experience or learning, and
- having fees paid by their employer.

Conversely the most common barriers to completing the training were:

- time needed to complete coursework while also working,
- cost of training, and
- difficulty in accessing suitable placement opportunities.

Note: the data collection for this project occurred in advance of or concurrently with the implementation of enhanced training support arrangements through the Clinical Assistant stream in the HPDO3, so the impact of this change is not reflected in the outcomes.

While some of these factors (course availability and recognition of prior learning) are beyond the control of HHSs, understanding the factors that support completion may be helpful in guiding and supporting AHAs in selecting and enrolling with a course provider. Further, clinical supervision provides an opportunity for ensuring on-the-job training reflects and complements the education program. One case site noted the value in having cohorts of AHAs completing training at the same time to increase peer learning and support.

5.4.2 On-the-job training

Clinical Training Instructions (CTIs) describe the best practice process for undertaking a delegated task. All case sites referenced the Queensland Health CTIs as the key tool for on-the-job training undertaken by AHAs in addition to mandatory training such as hand hygiene and basic life support. Interestingly, there was limited discussion of resources beyond the CTIs or of training approaches for non-clinical tasks or other work activities for which a CTI is not relevant. Training in each CTI is generally provided by the AHP that will delegate the task. Most teams reported using the OCAHO resources for training and “signing off” AHAs when they are competent in specific CTIs. Some teams conduct annual refreshers/reviews of CTIs with AHAs, although this is not universal and is influenced by the nature and complexity of the tasks and the day-to-day monitoring and supervision arrangements available to AHAs.

The on-the-job training approach enables AHPs to contextualise the CTIs to their circumstances and to develop confidence in the AHAs as they learn and develop their skills. However, several challenges were also noted. Rural and remote teams often have a high turnover of AHPs, impacting on the availability of AHPs to train AHAs and/or undertake regular reviews. Sites noted that AHP locums/short-stayers can have less understanding or commitment to using the AHA workforce and can see training as a burden. Training AHAs can be time consuming, particularly in models where there are several AHAs working in different sites. “Meeting the AHAs training and supervision requirements” was one of the five most commonly cited challenges identified in the AHP survey.

As noted by the Case site A team, it is logistically challenging to get everyone together to do training across their geographically dispersed team. Training sessions would often have to be repeated to ensure all AHAs have participated, placing burden on AHP trainers.

To address this challenge, the team developed training videos and quizzes for AHAs to use as initial and ongoing training for particular tasks. AHAs have found these particularly helpful, including as a reference for when they are delegated a task they do not perform regularly to refresh their knowledge and give them the confidence to perform the task. AHAs can use these resources independently of the AHP, saving time for busy clinicians and providing flexibility for AHAs in how and when they undertake additional training.

The Case site A team has a structured orientation program for new AHAs which occurs over four weeks and includes time on-site with the AHPs in the service hub and at the local site. The first two weeks includes all mandatory training (e.g., hand hygiene, basic life support etc.) while the second two weeks is more 'hands on', learning the role and completing relevant clinical task training.

The OCAHO CTIs cannot cover all potential tasks undertaken by AHAs across all rural sites. A stakeholder noted that there is a limited number of social work CTIs. Individual sites will continue to develop CTIs for these tasks that are relevant to their service model. However, there was strong support for continuing a centralised approach to developing CTIs for common tasks in order to minimise duplication of effort across teams statewide and to support teams with limited capacity to develop CTIs.

5.5 Processes that support delegation

AHAs and AHPs reported using a variety of mechanisms to support the delegation of tasks. Some services have a regular (e.g., weekly) multidisciplinary team meeting where they discuss current clients and workload. In some cases, delegation instructions will be provided at these meetings to an AHA for a specific client and task. Alternatively, AHPs will communicate directly with AHAs outside the meeting, either in person or via email or phone/telehealth. Similarly, documentation of delegated tasks varies between services. Some have a specific form that is used to record delegation instructions, while in other sites tasks are delegated via email and documented in clinical notes and client record systems.

Case site D has a delegation model which is a combination of protocol-driven (procedures) and AHP delegation instruction (mostly via telehealth). Protocol-driven delegation is applied to selected low-risk, routine assessments and activities. If a patient meets the protocol criteria for the task, the AHA implements designated assessments in the required timeframe and then reports outcomes to the AHP (usually via telehealth), who may then delegate further tasks or refer to other team members if required. Protocol-driven delegation is commonly used for initial assessment and information collection tasks, enabling the AHP team to understand the needs of new clients and triage further care.

Utilising AHAs effectively and safely requires AHPs to provide instruction, bespoke task training and monitor the process and outcomes of the task. Some stakeholders acknowledged that when AHPs have a high workload and many competing demands it can be challenging to find the balance between delegation and “getting through” their own work tasks. Further, many AHPs in rural and remote services are early career practitioners who are still learning in their practice and developing their clinical and professional skills including prioritisation and demand management. Many have had minimal or no experience of delegating to AHAs in their professional training and need support to work effectively in these service models. Where they have had previous experience, it has often been with single discipline AHAs, rather than generalists working in multidisciplinary service models.

Stakeholders identified that building trust between AHAs and AHPs is fundamental to successful delegation and that this can take time. Ensuring new AHPs are appropriately oriented to the service model and the skills and scope of AHAs in the team is important. This is challenging when there is high turnover of AHPs. Locums, in particular, can be reluctant to delegate and may not be in the service for long enough to develop knowledge of the delegation model and trust in the AHAs’ capabilities. Some interview participants noted that clear documentation describing the service model and how delegation works can assist new and short-term AHPs. This is crucial in small rural and remote multi-professional teams, as unlike large facilities incoming AHPs may not have another practitioner of the same profession to discuss or role model how delegation works within their practice area.

AHPs in case sites reported being conscious of the potential to underutilise AHAs full scope of practice and to undervalue AHA roles as members of the clinical team. In the case sites it was evident that there is variation in the availability of operational and administrative staff to support allied health teams, with AHPs often responsible for a range of non-clinical tasks such as cleaning of equipment and appointment management due to a lack of allied health support staff in the facility. A challenge, described by one participant as “delegation creep”, refers to the potential for AHPs to allocate a disproportionate number of these administrative and operational tasks to the AHA. Stakeholders identified the need to find an appropriate balance and to ensure that the AHA is not overly burdened with these tasks. Further, there is a risk in multidisciplinary AHA models without appropriate oversight of workload management that each AHP delegates a small amount of administration or cleaning which has the potential to add up to a considerable portion of an AHA’s day.

Rural allied health teams often have vacant AHP positions. Stakeholders identified that AHAs can be the most consistent workforce, while there is considerable turnover of AHPs. Some teams in case sites have used telehealth to regional teams to maintain service provision when there are AHP vacancies. In these cases, service responsibilities transferred to an AHP from another service in the HHS or a statewide service, may include responsibility for delegation to the AHA. Explicit orientation to this responsibility and the delegation model is required.

Case site E has used the Statewide high risk podiatry service to provide delegation and task monitoring, and also clinical supervision of the AHA when there have been podiatrist vacancies in the HHS, and the task had previously been delegated to the AHA under protocol. The statewide service has been available for the AHA to escalate care requirements if indicated by the protocol. The allied health team are now working with the statewide podiatry service to develop direct delegation to the AHAs i.e., tasks that are not included in existing protocols.

Further investigation is also underway for the AHA to be able to deliver diabetic foot screening to improve triage and waitlist management with the local and/or statewide tele-podiatry service. The model will support timely risk categorisation of patients referred to podiatry as part of their annual cycle of care. Screening and triage should assist the podiatry service to prioritise high risk cases and refer low risk cases back to the GP for ongoing monitoring as part of usual primary care. High-risk cases can be reviewed by the podiatrist and low risk cases can be referred from the podiatrist to the GP.

5.5.1 Delegation models

In multidisciplinary models, AHAs are trained in tasks that relate to the clinical service of multiple professions. However, often the majority of their work is generated by delegation from one or two professions, commonly physiotherapy and occupational therapy and, to a lesser extent, speech pathology, dietetics, and podiatry. This is reflected in the survey findings that showed AHAs overall reported 46% of their time was spent on delegated tasks from physiotherapy, 12% from occupational therapy, 8% from speech pathology and 6% from dietetics/nutrition.

AHPs in the interviews and survey identified workload allocation and division of AHA resources across professions as the most common challenge for rural and remote allied health teams.

The balance of delegated tasks performed by each AHA is determined by several factors including the service model and patient needs. Teams in case sites have a variety of mechanisms for managing AHA workload and prioritising delegated task. In some sites processes are not formally documented but rely on discussion and negotiation day to day. Stakeholders indicated that this can work well where AHAs are experienced and have the confidence to raise concerns with relevant AHPs if they feel they are overburdened or workload allocation is inefficient or inconsistent with care demands. However, there are also challenges in this approach (as outlined below), particularly for inexperienced AHAs.

AHPs from professions that are currently delegating less to AHAs suggested that they frequently identify opportunities for increased use of AHAs in their services but note that the AHAs are already working to their full capacity and/or that there is no mechanism for them to delegate new or additional tasks. This suggests there may be value for some services in reviewing the overall balance of delegated tasks periodically to ensure this is producing optimal outcomes for clients and the service.

Although trained and employed in multidisciplinary teams, it was noted by several interviewees that AHAs often have, or develop, a preference for a particular allied health profession or clinical area and can be reluctant to undertake delegated tasks from other professions. In some circumstances this can lead to AHAs preferencing some tasks over others, particularly in the absence of a structured work allocation and prioritisation process. In these situations, AHPs in case sites noted that they can find it challenging to delegate to AHAs and would prefer a “fairer” system of workload allocation that explicitly reflects service need. Where there is a focus on a practice area for a particular AHA position, this needs to be clearly articulated to both the AHA and the team.

AHPs in the case sites noted that where AHAs predominantly work in a focussed or narrow area of practice, the currency of skills and confidence to implement other tasks decrease over time. AHPs may also have reduced confidence in AHAs using a broader skill set. This can lead to loss of skills depth and breadth and reduce the flexibility of the AHA role for the team. Opportunities to maintain competencies, including using skills in the workplace and regular training, are important for maintaining a flexible and relevant AHA workforce with capabilities across the range of practice areas required by the service.

It is evident from interviews that team leaders and/or senior AHPs taking responsibility for workload allocation between AHAs (where there is more than one AHA in a team) is an important mechanism to ensure that both service and patient goals can be met. This includes both the day-to-day oversight of workload, and monitoring of AHA competencies/CTIs against the team's service and delegation model.

Case site E has recently introduced a centralised approach to allocation of AHA tasks. All delegations are sent to a central email address and an experienced AHA allocates tasks on a weekly basis, taking into consideration the individual skills, training goals and availability of each AHA. This approach addresses some of the challenges outlined above in relation to balancing tasks between professions and reduces the impact of individual preferences on the allocation of staffing resources.

Case site C has a daily collaboration meeting to promote communication across the team and optimise AHAs' workload allocation. The team has developed a timetable for tasks required to support scheduled group programs and care plans for individual consumers. There is a feedback template for the AHA to document the tasks completed for each group on that day.

In the Case site A delegation occurs on regular outreach visits, at the weekly multidisciplinary team meeting, through a telehealth meeting or via email or telephone. The team have a delegation form, however each AHP and AHA tend to work out their preferred communication methods for task delegation. Delegation requests, particularly for commonly-delegated tasks, are often sent via email directly from the AHP to the relevant AHA in the rural site.

5.5.2 Delegation Training

Delegation is one of the key elements of AHA-supported models of care and, as highlighted in the AHA Framework, it is important for both AHPs and AHAs to have a clear and common understanding of the nature and process of delegation and the related responsibilities and accountabilities. This project revealed variation in how sites implement delegation training.

Some case sites have undertaken formal delegation training for their teams at some point (e.g., a Cunningham Centre workshop). However, this was usually a one-off event due to the coordination and investment requirements of face-to-face training. While managers noted that delegation training is important for all staff, interviews suggest that many AHAs and AHPs have not had delegation training

either in their current or previous roles. About half the AHA and AHP survey respondents had undertaken specific training in delegation.

AHPs identified several reasons for not having participated in delegation training including being new to their positions or not having been present when a workshop was provided for the team. Some had undertaken training in previous positions, but this would not always have been contextualised appropriately to the rural service model in which they are now working. One case site noted a lack of suitable and accessible training options. Maintaining the currency of delegation training is a challenge where there is a high turnover of AHPs. It should be noted that the data collection for this project preceded the launch of the online, flexible learning [Foundations of Delegation Training Package](#) by the OCAHO in 2022.

AHPs noted that, while they may not have had formal delegation training, they generally felt comfortable in delegating to AHAs. However, several also noted that delegation training tailored to the specific service model was important and should be part of the orientation for new and locum staff in order to sustain their service models.

Identified options for improving the approach to delegation training included:

- promoting on-line delegation training options,
- incorporating delegation training into regular team meetings/calendars, and
- requiring delegation training as part of orientation and continuing professional development for AHPs.

5.6 Understanding and acceptance of AHA roles

The interviews and survey both found that AHPs report having a good understanding of the role of AHAs in the rural and remote service context. Sixty percent (60%) of AHP survey respondents had been a clinical supervisor of an AHA, either at the time of completing the survey or previously, and 96% had worked with an allied health assistant at some stage. Eighty eight percent (88%) agreed or strongly agreed with the statement “I understand the role of and Allied Health Assistant working in a healthcare team”. Eight six percent (86%) agreed that AHAs are integral to the outcomes delivered by their teams.

AHA survey respondents also overwhelmingly reported that they felt their role was understood and valued by the allied health team, the broader multidisciplinary team and by patients/consumers. Survey respondents felt the role is less well understood by other service providers such as general practice staff.

As previously described, AHAs in rural and remote services often work in situations where they are located in different sites than their managers and clinical supervisors, such as in small rural hospitals or MPHSs. In these facilities the AHAs work alongside nurses, doctors, and operational staff on a day-to-day basis. The extent to which others understand the role of AHAs was reported to vary. AHAs cited some instances of nurses or other staff requesting them to undertake an activity or task that was not part of their role, but this was not common. AHAs reported that they tend to build good rapport with non-allied health teams and these staff develop a sound understanding of the AHA roles.

The Case site A model involves AHAs working remotely from their line managers and mostly remotely from their clinical supervisors. Ensuring safety and appropriate governance was a primary consideration in the development of the model. Enabling factors for making this arrangement work include:

1. The allied health team leader developing and maintaining close working relationships (both formal and informal) with the DONs of the remote facilities. This is made easier in Case site A HHS as the allied health team leader and the DONs are in the same management stream. It was noted that these relationships have required active engagement and “will not happen magically”.
2. DONs are provided with orientation to the AHA role and allied health delegation model to ensure there is a common understanding.
3. DONs participate in recruitment panels for local AHA positions. This ensures they feel ownership of selection decisions. DONs are also well placed to provide advice about recruitment and retention from a local perspective.

The evaluation team only spoke directly to two consumers about their understanding and perceptions of AHAs. However, AHAs noted that they rarely refer to themselves as “an Allied Health Assistant” with their clients. Rather they would use terms such as “physiotherapy assistant” to make the delegating profession or scope of the delegated task clear to the client. They generally report that clients are happy to receive services from AHAs and that they understand their role as supporting the allied health team.

6 Findings: benefits

As previously described, AHA activity data was unable to be sourced that was adequately disaggregated and reliable to be used in this project to quantitatively examine AHA service contributions. However, through consultations and the surveys, participants were able to highlight a number of factors that illustrate the value of the AHA roles.

6.1 For patients

For communities and individual patients, the benefits identified by stakeholders included:

- Patients receiving more timely care
- Helping people to be discharged sooner from hospital through greater capacity for outpatient and home-based care
- Patients receiving more intensive therapy or intervention than would otherwise be possible with an outreach AHP service alone
- Provision of rehabilitation services that would otherwise not be available in smaller communities

- Delivering care that aims to enable people to stay in their homes for longer before moving into residential aged care
- Patients get to know the AHAs in the community
- People can receive services closer to home.

Delivering pre-admission clinics or follow up appointments via telehealth with AHA support was highlighted as an example of improved patient-orientated services and greater team efficiency. Individual patients can receive more frequent service than was previously available through a visiting AHP outreach service where they would often only see an AHP once or twice as an inpatient. This is important for many allied health services, for which best practice indicate an optimal therapeutic frequency in excess of that possible from periodic outreach e.g., rehabilitation.

6.2 For health services

Case site reports highlight that AHPs in rural and remote services are often sole practitioners in their professions, frequently covering large geographical areas and multiple small health facilities. Delegation of non-complex clinical tasks to AHAs enables AHPs to focus on more complex clinical demands and increases occasions of service provided by the allied health team.

In dispersed service delivery models AHAs can enhance continuity of care, including maintaining service frequency when outreach is limited (e.g., wet season) or during short periods of AHP absence through delegation and supervision from regional sites. AHAs also provide services with flexibility where two staff are required to oversee a programs or activity for safety of quality reasons and can support the cultural appropriateness of allied health services in some cases.

Stakeholders identified that AHAs can improve the efficiency of AHP visits to outreach sites by:

- ensuring clinical spaces are ready for visiting AHPs,
- having resources and equipment available, and
- assisting with the management and coordination of patient appointments, including across allied health professions.

Telehealth, facilitated and supported by AHAs, was demonstrated in the case sites to enable AHPs to deliver and monitor a range of services that would be difficult to implement through infrequent outreach. This approach can increase the number of patients that can be seen by AHPs by reducing travel time, minimising time between appointments and in some cases allowing group programs to be delivered across more than one location at the same time.

During COVID-19 some AHA models enabled ongoing telehealth services to be provided at local sites, even when AHPs were unable to conduct regular visits due to travel restrictions.

7 Factors influencing successful implementation of AHA positions

Every service model is different, as are the AHA roles and delegation models. This section aims to draw on the findings of the evaluation project to identify factors or 'key ingredients' that contribute to the successful implementation of AHA positions and delegation models in rural and remote health services.

7.1 Funding

While each of the service models investigated in case sites had different drivers and beginnings, they generally had some dedicated funding to support implementation of an AHA position, whether this was new or growth funding related to a specific program, or “repurposed” existing HHS funding e.g., workforce redesign. The success of the Case site A model is the result of a well-planned and trialled approach that has developed over many years through successfully advocating for growth and program funding when opportunities arose. The Case site C model grew from reallocating funds from professional and operational positions that had a history of chronic vacancies.

Access to recurrent funding for new AHA roles is clearly advantageous, but should not be a barrier to the design and development of new service models that use AHAs in rural and remote services. Beyond the development and trial stage, it was noted by stakeholders that recurrent funding is beneficial as it enables the establishment of permanent positions, which is an advantage for recruitment and retention.

7.2 Attraction, recruitment and retention

Engagement of local people as AHAs has benefits for both services and patients. Focussing recruitment strategies on finding suitable local candidates was reported to lead to better retention. This can include using ‘word of mouth’ to let people know of a vacancy and identifying potential candidates from within health services who may currently be in operational or other roles. Given there is no mandatory qualification for CA3 AHA positions, HHSs are able to ‘cast a wide net’ in terms of the backgrounds and previous experience of potential AHAs, and focus on supporting the successful recruit with formal and on-the-job training.

Attributes of successful AHAs that were identified by stakeholders include:

- compassion and empathy,
- interest in working with people,
- good communication skills, and
- flexibility.

7.3 Education and training

Most AHAs undertake their vocational qualification while already working as an AHA. A formal clinical supervision model provides an opportunity to support AHAs in their vocational education and to ensure that on-the-job training complements and reinforces what they are learning through their studies. This could be supported by ensuring AHPs’ access to Certificate course materials and improved understanding of training requirements.

The OCAHO CTIs are well used and valued by rural and remote allied health teams. Further development of training resources related to individual tasks would be welcomed by both AHAs and AHPs. Resources, such as short videos demonstrating particular tasks, would assist teams with both initial training as well as ongoing review. While some aspects of training need to be contextualised to individual sites, there is value and efficiency in the development of centralised resources that can be shared across HHSs. Similarly, as teams identify the need for and develop new CTIs to meet their needs, there would be value in sharing these across the network, supported by OCAHO.

7.4 Dispersed teams

AHAs in rural and remote areas frequently work at different sites from their delegating AHPs and team leaders, requiring good communication and high levels of trust between AHPs and AHAs. It is also important that AHAs have a good working environment at their local site. This can be supported by ensuring local staff (e.g., nurses and operational staff) have a clear understanding of the role of the AHA and the delegation process under which they work, for example by including them in delegation training or providing comprehensive orientation to the AHA role and delegation practices in allied health. Fostering relationships between allied health team leaders and managers of local services such as DONs can facilitate AHAs being embraced and supported in their day-to-day work.

Further it was noted that AHAs benefit from formal and social contact with other members of the allied health team and from the opportunity to visit other sites to network and learn from other AHAs. Regular outreach visits by AHPs are important for ongoing support of AHAs working in dispersed teams.

7.5 Delegation

To support consistent implementation, particularly for new recruits and locums, the delegation model should be well documented in the model of care. All AHPs and AHAs should have delegation training and orientation to the delegation model.

An easily accessible and up to date skills/competency matrix of AHA competencies across different disciplines is a useful resource supporting orientation of new AHPs, workload management and clinical governance.

AHPs and/or team leaders need to be responsible for oversight of workload management and prioritisation for AHAs in the team, ensuring this reflects patient and service needs rather than clinical practice interests or preferences of individual AHAs or the confidence and skills of AHPs in delegation.

8 Conclusion

There has been significant growth in rural and remote AHA positions since 2014. While the service models in which AHAs are working differ, this project has identified evidence to suggest that AHAs provide allied health teams with a stable workforce option and contribute significantly to the sustainability of allied health service delivery in rural and remote communities.

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10 Glossary

Term	Definition
AHA	Allied Health Assistant as described in the Queensland Health Allied Health Assistant Framework, 2022 .
AHP	Allied Health Professional meaning an individual with authority to practice in an allied health profession as recognised by the Office of the Chief Allied Health Officer .
CA	Clinical Assistant as defined in Queensland Health Health Practitioners and Dental Officers (Certified Agreement) , 2022
CaRS	Care in the Right Setting
CI	Confidence Interval
CTI	Clinical Task Instruction meaning a document that describes the best practice process for undertaking delegated tasks. Examples are published by the Office of the Chief Allied Health Officer .
DON	Director of Nursing
FTE	Full-time Equivalent
GP	General Practitioner
HiTH	Hospital in the Home
HHS	Hospital and Health Service as described by Queensland Health .
HPDO	Health Practitioners and Dental Officers (Certified Agreement)
HREC	Human Research Ethics Committee
KBC	Kristine Battye Consulting Pty Ltd
MMM	Modified Monash Model as described by the Australian Government
MPHS	Multipurpose Health Service
OCAHO	Office of the Chief Allied Health Officer
OO	Operational Officer as defined in Queensland Health Queensland Public Health Sector Certified Agreement (No. 9) 2016 and preceding agreements. Note: Allied Health Assistants transitioned to employment as Clinical Assistants in HPDO3 2019.
QH	Queensland Health
RACF	Residential Aged Care Facility
SSA	Site Specific Assessment
VET	Vocational Education and Training

Note on terminology used in this document:

The term for a health service user varies across the health system and includes 'client', 'patient' and 'consumer'. In this document, the terms are used interchangeably and have the same meaning.

11 Acknowledgements

Project team

KBC Australia

Dr Kristine Battye	Managing Director
Dr Cath Sefton	Consultant
Katrina Bird	Consultant
Sally Butler	Consultant

OCAHO

Liza-Jane McBride	Chief Allied Health Officer (project sponsor)
Ilsa Nielsen	Principal Workforce Officer
Tae Jostsons	Workforce Officer
Dr Rachelle Pitt	Director Health Practitioner Research

Project advisory group

Leigh Burton	Cairns & Hinterland HHS / Townsville HHS
Lee-Anne Polkinghorne	Central Queensland HHS
Marea Webb	Darling Downs HHS
Michelle Forrest	Darling Downs HHS
Sarah Willey / Sarah Bohan	North West HHS
Helen Wassman	South West HHS
Lisa Baker	Wide Bay HHS

Contributors

Case site managers and teams in Darling Downs, South West, Torres and Cape, Townsville, and Wide Bay Hospital and Health Services.