Allied Health Rural Generalist Training Positions

2015 - 2016 Implementation Report

October 2017

Queensland Government

Allied Health Rural Generalist Training Positions: 2015-2016 Implementation Report

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Overview

The Allied Health Rural Generalist (AHRG) Training Positions are a rural and remote workforce and service development strategy sponsored by the Allied Health Professions' Office of Queensland (AHPOQ). The initiative provides funding to rural and remote teams in Queensland hospital and health services (HHS) to implement supernumerary early career training positions. The first cohort of 11 AHRG Training Positions was implemented in 2014. Following positive evaluation outcomes, the roles were continued for a two-year term in 2015 and 2016.

Allied Health Rural Generalist Training Positions in 2015 and 2016

The eleven 2014 host sites were offered the opportunity to continue the AHRG Training Position implementation in 2015, with ten of these sites continuing in 2016. In 2015, eleven supernumerary Health Practitioner Level 3 (HP3.1) positions (10.6FTE) were implemented in nine HHSs and six professions: nutrition and dietetics, radiography, physiotherapy, occupational therapy, speech pathology and pharmacy. In 2016, ten supernumerary HP3 positions (9.6FTE) were implemented in eight HHSs across five professions: nutrition and dietetics, radiography, physiotherapy, occupational therapy and pharmacy. The AHPOQ funding commitment to the AHRG Training Position sites was $939,273 in 2015 and $887,411 in 2016. Funding agreements required sites to implement and report on the workforce and service development objectives of the initiative.

Workforce development objectives for local implementation sites

1. Support rural and remote allied health workforce growth and sustainability by employing a graduate/early career professional (fewer than two years professional experience).
2. Define, implement and evaluate a development plan for a graduate / early career rural or remote generalist allied health professional.
3. Implement 0.2FTE designated development time for the AHRG Training Position incumbent to complete their individual development plan, participate in supervision and engage in local service development project activities.
4. Provide local supervision to the AHRG Training Position incumbent through a co-located position of the same profession and a clinical governance process which is consistent with the requirements of the *Health Service Directive Guideline for Credentialing and Defining the Scope of Clinical Practice and Professional Support for Allied Health Professionals* (Queensland Health, 2015a).

Service development objectives for local implementation sites

1. Increase access to allied health professional services for the local community.
2. Develop, implement and evaluate rural and remote generalist service development/re-design strategies that enhance healthcare access and health outcomes of the local community.

Outcomes, findings and actions

Workforce outcomes: AHRG Training Positions

- Generally strong recruitment pools to AHRG Training Positions.
- No attrition from AHRG Training Positions during the one or two year term of the local implementation.
- Employment destination six months post-separation from the temporary AHRG Training Position for the 13 allied health professionals in the 2015-2016 positions was: 15.3% remote, 7.6% rural, 46.1% regional, 7.6% metropolitan and 23.0% unknown (not employed by Queensland Health). Most commonly the position holders secured their next job in the regional centre closest to their training position location.
- Sites achieved completion of all or most planned rural generalist training and development activities for the position holder.
- All sites implemented supervision for the position holder, with challenges experienced in some sites due to vacancies or locum staffing of the local supervisor role.

Service outcomes: AHRG Training Position implementation sites

Service development activities undertaken by local sites included the planning, implementation and evaluation of: telehealth, delegation to support workers and/or a range of new services for rural and remote consumers. The full description of local site project outcomes is shown in Appendix 1 with some highlights listed below.

- New telehealth clinics were established for pharmacy in Central Queensland HHS, dietetics in the Atherton Tablelands, and new group sessions were delivered via videoconference for clients with lymphoedema across Central West HHS facilities.
- A 120% increase in occupational therapy occasions of service (OOS) were provided to clients in the western Darling Downs in 2016.
- Telehealth-delivered physiotherapy OOS to rural outreach sites in Wide Bay HHS increased 700% between 2014 and 2016, and there was a 50% decrease in the Category 2 physiotherapy waiting list and 71% decrease in Category 3 waiting list numbers. Evaluation found non-inferior clinical outcomes for clients attending telehealth clinics compared to traditional face-to-face service delivery.
- In 2015 a total of 2940km client travel was avoided through the development of telehealth physiotherapy services in South West HHS.
- AHA-delivered OOS that included implementation of specified delegated clinical tasks increased 7% between 2014 and 2015 and a further 28% between 2015 and 2016 in Innisfail.

Challenges for service development strategies included the disruptive effect of staff turnover and vacancies in key positions, and access to project management, change leadership and evaluation experience and expertise in small rural allied health teams.

Recommendation 1

Continue implementation of the AHRG Training Positions initiative in 2017-2018, and progress the embedding of the employment model in statewide rural and remote workforce structures.

The AHPOQ continued to fund supernumerary AHRG Training Positions for a two-year funding term that commenced in January 2017. The 2017-2018 implementation in new host sites will further test the AHRG Training Positions employment model, particularly the inclusion of a formal education program (see recommendation 2).

Action 1(a):

The AHPOQ and HHSs progress the integration of the AHRG Training Position employment model into existing and new HP3 rural and remote positions. For health service-funded AHRG Training Positions (positions in existing establishment) the employment model for early career practitioners (0-3 years professional experience) should include:

- dedicated development and supervision time of 0.1FTE - 0.2FTE (minimum 4 hours per week),
- a development plan including participation in a formal rural generalist education program,
- funding to support participation in the development plan activities and education program,
- co-located or highly accessible (onsite >50% work hours) profession-specific local supervisor implementing a formal supervision process, and
- active engagement and contribution to local rural generalist service development strategies that improve client care and service outcomes.

Stakeholders should work collaboratively to identify barriers and implement trials of HHS-funded AHRG Training Positions in parallel with the AHPOQ-funded roles in 2017-2018.

Action 1(b):

The AHPOQ, Cunningham Centre and stakeholders in HHSs and the Department of Health collaborate to address barriers and implement strategies to develop an Allied Health Rural Generalist Pathway in Queensland Health including an integrated human resources / employment and education model.

Recommendation 2:

Develop, implement and evaluate a formal rural generalist education program.

In late 2016, the AHPOQ engaged James Cook University (JCU) in collaboration with QUT to develop and deliver a two-level rural generalist education program that includes clinical training streams for seven allied health professions: nutrition and dietetics, medical imaging, occupational therapy, pharmacy, physiotherapy, podiatry and speech pathology.

Action 2:

The AHPOQ and HHSs support the trial of the JCU / QUT Rural Generalist Program including building the program into the AHPOQ-funded AHRG Training Positions and into health service-funded training positions as they emerge.

Recommendation 3:

Improve local (HHS) implementation processes and supports for the 2017-2018 implementation of AHPOQ-funded AHRG Training Positions.

Action 3:

The AHPOQ, Cunningham Centre and HHSs support project management capacity building strategies in AHRG Training Position host sites, with a particular focus on investment in key professional and operational leadership roles.

Overview

Background

The Allied Health Rural Generalist Training Positions (AHRG Training Positions) are a rural and remote workforce and service development strategy sponsored by the Allied Health Professions' Office of Queensland (AHPOQ). The initiative provides employment opportunities for early career allied health professionals in rural and remote health services, and supports the development, implementation and evaluation of rural generalist workforce and service models at host sites.

Eleven (10.6FTE) AHRG Training Positions were allocated to rural or remote host sites in Queensland hospital and health services (HHSs) in 2014. The 2014 trial was evaluated by Southern Cross University (SCU) and the AHPOQ. Based on positive evaluation outcomes the initiative was continued in 2015 and 2016 with recommendations from 2014 trial adopted.

Aims

The aims of the statewide AHRG Training Positions initiative in 2015-2016 reflected the workforce and service development priorities for rural and remote health services in Queensland.

Workforce

Workforce development aims were to:

1. increase employment of new graduates and early career allied health professionals in rural and/or remote health services,
2. establish and evaluate a model for early career employment in rural and remote areas including development and support requirements, and
3. incentivise rural and remote practice for early career professionals and support the sustainability of the rural and remote allied health workforce.

Service

Service development aims were to:

1. increase access to allied health services for rural and remote Queenslanders including expanding the range of services available "closer to home", and
2. improve the quality and safety, appropriateness, efficiency and sustainability of rural and remote allied health services.

Objectives

In 2015, eleven (10.6FTE) AHRG Training Positions were implemented in nine HHSs. In 2016, ten (9.6FTE) positions were implemented in eight HHSs. Workforce and service development aims of the initiative were actioned through a funding agreement between the AHPOQ and the AHRG Training Position host HHS. Host site workforce and service development objectives reflected the aims of the statewide AHRG Training Positions initiative.

Workforce development objectives

Workforce development objectives for host sites in 2015-2016 were to:

1. support rural and remote allied health workforce growth and sustainability by employing a graduate/early career professional (fewer than two years professional experience at commencement in the role),
2. define, implement and evaluate a development plan for a graduate / early career rural or remote generalist allied health professional,
3. implement 0.2FTE designated development time for the AHRG Training Position incumbent to complete their individual development plan, participate in supervision and engage in local service development project activities, and
4. provide supervision for the AHRG Training Position incumbent through a co-located position of the same profession and a clinical governance process which is consistent with the requirements of the *Health Service Directive Guideline for Credentialing and Defining the Scope of Clinical Practice and Professional Support for Allied Health Professionals* (Queensland Health, 2015a).

Service development objectives

Service development objectives for host sites in 2015-2016 were to:

1. increase access to allied health professional services for the local community, and
2. develop, implement and evaluate rural and remote generalist service development/re-design strategies that enhance healthcare access and health outcomes of the local community.

Resourcing

The AHPOQ funding allocation to the AHRG Training Positions in HHSs was $939,273 in 2015 and $887,411 in 2016. HHSs received non-recurrent funding to implement the AHRG Training Positions in the location and profession identified in the funding agreement. Funding was provided in six-monthly transfers. The funding model was:

- salary at HP3.1 for 52 weeks + 25% on-costs,
- rural or remote allowance applicable to position location,
- professional development funding equivalent to that paid to permanent employees in the same location, and
- one site was provided with funding for accommodation support.

All HHSs contributed resources to support the AHRG Training Position host site implementation through budget allocations (e.g. accommodation support, additional professional development funding), and/or in-kind resourcing (e.g. professional supervision and training from local and regional clinicians).

Implementation activities in 2015-2016

Statewide implementation and coordination activities

The 2015-2016 statewide implementation activities reflected the recommendations of the 2014 evaluation and further development of the strategy.

a) Management of the Queensland Health AHRG Training Positions trial

The AHPOQ continued to fund supernumerary AHRG Training Positions in 2015 and 2016 as recommended by the 2014 evaluation. The extension of the strategy beyond its initial 12-month pilot phase aimed to further test and embed the concept of rural generalism and a rural generalist training pathway. The AHPOQ elected to extend funding arrangements with the 2014 host sites to allow the model to be fully developed in those locations. All host sites that were offered an extension to the AHRG Training Position funding agreement accepted the offer. This included 10 sites offered a two-year extension and one site offered a one-year extension. The latter was to align with the training timeframe for the incumbent. The majority of sites chose to continue with the same profession for the position during 2015 and 2016, with one site changing profession. New incumbents were recruited to all positions except one in 2015, and to four positions in 2016. All incumbents completed the full term of their one or two year appointment.

Host sites and AHRG Training Position professions for 2015-2016 are shown in Table 1.

b) Transition of statewide operational management and coordination

Coordination and statewide operational management of the initiative moved from the AHPOQ to the Cunningham Centre, Darling Downs HHS in January 2016. The Cunningham Centre took responsibility of host site support and the coordination of funding and reporting. The AHPOQ remained responsible for funding decisions and endorsement of local site implementation plans and reports. An AHRG Training Position Steering Group was formed that included representatives from the Cunningham Centre, the AHPOQ and a Director of Allied Health from a HHS with a training position host site. The steering group met quarterly during 2015-2016.

A range of resources were developed to support host site implementation activities including templates and examples of implementation and evaluation plans, progress and completion report templates, recruitment advertisement flyers and development plan templates.

c) Annual showcase

An annual host site implementation showcase was facilitated to support sharing of site outcomes and learnings and to build awareness of the AHRG Training Positions. Showcases were held by videoconference in April 2016 and May 2017, covering implementation in the previous calendar year. Showcase attendance continued to be strong at more than 35 videoconference sites. Attendees included employees of Queensland HHSs, health services in the Northern Territory and universities.

d) Allied Health Rural Generalist Education Framework and formal education program

The 2014 evaluation identified that the lack of a formal rural generalist education program was a barrier to the development of a rural generalist pathway for the allied health professions. To address this barrier the following projects were undertaken in 2015 and 2016:

- The AHPOQ funded the Cunningham Centre to develop an allied health rural generalist education framework, reflecting inter-professional non-clinical and profession-specific clinical capabilities for seven professions: occupational therapy, nutrition and dietetics,

pharmacy, podiatry, medical imaging, speech pathology, and physiotherapy. These professions were prioritised for the framework as they had training positions in 2015 or 2016.

- An expert review of the education framework was funded by the AHPOQ and coordinated by the Greater Northern Australia Regional Training Network (GNARTN) in early 2016. Reviewers were senior academics from the seven relevant professions and who possessed educational design and/or accreditation experience.
- An expression of interest process was coordinated by the AHPOQ to identify an education provider to develop and implement a formal two-level education program for allied health rural generalists. The program will be based on the education framework. James Cook University in partnership with QUT were engaged to undertake this work.

e) National collaboration and stakeholder awareness raising

The AHPOQ continued active engagement in and leadership of some inter-jurisdictional / national allied health rural generalist projects. Stakeholder engagement included meetings with government and non-government health services, and primary health networks in and beyond Queensland, Commonwealth government departments, professional associations / peak bodies, rural health workforce agencies, universities, and other groups. Presentations were also provided to the 11th National Allied Health Conference 2015, 12th Services for Australia Rural and Remote Allied Health (SARRAH) Conference 2016; 2nd Developing Northern Australia Conference 2016, Society of Hospital Pharmacists Futures Summit 2016, and the Queensland Health Statewide Rural and Remote Clinical Network Forums and Workshops in 2015 and 2016.

Host site implementation activities

a) Management of site implementation and reporting to the funding provider

Hospital and Health Services managed the local implementation of AHRG Training Positions in their nominated location/s. The planning and reporting requirements of HHSs to the AHPOQ in 2015 and 2016 were:

- Local site implementation plans including a 12-month development plan for the incumbent, service development project plan, and an evaluation and monitoring plan for workforce and service development objectives (due late February),
- Brief progress report (due late July),
- Annual implementation report (due late March 2016 and late February 2017).

b) Recruitment and management of the AHRGT Position

Hospital and Health Services managed recruitment to the AHRG Training Positions as per usual processes. A role description template was provided to all sites, but its use was not mandatory.

Operational and professional management was implemented by the employing work unit. Apart from administering the professional development funding allocation for the temporary incumbent, management was consistent with normal human resource processes.

c) Professional support and development for the AHRGT Position

During 2015 and 2016, the operational manager and local profession-specific supervisor generated a 12-month development plan in consultation with the incumbent and other relevant staff e.g. clinical educator in the regional centre. Professional support (supervision)

arrangements were also developed and implemented. The development and professional support plan was approved by the relevant professional-specific and/or allied health leader in the HHS (e.g. director of profession and director of allied health) and submitted to AHPOQ as a component of the annual implementation plan.

A template for the 2015 development plan was provided that included major clinical and non-clinical development topics. A scoping project undertaken during 2015 resulted in the development of a rural generalist education framework that included clinical training requirements for seven professions. This framework was used as a base for a more structured and profession-tailored template that was provided to sites in 2016. The framework and resulting template identified four key domains for capability development: service delivery, rural and remote practice, profession-specific clinical skills, and service-specific clinical skills.

The operational manager and local supervisor were responsible for monitoring and reporting on the implementation of the development plan and professional support arrangements to the AHPOQ as part of the progress and completion reports.

d) Service development strategies

AHRG Training Position host sites were responsible for the development, implementation and evaluation of one or more rural generalist service development projects. Local projects needed to focus on one or more of the following allied health rural generalist service delivery strategies:

- delegation and better use of support workers (e.g. allied health assistants, licenced X-ray operators)
- extended scope of practice including:
  - skill sharing between allied health professions,
  - primary contact (complex practice) roles, or extended scope clinical functions such as prescribing, imaging and pathology ordering and interpretation beyond entry-level competency,
- telehealth, and
- new services, including the use of partnerships, that move care from larger centres to rural/remote facilities if safe and appropriate to do so.

The projects were outlined in annual local site implementation plans approved by the HHS sponsor and endorsed by the Chief Allied Health Officer. The local site implementation plan included a description and rationale for each project, performance indicators and an evaluation plan, as well as governance and stakeholder engagement plans. Progress against the nominated indicators and the status of the project were reported in the progress and completion reports. Host sites were able to develop projects that were most relevant to their context, service model and community needs. This allowed tailoring of the implementation to local demands and priorities. However, the approach limited the capacity for the AHPOQ to standardise implementation resources and evaluation indicators, and restricts the synthesis of outcomes data for the statewide initiative.

Table 1 Locations and professions of 2015-2016 AHRG Training Positions

Hospital and Health Service	Location	2015 AHRG Training Positions profession	2016 AHRG Training Positions profession
Cairns and Hinterland	Atherton	Dietetics	Dietetics (continuing incumbent)
Cairns and Hinterland	Innisfail	Physiotherapy	Physiotherapy (continuing incumbent)
Central Queensland	Emerald	Pharmacy	Pharmacy (new incumbent)
Central West	Longreach	Occupational therapy	Occupational therapy (continuing incumbent)
Darling Downs	Chinchilla	Occupational therapy	Occupational therapy (continuing incumbent)
Darling Downs	Kingaroy	Physiotherapy	Physiotherapy (continuing incumbent)
Mackay	Moranbah	Medical imaging (2014 continuing incumbent)	N/A – no position in 2016
North West	Mount Isa	Speech pathology	Occupational therapy (new incumbent)
South West	St George	Physiotherapy	Physiotherapy (continuing incumbent)
Torres and Cape	Weipa	Medical imaging	Medical imaging (new incumbent)
Wide Bay	Gayndah	Physiotherapy	Physiotherapy (new incumbent)

Outcomes, key learnings and actions

Outcomes and performance

The outcomes of the AHRG Training Positions implementation against the five aims of the statewide initiative are discussed below.

Workforce development aim 1:
Increase employment of allied health new/recent graduates in rural and/or remote health services

Eleven (10.6 FTE) supernumerary positions were implemented in rural and remote areas in 2015, and ten (9.6 FTE) were implemented in 2016. All host sites successfully recruited to the positions in both 2015 and 2016. (Note: North West HHS elected to change the profession of their AHRG Training Positions in 2016 from podiatry to occupational therapy after being unable to recruit to the podiatry position). All incumbents remained in their positions for the one or two-year appointment term.

The implementation of the supernumerary roles, coupled with a complete recruitment and retention outcome, indicate the initiative was successful in increasing opportunities for new/recent graduate employment in these allied health professions in rural and remote services.

In 2015, seven incumbents were new graduates/professional entry, with the remaining four having 12 months professional experience. In 2016, two incumbents were new to professional practice, seven had 12 months experience (six of these were continuing incumbents from 2015), and one was two years post-completion of professional entry requirements.

Workforce development aim 2:
Establish and evaluate a model for early career employment in rural and remote areas including development and support requirements

The 2015-2016 implementation focussed on further refining the employment model for early career professionals in rural generalist training positions, and implementing the recommendations of the 2014 evaluation. Changes included:

- The criterion for eligible recruits was expanded from new graduates to early career professionals (up to two years' professional experience at the commencement date in the role). Earlier advertising and marketing of positions was also encouraged by the AHPOQ. These strategies were used to maximise the likelihood of successful recruitment outcomes. In 2014 two of 11 positions had failed to recruit. In 2015 and 2016 all positions but one were successfully recruited as planned. Recruitment to a podiatry position advertised for commencement in January 2016 was unsuccessful. The HHS changed profession to occupational therapy and the position was successfully filled. In addition to the podiatry position three other positions had recruitment delays with incumbents commencing in late February or March. Two of these roles were the only ones not advertised in the previous year. Failure to progress to advertisement by mid-November has been consistently shown to introduce a delay of several months to commencement of the position holder.

- HHSs were provided with the opportunity to offer 2015 incumbents a one year extension in the AHRG Training Position. This change was prompted by stakeholder recommendations for a two year employment term to allow greater training and experience of the incumbent in the rural service. Implementation of a two-year term was favoured by most (six), but not all host sites (four).
- The allied health rural generalist education framework created by the Cunningham Centre, was used as the basis of detailed profession-specific development plan templates provided to host sites in late 2015. The template structure and objectives were informed by the education framework. A range of inter-professional and profession-specific learning activities were pre-loaded in the template. Supervisors and manager provided positive feedback on the value of the development plan template. Greater consistency was noted in the locally-generated development plans for the 2016 AHRG Training Position incumbents. All sites achieved completion of all or most planned development activities by the end of 2016.

Workforce development aim 3: Incentivise rural and remote practice for early career professionals and support sustainability of the rural and remote allied health workforce.

Attraction

Recruitment processes for AHRG Training Positions in 2015-2016, and for the 2017-2018 cohort demonstrated significant interest from early career allied health professionals. HHSs were requested to report application numbers in 2015-2016 with data supplied for 10 positions. Positions filled through placement of a rural scholarship holder or through a statewide centralised recruitment process or HHS expression of interest could not report on an applicant pool size. Of the seven positions recruited through open advertisement, the average number of applicants was 32 (range 3-80). Some recruiting managers provided feedback that applicant numbers were stronger than for similar HP3 positions in the same location. Radiography and podiatry roles were the most difficult to recruit to.

Rural retention

Thirteen allied health professionals commenced in an AHRG Training Position in 2015 or 2016, with one employee continuing from 2014 in the same role. The work locations of these employees at six months post-separation from their AHRG Training Positions were tracked using Queensland Health payroll data. Rural and remote employment destination outcomes are impacted by the funding model for the supernumerary AHRG Training Positions. Small rural teams may not have a permanent HP3 position or an HP3 vacancy may not coincide with the conclusion of the temporary training position, which provides no local options for recruitment of the employee. The six-month employment destinations for the 2015-2016 incumbents are shown in Table 2 along with data that includes the 2014 cohort. The data shows a trend towards employment of incumbents in a regional centre, generally the nearest regional centre to the training position site.

Table 2 Employment destination 6 months after separation from AHRG Training Position

Location	Position holders commencing role in 2015 or 2016	Position holders commencing role in 2014, 2015 or 2016
Remote [1]	2 (15%)	4 (18%)
Rural [1]	1 (8%)	4 (18%)
Regional [1]	6 (46%)	8 (36%)
Metropolitan [1]	1 (8%)	2 (9%)
Unknown [2]	3 (23%)	4 (18%)
Total [3]	13	22

NOTE 1: "Remote" defined as category B locations, and "Rural" as category A locations in HR Policy C42; "Metropolitan" defined as all locations in Metro North, Metro South, Gold Coast, Sunshine Coast and West Moreton Hospital and Health Services; "Regional" includes all other locations in Queensland.

NOTE 2: Individuals not appearing in Queensland Health payroll data (no current appointment, employed but on leave without pay, maternity leave etc.) cannot be tracked.

NOTE 3: Percentages rounded to nearest whole number.

Service development aim 1: Increase access to allied health services for rural and remote Queenslanders including expanding the range of services available "closer to home"

Service access outcomes can be broadly summarised as those (a) directly related to the addition of supernumerary staffing and (b) those related to changes to the service model enabled by the increased capacity to complete service development activities. The distinction is important, as the former is a transient product of the AHRG Training Position's non-recurrent funding model, but the latter has the potential to produce ongoing benefits for host teams. However, as service development projects were occurring in parallel with the temporary increase in FTE, attributing observed changes to just one component of the AHRG Training Position implementation is difficult. Changes more clearly related to service development and re-design are reported against service development aim 2 (below).

The main access and activity outcome indicators reported by sites included:

- waiting list and/or waiting time changes,
- activity volume (occasions of service) changes,
- service continuity improvements including less frequent or shorter periods of diminished service capacity associated with staff leave or outreach schedules, and
- increased number of locations receiving allied health services, generally due to telehealth implementation in remote/small facilities (see service development aim 2) but also related to greater outreach frequency resulting from the temporary increase in FTE.

Positive examples of outcomes in relation to access and activity in 2015-2016 included:

- 82% increase in inpatient dietetics occasions of service (OOS) at Atherton Hospital in 2015,
- 84% decrease in unseen physiotherapy inpatients at Innisfail Hospital in 2015,
- 120% increase in occupational therapy OOS provided to clients in the western cluster of the Darling Downs HHS in 2016, and

- weekdays without sonography services in Moranbah decreased from 42 days in 2013 to 0 days in 2014 and 2015, as the increased FTE allowed the hub site to remain staffed while outreach to satellite sites occurred.

The activity data reported by 2015-2016 sites also demonstrates the influence of factors other than the AHRG Training Position, particularly staffing stability of the remainder of the team. Several sites fell short of service activity growth targets during the AHRG Training Position implementation due to vacancies in other positions of the same profession or allied health assistant roles. Changes in service demand related to new medical services such as the introduction of rural chemotherapy or dialysis, and new allied health services such as primary contact (complex practice) roles also affected service demand and activity outcomes in some sites.

Service development aim 2: Improve the quality and safety, appropriateness, efficiency and sustainability of rural and remote allied health services

Project implementation

HHSs were independently responsible for developing and managing one or more service development projects. Projects were designed by the rural or remote team to meet local needs and priorities. Leanings and recommendations from the 2014 evaluation were implemented by the AHPOQ and Cunningham Centre to support project activities and reporting. These included:

- more explicit separation of workforce development and service development aims in implementation and reporting templates and supporting information, leading to improved quality and clarity of local implementation and evaluation plans,
- greater clarity in communication and implementation documentation on the local manager and/or supervisor's responsibilities for the service development projects to ensure that the AHRG Training Position incumbent's role was focussed on participation rather than project management, and
- reporting templates were tailored for each site by the AHPOQ/Cunningham Centre with relevant information drawn from the local implementation plan pre-loaded into the template. This strategy was partially successful in improving timeliness and quality of reporting.

A general trend towards improved project management and reporting was noted compared to the 2014 implementation but issues remained for some sites. The main issues noted by HHSs, the Cunningham Centre and AHPOQ were:

- difficulties developing the implementation plan as the proposed project scope was beyond the capacity of the team or available timeframes, was inadequate considering the level of additional resources available (1FTE), or was unlikely to produce substantial benefits for the service and consumers,
- project governance problems including unclear responsibilities and accountabilities for decision-making, monitoring of activities and outcomes, and reporting,
- inadequate project risk monitoring leading to delayed identification of problems and remediation strategies,
- inadequate planning of who would be responsible and how evaluation data would be obtained, leading to failure or delayed reporting or data validity problems, and

- use of evaluation indicators that were unable to demonstrate the project objective, generally due to low client numbers or many confounding variables affecting the findings.

Vacancies or locum staffing contributed to challenges in project implementation and timely reporting. Stakeholders also identified that between rural teams there is considerable variation in experience implementing workforce and service change projects or managing externally funded initiatives that have formal reporting requirements. These learnings were integrated into 2017-2018 AHRG Training Position statewide implementation planning by the AHPOQ and Cunningham Centre (see Recommendations section).

Project outcomes

The service development projects implemented by AHRG Training Position sites in 2015 and 2016 aimed to improve allied health service access, quality and safety, appropriateness, efficiency and sustainability. The rural generalist service development strategies for each site are presented in summary in Tables 2 and 3 (over) and outcomes are shown in Appendix 1.

Access indicators related to service changes included:

- service activity (e.g. occasions of service, new patients),
- the introduction of new services not previously available locally,
- the frequency of services provided in outreach sites through delegation and/or telehealth,
- the number of clients on waiting lists or average waiting times, and
- travel time or distance for clients to access services.

The main outcome indicators reported by sites in relation to quality and safety, appropriateness, efficiency and sustainability included:

- patient travel costs and/or travel time for clinicians,
- revenue generated by telehealth services,
- client and staff satisfaction with new service delivery models, and
- clinical quality measures including improved compliance with clinical care standards / guidelines, performance of new services with regard to clinical outcomes or reported adverse events, and improved coordination of care for clients with complex needs.

Table 3 AHRG Training Positions host site service development projects 2015

Location	Profession	Service development focus areas 2015
Atherton	Dietetics	Telehealth, new services (chemotherapy clinic, chronic disease programs)
Innisfail	Physiotherapy	Delegation to AHAs, new services (group-based interventions)
Emerald	Pharmacy	Telehealth
Longreach	Occupational therapy	Telehealth
Chinchilla	Occupational therapy	Telehealth, new services (paediatrics)
Kingaroy	Physiotherapy	Delegation to AHAs, new services (slow stream rehab)
Moranbah	Medical imaging	X-ray operator delivered services
Mount Isa	Speech pathology	Telehealth
St George	Physiotherapy	Telehealth
Weipa	Medical imaging	X-ray operator delivered services
Gayndah	Physiotherapy	Telehealth, delegation to AHAs, new services (group-based interventions)

Table 4 AHRG Training Positions host site service development projects 2016

Location	Profession	Service development focus areas 2016
Atherton	Dietetics	Telehealth
Innisfail	Physiotherapy	Delegation to AHAs, new services (group programs)
Emerald	Pharmacy	New services (emergency department, maternity inpatients, pre-admission clinic, trial of amalgamated rural medication safety committee)
Longreach	Occupational therapy	Telehealth, new services (group program)
Chinchilla	Occupational therapy	Telehealth
Kingaroy	Physiotherapy	Telehealth, new services (lymphoedema outpatients)
Mount Isa	Occupational therapy	New service (baby development clinic, partnership model for paediatric NDIS clients)
St George	Physiotherapy	Telehealth
Weipa	Medical imaging	X-ray operator delivered services
Gayndah	Physiotherapy	Telehealth, delegation to AHAs, new services (group programs)

a) New services

Examples of new services developed and implemented by AHRG Training Position sites in 2015-2016 are shown below.

- New telehealth clinics:
  - Telepharmacy services implemented for inpatients at Blackwater and Springsure hospitals to improve timeliness of pharmacy intervention including medication counselling for clients with new or complex medication regimens.
  - Group sessions via videoconference for clients with lymphoedema across Central West HHS facilities. The new service was positively evaluated by participants.
- New or expanded outpatient / ambulatory care clinics and programs:
  - Paediatric occupational therapy clinics in Chinchilla and Mount Isa.
  - Multi-site rehabilitation, falls and balance, chronic pain and pre-admission clinics implemented in Wide Bay HHS rural facilities, supported by telehealth and allied health assistants.
  - Dietetics chronic disease programs for inpatients and outpatients at Atherton Hospital.
  - Allied Health Assistant (AHA) supported back pain group for Cassowary Coast clients.
- Expanded rural hospital inpatient services:
  - Inpatient pharmacy services for clients in the Emergency Department, maternity ward and pre-admission clinics at Emerald Hospital.
  - Slow stream physiotherapy rehabilitation service implemented at Nanango Hospital.
  - Dietetics service at Atherton Hospital expanded into chemotherapy clinic, chronic disease programs and malnutrition screening audits.

b) Access and activity

- 700% increase in telehealth-delivered physiotherapy OOS to rural outreach sites in Wide Bay HHS between 2014 and 2016
- Between January 2016 and February 2017, 50% decrease in the Category 2 physiotherapy waiting list and 71% decrease in Category 3 waiting list numbers in the North Burnett region.
- 126% increase in dietetics telehealth OOS provided to western communities in Cairns and Hinterland HHS in 2016 compared to the previous year.
- AHA-delivered OOS that included implementation of specified delegated clinical tasks increased 7% between 2014 and 2015 (project development phase) and a further 28% between 2015 and 2016 to 1877 in Innisfail.
- Provision of speech pathology services to Cloncurry Hospital via telehealth resulted in patient waiting time being reduced by over ten weeks.
- In 2015 a total of 2940km of client travel to access physiotherapy services was avoided after the introduction of telehealth clinics in South West HHS.
- 74% patients attending pre-admission clinic and 64% mothers who had a caesarean at Emerald Hospital were seen by a pharmacist in 2016 compared to very limited service provided in these units in previous years.

c) Appropriateness

- High client satisfaction with the dietetics telehealth service to the Atherton Tablelands and western communities of Cairns and Hinterland HHS.
- Two HHSs found high client satisfaction with travel time and cost savings, and moderate satisfaction with occupational therapy and physiotherapy clinical service delivery via telehealth.

d) Quality and safety

- 'Every image, every day' programs implemented in Torres and Cape HHS and Mackay HHS radiography rural generalist training position sites to ensure diagnostic quality standards are met for X-ray operator images.
- Clinical outcomes for a Wide Bay HHS physiotherapy falls and balance program delivered using telehealth and allied health assistants were at least equivalent to outcomes achieved using traditional face-to-face delivery.

e) Efficiency and sustainability

- 29% decrease in clinician travel time (hours per month) after the introduction of telehealth-delivered physiotherapy services for rural and remote outreach sites in South West HHS.
- Physiotherapist travel time reduced from 18.2 hours per fortnight to between 1.5 and 8 hours per fortnight after the introduction of telehealth and delegation to AHAs in rural sites in Wide Bay HHS.
- Greater than five-fold increase in telehealth revenue for the Atherton Tablelands dietetics service in the 2015-2016 AHRG Training Position implementation period.

The service development project outcomes reported by host sites also indicate that not all planned project outcomes were achieved. Projects that did not produce intended results included a redesigned medication safety committee structure, and a workforce development strategy aiming to produce a more consistent scope of occupational therapy service availability across rural outreach sites. Some strategies produced positive outcomes but did not experience the level of demand anticipated for the service including a telehealth-supported paediatrics assessment clinic and lymphoedema management clinic. These outcomes reflect the realities of implementing change in health services and may provide learnings for other rural or remote teams. They are reported in Appendix 1.

Project outputs

AHRG Training Position host sites developed a range of resources that can support implementation at other sites including:

- delegation clinical task instructions (physiotherapy and occupational therapy tasks), training rosters and delegation audit tools,
- intake and prioritisation tools for paediatric services,
- local telehealth procedures and assessment tools, and
- client and staff satisfaction surveys and other evaluation data collection tools.

Systems for sharing resources require further development. Some resources such as clinical task instructions have existing statewide sharing / dissemination mechanisms. However, increased opportunities for AHRG Training Position host sites to collaborate, and for dissemination of outputs to other rural and remote teams would be beneficial.

Findings and learnings

Benefits realisation

Service development

The AHRG Training Positions continued to demonstrate value as an enabler of service development in host teams. The Southern Cross University evaluation of the 2014 implementation labelled this the “system disrupter” effect of the positions (Queensland Health, 2015b). Host sites in 2015-2016 implemented service development initiatives that included delegation to allied health assistants, telehealth and a range of new services that moved care closer to rural and remote clients. All host sites completed the development, implementation and evaluation of at least one service development strategy.

Sustainability of service development strategies was a critical consideration for 2015-2016 host sites. At the conclusion of the 2016 AHRG Training Positions implementation host sites lost the supernumerary AHRG Training Position and most expected to return to their core staffing levels. The implementation of service development strategies commonly led to efficiencies in service delivery which allowed new/redesigned services to be integrated into usual business and continued at the conclusion of the AHRG Training Positions implementation period. Most sites continued in the post-funding period to implement at least some components of the service model developed during the AHRG Training Position implementation. Three sites secured additional staffing prior to or at the end of the AHRG Training Position funding cycle. Some sites reported limited capacity to fully transition service development outcomes into the ongoing service model. This highlighted the need to consider sustainability strategies early in the planning process at implementation sites, and reinforced a known limitation of using supernumerary positions as workforce and service development enablers.

Workforce development

The 2015-2016 implementation continued to support the findings of the previous trial that the AHRG Training Positions provide an appropriate structure for employment of a graduate / early career allied health professional in rural or remote areas. The mandatory components of the position were further tested through formal feedback and learnings provided in local site completion reports and by examining outcomes from sites that had vacancies or turnover that posed barriers to maintaining the support requirements.

a) Development time and development plan

Several host sites reported the importance of formally quarantining and carefully monitoring the allocated 0.2FTE development and supervision time. Sites that did this were noted to be more likely to have AHRG Training Position incumbents that completed their development plan.

Local managers and supervisors reported that it was valuable to have greater guidance provided in 2016 on the structure and content of development plans including comprehensive coverage of clinical and non-clinical development goals.

Feedback indicated a two-year employment term for trainees supported the staged implementation of the development plan.

b) Co-located profession-specific supervision

Sites reported that strong local profession-specific supervision is necessary to support the AHRG Training Positions. This was particularly evident in sites that had experienced extended

vacancies in the local supervisor role. Most sites demonstrated that co-location of the trainee and supervisor for 100% of work hours was not critical beyond the initial orientation period, particularly for trainees with one or more years' experience. One 2015-2016 site had the incumbent and supervisor located in different facilities separated by approximately 20 minutes drive but with co-location some days of the week through outreach. The learnings from 2015-2016 indicate that the profession-specific supervisor should be co-located for 50% or more of work hours (direct contact between the supervisor and trainee 3 days per week) with support via telehealth and local inter-professional networks at other times.

All sites implemented formal supervision or a similar form of professional support. Formal arrangements, including a documented supervision agreement, were noted to be particularly important during a transition between supervisors.

Implementation challenges

Staff turnover

Seven of 11 host sites experienced turnover or extended periods of leave or backfill (e.g. maternity leave, long service leave, secondment) of the local supervisor role and four sites of the team leader/manager role in 2015-2016. Only three sites did not experience turnover or periods of extended leave for either position.

Turnover in key positions was noted in a number of local site completion reports to have negatively impacted the AHRG Training Position implementation. Impacts included:

- Project management
  - Loss of corporate knowledge / inadequate hand over regarding project aims, timeframes, milestones, reporting requirements, funding agreement terms with the AHPOQ etc.
  - Loss of data and key documents as files were not held centrally or handed over.
- Supervision and support of the AHRG Training Position
  - Reduced support particularly during vacancies in the local supervisor role.
  - Risks to development time allocation as clinical demands took priority during period of staffing shortage.

Host sites identified a range of risk mitigation strategies to address the challenges of staff turnover:

- Negotiate, establish and record in the implementation plan the strategies for managing supervision requirements and service development project coordination during periods of vacancy in key roles. Numerous sites emphasised the importance of building an assumption of vacancies into the plan so that the remedial actions are clear and preparatory work such as establishing connections with a secondary supervisor are undertaken in advance.
- Establish a strong link and routine supportive engagement between the AHRG Training Position incumbent and senior staff of the same profession locally and in neighbouring centres from the commencement of the role e.g. team leader of the same professional background, senior staff in nearby rural locations or regional centre, clinical education support roles in regional or metropolitan centres. This can augment and support local supervision and training throughout the AHRG Training Position implementation, and also provide bridging support in the event of a vacancy or leave of the local supervisor.

- During periods of vacancy or leave of the local supervisor implement supervision via telehealth and increase outreach, site visits or work shadowing placements for the AHRG Training Position incumbent or reciprocal visits by the temporary supervisor.
- Provide comprehensive and early orientation of the incoming supervisor or manager to the AHRG Training Position purpose, aims and reporting requirements, including the workforce and service development requirements. This may be assisted by scheduling a meeting with the Cunningham Centre or the AHPOQ for the incoming manager.
- Establish governance structures for supervision and project management that are robust, documented and have responsibilities shared by a small group rather than sitting with a single individual. Establishing from the outset some redundancy in key personnel responsible for the implementation was strongly recommended by 2015-2016 host site managers.

Managing the training and development plan including development time

Despite the supernumerary funding model for training positions, many sites reported that maintaining the allocated development and supervision time required ongoing monitoring and management. It was particularly challenging for the AHRG Training Position incumbent and team during periods of leave or vacancy in other positions or during spikes in service demand.

Strategies for managing the allocated development time that were reported by sites included:

- scheduling dedicated time in the team diary and clinical / outreach schedule,
- strong leadership and role modelling of protecting the incumbent's development time by managers and supervisors including initial and ongoing discussions with local nursing, medical and allied health staff about the construct of the role, and
- flexibility to allow an increase in development time during periods of relatively lower clinical demand and accommodating short periods of higher service activity e.g. leave in other positions.

Service development project management

The outcomes of service development/redesign projects were strongly influenced by the senior clinicians and team leaders/managers at the host site. Vacancies and/or turnover of senior staff during the implementation period often resulted in delays to the service development project timelines. The level of project management/change management experience of senior staff was noted to influence project outcomes, the level of support required from outside the local team or HHS and the likelihood that the team required amendment to the project plan or scope. Formal governance processes, such as a project steering group, were also observed to contribute to project success and provided protection against disruptions caused by workforce turnover.

Recommendations and actions

Recommendation 1:
Continue implementation of the AHRG Training Positions initiative in 2017-2018, and embed the employment model in statewide rural and remote workforce structures.

The AHPOQ has committed to fund 11 supernumerary AHRG Training Positions for a two-year funding term commencing January 2017. The employment model for early career practitioners in rural and remote health services has been successfully trialled and evaluated in all respects except the integration of a formal training program. This is the final component requiring development and evaluation (see Action 2), justifying the continued use of AHPOQ-funded

positions in this period. However, the limited and non-indexed funding pool for supernumerary positions is unlikely to be sustainable or beneficial beyond the evaluated trial of the education program. Funding support should be refocussed on education and training support for rural and remote early career allied health professionals statewide to reduce financial barriers for HHSs to designating existing roles as AHRG Training Positions.

The supernumerary nature of the AHRG Training Positions in the current trial potentially limits the benefits realisation for rural retention. As noted in the outcomes section (workforce aim 1), there appears to be a flow from AHRG Training Positions to HP3 roles in nearby regional centres. A fundamental barrier to progressing the rural generalist strategy for allied health in Queensland Health is the lack of a single employment pathway from HP3.1 (AHRG Training Position) through to higher level HP3 and into HP4 roles in a single rural or remote work unit. Rural and remote services are currently unable to fully capitalise on the 'own grown' benefits a training pathway should provide and early career professionals are generally unable to remain in the community in which they completed their training role.

Medium to long term sustainability of the allied health rural generalist pathway will require Queensland Health to move away from a limited number of temporary supernumerary positions to a system-level approach to rural and remote allied health workforce development and management. A rural generalist pathway from entry-level through to senior rural generalist roles is required that includes employment structures and education requirements that support this progression. In the short to medium term, the early career employment model needs to transition to 'business as usual' for rural and remote services through designating existing roles as rural generalist training positions where the support requirements can be met.

ACTION 1(a):

The AHPOQ and HHSs progress the integration of the AHRG Training Position employment model into existing and new HP3 rural and remote positions. For health service-funded AHRG Training Positions (positions in existing establishment) the employment model for early career practitioners (0-3 years professional experience) should include:

- dedicated development and supervision time of 0.1FTE - 0.2FTE (minimum 4 hours per week),
- a development plan including participation in a formal rural generalist education program,
- funding to support participation in the development plan activities and education program,
- co-located or highly accessible (onsite >50% work hours) profession-specific local supervisor implementing a formal supervision process, and
- contribution to local rural generalist service development strategies that improve client care and service outcomes.

Stakeholders should work collaboratively to identify barriers and implement trials of HHS-funded AHRG Training Positions in parallel with the AHPOQ-funded roles in 2017-2018.

ACTION 1(b):

The AHPOQ, Cunningham Centre and stakeholders in HHSs and the Department of Health collaborate to address barriers and implement strategies to develop an Allied Health Rural Generalist Pathway in Queensland Health including an integrated human resources / employment and education model.

Recommendation 2:
Develop, implement and evaluate a formal rural generalist education program

In late 2016, the AHPOQ engaged James Cook University (JCU) in collaboration with QUT to develop and deliver a two-level rural generalist education program for seven allied health professions: nutrition and dietetics, medical imaging, occupational therapy, pharmacy, physiotherapy, podiatry and speech pathology. The Level 1 program, tailored to AHRG Training Position incumbents and other early career professionals, commenced in May 2017. The Level 2 program is expected to be offered from 2018.

ACTION 2:

The AHPOQ and HHSs support the trial of the JCU / QUT Rural Generalist Program (2017-2019) including building the program into the AHPOQ-funded and HHS-funded AHRG Training Positions, and supporting engagement in the program by other early career rural and remote allied health professionals.

Recommendation 3:
Improve AHRG Training Positions local (HHS) implementation processes and supports

During 2015 and 2016, AHRG Training Position implementation sites were provided with assistance with implementation planning, as well as site-specific progress and completion report templates. Following positive feedback and outcomes, these strategies should be continued in 2017-2018. It was identified during 2015-2016 that the majority of host sites would benefit from investment in project management capacity building. As this need became apparent strategies were planned and implemented in 2016 for the next cohort of positions as follows:

- The criteria for host site selection used for the 2017-2018 funding round were strengthened to include factors associated with successful service development project implementation at previous host sites. This included an assessment of local leadership capacity, governance, readiness for change and the ability to support new/recent graduates.
- The AHPOQ committed funding in the 2016/17 and 2017/18 financial years to support a manager or supervisor from each host site to attend the Manage 4 Improvement Program offered by Clinical Excellence Division.
- A program of one-on-one meetings between new host sites and the Cunningham Centre or AHPOQ staff were implemented in late 2016 / early 2017 during the project scoping phase.
- The Cunningham Centre facilitated the formation of host site peer groups to share learnings and resources as projects progressed.

ACTION 3:

The AHPOQ, Cunningham Centre and HHSs support project management capacity building strategies in AHRG Training Position host sites, with a particular focus on investment in key professional and operational leadership roles.

Abbreviations

AHA(s)	Allied Health Assistant(s)
AHPOQ	Allied Health Professions' Office of Queensland
AHRG	Allied Health Rural Generalist
FTE	Full time equivalent (staffing)
HHS(s)	Hospital and Health Service(s)
GNARTN	Greater Northern Australia Regional Training Network
JCU	James Cook University
OOS	Occasion of service
NDIS	National Disability Insurance Scheme
PDY	Professional Development Year
QH	Queensland Health
SCU	Southern Cross University
XO(s)	X-ray Operators(s)

References

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Appendix 1: HHS-reported outcomes/outputs summary 2015 & 2016

Cairns & Hinterland HHS	Site: Atherton	Profession: Dietetics
Local implementation objectives	**Outcomes (summary)**	
Workforce development objectives		
Recruit and maintain AHRG Training Positions on establishment in rural/remote location during 2015 and 2016	Graduate dietitian employed in AHRG Training Position from January 2015 until December 2016.	
Supervision and support provided to AHRG Training Position incumbent	Co-located practitioner of same profession. Professional supervision agreement in place for AHRG Training Position incumbent.	
Development time (0.2FTE) and individual development plan implemented	Development plan implemented including: • Clinical focus areas: diabetes management, paediatrics. • Non-clinical focus areas: delegation to allied health assistants, telehealth skills, cultural competency and evidence based practice.	
Service development objectives		
Increased access to services 'closer to home'	Increased dietetics occasions of service (OOS) at Atherton Hospital: • 82% increase in total inpatient OOS in 2015 (1020) compared to 2014 (560). • Total inpatient OOS decreased in 2016 (865), but was 54% higher than 2014 and 94% higher than 2013 (341) (prior to the AHRG Training Position). • Outpatient OOS increased by 33% in 2015 (555) compared to 2013 (417), and increased further in 2016 to be 48% higher in 2016 (820) compared to 2015. Decreased dietetics outpatient waiting list at Atherton Hospital: • 89% decrease in the number of patients on outpatient waiting list in 2015 (compared to 2014). • Changes to outpatient referral volume related to new chemotherapy and dialysis services that commenced in 2016 and additional dietetics FTE make comparison to 2015 data difficult. However all outpatients were seen within waiting time requirements as at December 2016.	

Cairns & Hinterland HHS	Site: Atherton	Profession: Dietetics
Local implementation objectives	**Outcomes (summary)**	
Implement service development projects: 1. Expand dietetic telehealth services commenced in 2014 to a wider range of locations (2015) and embed within usual service delivery models (2016)	Dietetics telehealth service implemented for Croydon, Forsayth, Georgetown, Ravenshoe and Mount Garnet: • Telehealth OOS 2015 = 19 (no increase compared to 2014 due to low number of referrals from rural sites) • Telehealth OOS 2016 = 43 (126% increase compared to 2015). Waiting time for assessment met targets. Staff and client resources for telehealth implementation were developed. High level of client satisfaction with telehealth service was recorded (survey). Staff feedback indicated ongoing work required to network with rural and remote staff to ensure appropriate referrals were received. Revenue generated through use of telehealth increased by 515% in 2016 compared to 2015 ($12,901). No increase in revenue during 2015 (compared with 2014) due to low referral numbers.	
2. Implement and consolidate new services for inpatients and outpatients at Atherton Hospital (2015)	New/expanded dietetics services implemented for inpatients and outpatients at Atherton Hospital including: chemotherapy clinic, gestational diabetes case conference, chronic disease programs and malnutrition screening audits.	

Cairns & Hinterland HHS	Site: Innisfail	Profession: Physiotherapy
Local implementation objectives	**Outcomes (summary)**	
Workforce development objectives		
Recruit and maintain AHRG Training Positions on establishment in rural/remote location during 2015 and 2016	Graduate physiotherapist commenced in AHRG Training Position January 2015 and continued in position until December 2016.	
Supervision and support provided to AHRG Training Position incumbent	Co-located practitioner of same profession. Professional supervision agreement in place for AHRG Training Position incumbent.	
Development time (0.2FTE) and individual development plan implemented	Development plan implemented including: • Clinical focus areas: Cardio-respiratory, orthopaedics, emergency department (ED) primary contact physiotherapy, paediatrics, suctioning and airway management, neuro assessment and treatment. • Non-clinical focus areas: communication and team work, time management, delegation to allied health assistants.	
Service development objectives		
Increase access to services 'closer to home'	Increased physiotherapy occasions of service (OOS) at Innisfail Hospital • Minor changes in inpatient (-10%) and outpatient (+5%) OOS in 2015 (compared to 2014), partially influenced by allied health assistant staffing stability. • 84% decrease in unseen inpatient numbers in 2015 (compared to 2014). • 40% increase in inpatient OOS in 2016 (compared to 2015). • 11% increase in outpatient OOS in 2016 (compared to 2015). Decreased outpatient waiting times at Innisfail Hospital: • Wait times across all clinical categories reduced by 40-87% in 2015 (compared to 2014). • Wait times for Category 2 and 3 patients reduced by 68-87% in 2016 (compared to 2015). Wait time for Category 1 patients increased by 45% in 2016 due to new primary contact role generating increased referrals.	

Cairns & Hinterland HHS	Site: Innisfail	Profession: Physiotherapy
Local implementation objectives	**Outcomes (summary)**	
Implement service development project: Develop, implement and evaluate a physiotherapy delegated clinical service model using allied health assistants (AHAs) (2015) and extend range of services provided using this model (2016).	Allied Health Assistants (AHAs) trained in 16 clinical task instructions (physiotherapy and occupational therapy delegated tasks) to increase use of AHAs clinical scope. Increased services delivered by AHAs: • AHA-delivered OOS that included implementation of specified delegated clinical tasks increased 7% to 1458 between 2014 and 2015 (during the implementation project) and a further 28% to 1877 between 2015 and 2016. • New outpatient group services supported by AHAs were implemented – hand clinic, back pain group. Client compliments received and registered; no complaints received.	

Central Queensland HHS	Site: Emerald	Profession: Pharmacy
Local implementation objectives	**Outcomes (summary)**	
Workforce development objectives		
Recruit and maintain AHRG Training Positions on establishment in rural/remote location during 2015 and 2016	Post-intern pharmacist employed in AHRG Training Position for 12 months between January and December 2015; and Two years post-intern pharmacist employed in AHRG Training Position for 12 months between January and December 2016.	
Supervision and support provided to AHRG Training Position incumbent	Co-located practitioner of same profession. Professional supervision agreement in place for both AHRG Training Position incumbents.	
Development time (0.2FTE) and individual development plan implemented	Development plan implemented in 2015 including: • Clinical focus areas: generalist clinical skills, paediatrics/maternity, renal/heart failure, mental health, palliative care, skill shared task: malnutrition screening. • Non-clinical focus areas: communication and team work, quality improvement and evidence-based practice, workload management, delegation. Development plan implemented in 2016 including: • Clinical focus areas: medication safety, dispensing, chemotherapy and palliative care, skill shared tasks: malnutrition screening and swallowing/communication screening. • Non-clinical focus areas: project management, primary health care, ethical practice, community engagement, introduction to telehealth.	
Service development objectives		
Increase access to services ‘closer to home’	Increased occasions of service (OOS) at rural sites in region covered by Emerald pharmacy team: • 43% increase in inpatient OOS across sites in 2015 (1781) compared to 2014 (1248). • 17% increase in inpatient OOS across sites in 2016 (2077) compared to 2015.	

Central Queensland HHS	Site: Emerald	Profession: Pharmacy
Local implementation objectives	**Outcomes (summary)**	
Increase access to services 'closer to home' (cont.)	Improvement in some service outcome measures: • Completion of medication action plans increased by 41% in 2015 (compared to 2013). Completion numbers not reported in 2016. • Clinical interventions provided decreased by 53% in 2015 (compared to 2014) largely due to decreased intervention numbers at Emerald Hospital. Clinical interventions provided increased by 223% in 2016 (compared to 2015). Cause of variation in 2015 not clear but may include data capture problems. • Discharge medication record completion across all sites decreased by 16% in 2015 (compared to 2014), and increased by 10% in 2016 (compared to 2015).	
Implement service development projects: 1. Develop, implement and evaluate telepharmacy services (2015)	Telepharmacy service implemented for Blackwater and Springsure • 29 telehealth OOS provided to Blackwater and Springsure inpatients in 2015 (no telehealth OOS recorded prior to project). Telepharmacy outpatient service offered at Blackwater and Springsure in 2015. • Low demand - three patients referred failed to attend. Consequently, planned outpatient revenue and OOS targets not met. Insufficient response to staff survey to determine satisfaction with new telehealth services, however difficulties engaging staff at recipient sites were noted.	
2. Implement and evaluate clinical pharmacy services to emergency dept., maternity and pre-admission clinic at Emerald Hospital (2016)	New pharmacy services implemented at Emerald Hospital: • 304 OOS provided in Emergency Department (ED), 47 OOS in maternity and 143 in pre-admission clinic between Jan and June 2016. Clinical interventions completed included 75 in ED, 9 in maternity and 22 in pre-admission clinic. • 74% pre-admission clinic patients and 64% mothers who had a caesarean were seen by a pharmacist (no service provided in these service units prior to the project). • 54% patients admitted to Emerald Hospital received a pharmacist review in 2016 (compared to 39% in 2015). • Positive feedback from multi-disciplinary team in these service units.	

Central Queensland HHS	Site: Emerald	Profession: Pharmacy
Local implementation objectives	**Outcomes (summary)**	
Implement and evaluate clinical pharmacy services to emergency dept., maternity and pre-admission clinic at Emerald Hospital (2016) (cont.)	New pharmacy services implemented at Emerald Hospital (cont.): • Compliance with selected clinical care standards/guidelines in service units: improved surgical prophylaxis, AMS data and VTE risk assessment completion rates require further assessment and management strategies.	
3. Trial amalgamation of medication safety committees at rural sites	Three month trial completed. Amalgamated committee found to be ineffective therefore previous model reinstated.	

Central West HHS	Site: Longreach	Profession: Occupational therapy
Local implementation objectives	**Outcomes (summary)**	
Workforce development objectives		
Recruit and maintain AHRG Training Positions on establishment in rural/remote location during 2015 and 2016	Early career occupational therapist (12 months' experience) employed in AHRG Training Position from January 2015 until December 2016. The occupational therapist had previously completed 12 months in the 2014 AHRG Training Position in Darling Downs HHS.	
Supervision and support provided to AHRG Training Position incumbent	Co-located practitioner of same profession and supervision from team leader (same profession) and support from regional site during periods of local supervisor vacancy. Professional supervision agreement in place for AHRG Training Position incumbent.	
Development time (0.2FTE) and individual development plan implemented	Development plan implemented including: • Clinical focus areas: lymphoedema management, paediatrics, hand therapy, home modifications. • Non-clinical focus areas: evidence-based practice, quality improvement, primary health care, workload management, Calderdale Framework (workforce development/re-design) foundation training, telehealth.	
Service development objectives		
Increase access to services 'closer to home'	Increased occasions of service (OOS) provided by occupational therapists: • 52% increase in total OOS in January to June 2015 (compared with same period in 2014). • 18% decrease in total OOS in 2016 (compared to 2015) due to vacancies in other occupational therapy position in the team.	
Implement service development project: Develop, implement and evaluate telehealth-delivered occupational therapy services	Telehealth-delivered occupational therapy service implemented for Central West HHS clients: • 49% increase in telehealth OOS provided by occupational therapists in 2015 (compared to 2014). • 6% decrease in telehealth OOS provided by occupational therapists in 2016 (compared to 2015). However other allied health professionals within the team increased telehealth services during 2016. • 'How-to' guide for telehealth-delivered services for health professionals developed and published locally.	

Central West HHS	Site: Longreach	Profession: Occupational therapy
Local implementation objectives	**Outcomes (summary)**	
Develop, implement and evaluate telehealth-delivered occupational therapy services (cont.)	Telehealth-delivered occupational therapy service implemented for Central West HHS clients (cont.): • New outpatient lymphoedema management group implemented to remote facilities using telehealth. Two groups were conducted during 2016 that included 21 clients. • High level of client satisfaction with telehealth group sessions.	

Darling Downs HHS	Site: Chinchilla	Profession: Occupational therapy
Local implementation objectives	**Outcomes (summary)**	
Workforce development objectives		
Recruit and maintain AHRG Training Positions on establishment in rural/remote location during 2015 and 2016	Graduate occupational therapist employed in AHRG Training Position from January 2015 until December 2016.	
Supervision and support provided to AHRG Training Position incumbent	Co-located practitioner of same profession and supervision from Dalby occupational therapist and increased inter-professional support during vacancy in local supervisor role. Professional supervision agreement in place for AHRG Training Position incumbent.	
Development time (0.2FTE) and individual development plan implemented	Development plan implemented including: • Clinical focus areas: paediatrics, burns management, home modifications, autism support, continence management, oedema management. • Non-clinical focus areas: evidence-based practice, project management, primary health care, communication and team work, student supervision skills, telehealth.	
Service development objectives		
Increase access to services 'closer to home'	Overall, increased occasions of service provided by occupational therapists: • 14% increase in total OOS provided by occupational therapists in July – December 2015 (compared to Jan – June 2015). • Aim to increase inpatient and outpatient OOS provided across sites in July – December 2015 was achieved at Chinchilla and Dalby, but not at outreach sites due to staff leave and reduced referral rates across the service. • 120% increase in total OOS provided by occupational therapists in 2016 (compared to 2013, prior to the AHRG Training Positions implementation).	

Darling Downs HHS	Site: Chinchilla	Profession: Occupational therapy
Local implementation objectives	**Outcomes (summary)**	
Increase access to services 'closer to home' (cont.)	Decreased outpatient waiting times: • Waiting time for outpatient intervention reduced by two months in July – December 2015 period, with all categories of patient seen within recommended waiting times. • All outpatients seen within prescribed maximum wait times in 2016. No growth in waiting lists observed.	
Implement service development projects: 1. Implement a core skill set for rural generalist occupational therapist in Western Downs (2015)	Core skill set for rural generalist occupational therapists implemented. Core skill set identified with all occupational therapists receiving required training to enable a consistent scope of services across all service locations in the western Darling Downs region. Post-implementation there was no significant change in caseload distribution (case mix) for individual practitioners indicating planned outcomes were not met in the trial period.	
2. Increase use of telehealth to provide services to outreach sites (2015-2016)	Telehealth delivered services provided to outreach sites Taroom and Wandoan: • Hand clinic and paediatric assessment trialled with some clinical limitations experienced with the latter. • Low number of appropriate referrals - 3 telehealth OOS provided in 2015, and 5 provided in 2016 • 100% client satisfaction with telehealth service.	
3. Implementation of a paediatric drop-in clinic (2015)	New paediatric drop-in clinic implemented in Chinchilla: • 4 multidisciplinary screening clinics provided in 2015, with 90% referrals screened using a consistent prioritisation tool. • 100% Category 1, 75% Category 2 and 35% Category 3 referrals seen within required timeframes (Note: Category 3 referral numbers increased significantly by occupational therapy student screening activities).	

Darling Downs HHS	Site: Kingaroy	Profession: Physiotherapy
Local implementation objectives	**Outcomes (summary)**	
Workforce development objectives		
Recruit and maintain AHRG Training Positions on establishment in rural/remote location during 2015 and 2016	Graduate physiotherapist employed in AHRG Training Position from January to December 2015 and Graduate physiotherapist employed in AHRG Training Position from January to December 2016.	
Supervision and support provided to AHRG Training Position incumbent	Co-located practitioner of same profession. Professional supervision agreement in place for both AHRG Training Position incumbents.	
Development time (0.2FTE) and individual development plan implemented	Development plan implemented in 2015 including: • Clinical focus areas: rehabilitation, musculoskeletal, paediatrics, chronic disease management, cardio-respiratory and orthopaedic physiotherapy. • Non-clinical focus areas: quality improvement, delegation. Development plan implemented in 2016 including: • Clinical focus areas: cardio-respiratory and orthopaedic physiotherapy, paediatrics, chronic disease management, women's health, gerontology, neurology, lymphoedema. • Non-clinical focus areas: primary health care, quality improvement, evidence-based practice, workload management, delegation, ethical practice, telehealth.	
Service development objectives		
Increase access to services 'closer to home'	Increased physiotherapy occasions of service (OOS) provided: • Compared to 2013 total physiotherapy OOS was 10% higher in 2015 (4117) and 4% higher in 2016 (3889), with outcomes influenced by vacancies in other positions. Decreased outpatient waiting lists: • 21% increase in total number of outpatients on waiting lists during 2015 (compared to 2014). • Between January 2016 and February 2017, Category 1 waiting list was stable, 50% decrease in Category 2 waiting list and 71% decrease in Category 3 waiting list numbers.	

Darling Downs HHS	Site: Kingaroy	Profession: Physiotherapy
Local implementation objectives	**Outcomes (summary)**	
Implement service development projects: 1. Implement a slow stream rehabilitation service at Nanango Hospital (2015)	Slow stream rehab service implemented at Nanango Hospital: • 209 inpatient OOS provided during 8-month trial period, which met the service target of 24 OOS/month. • 38 patients were transferred to Nanango Hospital for slow stream rehab during the trial period (average 4.75 per month), which met the service target of >2 patients/month.	
2. Implement and evaluate a telehealth-delivered physiotherapy service for clients with stable lymphoedema in the South Burnett region (2016)	Kingaroy had not had a lymphoedema therapist available locally since 2013, with patient flow to Toowoomba. A telehealth-supported dual clinician model of lymphoedema service delivery between regional and rural site was developed and trialled to reduce the need for local clients to attend Toowoomba for routine services. • Generalist physiotherapist completed compression garment training. • 12 telehealth OOS provided to clients with lymphoedema in 2016 (compared with 1 OOS in 2015). • Impact on need for patients to travel to a larger centre for treatment unable to be determined due to changes in patient travel recording system during project implementation. • High levels of client satisfaction with telehealth-delivered service. The level of demand for the lymphoedema service was determined to be too low to support ongoing provision of this service beyond the trial period.	

Mackay HHS	Site: Moranbah	Profession: Medical imaging
Local implementation objectives	**Outcomes (summary)**	
Workforce development objectives		
Recruit and maintain AHRG Training Positions on establishment in rural/remote location during 2015 and 2016	Radiographer employed in the AHRG Training Position during 2014 continued in the position from January to December 2015. Implementation at this site concluded on 31 December 2015.	
Supervision and support provided to AHRG Training Position incumbent	Co-located practitioner of same profession and supplementary supervision for sonography training provided by the Rural and Regional Ultrasound Training Program. Professional supervision agreement in place for AHRG Training Position incumbent.	
Development time (0.2FTE) and individual development plan implemented	Development plan implemented in 2015 focused on sonography training, with the AHRG Training Position incumbent completing requirements for the Graduate Diploma in Ultrasound (University of South Australia).	
Service development objectives		
Increase access to services 'closer to home'	Increased medical imaging services provided at Moranbah Hospital: • Days per year of radiography service provision at Moranbah Hospital in 2015 maintained at 2014 level (250 days per year). • 8% increase in number of X-ray examinations provided at Moranbah Hospital in 2015 (compared to 2014). • Weekdays without sonography service decreased from 42 days in 2013 to 0 days in 2014. Maintained at 0 days during 2015.	
Implement service development project: Improve supervision and support of X-ray operators in Dysart and Clermont, including completion of quality audit of all images taken	100% images taken by three X-ray operators in Dysart and Clermont were reviewed by the radiographer during 2015. An X-ray operator training program was implemented in collaboration with Mackay Medical Imaging Department. Average quality score of images taken by X-ray operators was consistently 6-7 out of 10, indicating images consistently reached acceptable level of diagnostic quality.	

North West HHS	Site: Mount Isa	Profession:	Speech pathology (2015) Occupational therapy (2016)
Local implementation objectives	**Outcomes (summary)**		
Workforce development objectives			
Recruit and maintain AHRG Training Positions on establishment in rural/remote location during 2015 and 2016	Graduate speech pathologist employed in AHRG Training Position January to December 2015; and Graduate occupational therapist employed in AHRG Training Position March to December 2016. Note: failed recruitment to a planned podiatry AHRG Training Position in 2016, with subsequent switch to occupational therapy.		
Supervision and support provided to AHRG Training Position incumbent	Co-located practitioner of the same profession for both incumbents. Professional supervision agreements in place for both AHRG Training Position incumbents.		
Development time (0.2FTE) and individual development plan implemented	Development plan implemented in 2015 (speech pathology) including: • Clinical focus areas: early language intervention, paediatrics, cervical auscultation, autism, dysarthria • Non-clinical focus areas: collaborative practice, quality improvement, evidence-based practice, telehealth, workload management, cultural competence. Development plan implemented in 2016 (occupational therapy) including: • Clinical focus areas: oedema management, hand therapy, wound management, paediatrics • Non-clinical focus areas: primary health care, quality improvement, evidence-based practice, project management, workload management, communication and teamwork, collaborative practice.		
Service development objectives - 2015			
Increase access to services ‘closer to home’	Increased outpatient occasions of service (OOS) at Mount Isa Hospital: • 7.5% increase in outpatient speech pathology OOS provided in 2015 (compared to 2014). Reduced waiting time for outpatients at Mount Isa Hospital • All outpatients on waiting list were seen within recommended timeframes according to triage category.		

North West HHS	Site: Mount Isa	Profession:	Speech pathology (2015) Occupational therapy (2016)
Local implementation objectives	**Outcomes (summary)**		
Implement service development project: Develop, implement and evaluate a telehealth-delivered speech pathology service for Cloncurry Hospital	Telehealth service implemented for Cloncurry Hospital: • 20 telehealth OOS provided to Cloncurry Hospital in 2015 (previously no speech pathology services available at this site). • Waiting time for Cloncurry Hospital reduced by >10 weeks (compared to previous visiting service model). • Comparison of average staff time attributable to one OOS for telehealth vs face-to-face was 55-75mins for telehealth and 60-65mins for face-to-face. This does not include outreach travel time for face-to-face. • Client surveys indicated telehealth service saved time and travel costs. Positive staff feedback. • Variable outcomes against clinical goals but small client numbers in the trial limit interpretation of the data. • Met relevant clinical care guidelines regarding recommended frequency of intervention.		
Service development objectives - 2016			
Increase access to services 'closer to home'	Increased occasions of service (OOS) provided by occupational therapists: • 49% increase in total occupational therapy OOS provided at Mount Isa Hospital in March – Dec 2016 compared to same period 2015 but data in 2015 was influenced by vacancies.		
Implement service development project: Redesign paediatric outpatient service at Mt Isa Hospital to improve efficiency of services to Baby Development Clinic and improve coordination of care for complex clients.	Redesigned and new paediatric OT services implemented: • 72 OOS provided to Baby Development Clinic in 2016 (an increase of 11% compared to 2015). • 36 OOS provided to Paediatric Assessment Clinic in 2016 (new service). • High levels of referring staff satisfaction with services (no client satisfaction surveys returned). • Plan to develop shared care model for NDIS clients was delayed due to slower than anticipated NDIS roll-out prior to December 2016.		

South West HHS	Site: St George	Profession: Physiotherapy
Local implementation objectives	**Outcomes (summary)**	
Workforce development objectives		
Recruit and maintain AHRG Training Positions on establishment in rural/remote location during 2015 and 2016	Graduate physiotherapist employed in AHRG Training Position from January 2015 until December 2016.	
Supervision and support provided to AHRG Training Position incumbent	Co-located practitioner of same profession and supplementary support from other areas of HHS when supervisor role was unfilled. Professional supervision agreement in place for AHRG Training Position incumbent.	
Development time (0.2FTE) and individual development plan implemented	Development plan implemented including: • Clinical focus areas: consolidation of generalist physiotherapy skills, prevention and self-management, radiology for physiotherapists' course. • Non-clinical focus areas: service evaluation and planning, quality improvement, project management, workload management, student supervision skills, delegation.	
Service development objectives		
Increase access to services 'closer to home'	OOS influenced by vacancy in other physiotherapy position: 8% and 17% decrease in 2015 and 2016 OOS respectively compared to 2014 but remained higher than pre-AHRG Training Positions implementation level in 2013. 40% decrease in OOS provided to outreach sites in 2015 (compared to 2014) due to changes to service model (reduced frequency of outreach visits) and changes in eligibility at cross-border sites.	
Implement service development project: Implement telehealth-delivered physiotherapy services for outreach sites	Telehealth-delivered physiotherapy services implemented for Dirranbandi, Mungindi, Augathella and Cunnamulla: • Nine telehealth OOS provided during 2015. • Waiting times for treatment in these sites reduced by 11.6 days per patient in 2015. • 29% decrease in hours per month of clinician travel as telehealth partially replaced traditional visiting outreach service model in 2015.	

South West HHS	Site: St George	Profession: Physiotherapy
Local implementation objectives	**Outcomes (summary)**	
Implement telehealth-delivered physiotherapy services for outreach sites (cont.)	Telehealth-delivered physiotherapy services implemented for Dirranbandi, Mungindi, Augathella and Cunnamulla (cont.): • 2940km total client travel saved in 2015 due to introduction of telehealth (average 327km per client, with the most remote client saving 780km in travel). • High levels of client satisfaction with time and travel saving associated with telehealth services, moderate levels of satisfaction with the mode of service delivery. • Telehealth activity data for 2016 not reported by individual facility/location. Further development of the telehealth model was delayed by senior staff vacancies during 2016.	

Torres and Cape HHS	Site: Weipa	Profession: Medical imaging
Local implementation objectives	**Outcomes (summary)**	
Workforce development objectives		
Recruit and maintain AHRG Training Positions on establishment in rural/remote location during 2015 and 2016	Graduate radiographer employed in AHRG Training Position from February to December 2015; and Graduate radiographer employed in AHRG Training Position from January to December 2016.	
Supervision and support provided to AHRG Training Position incumbent	Co-located practitioner of same profession with remote supervision from TCHHS radiographers during periods of locum staffing in co-located senior radiographer role. Professional supervision agreements in place for both AHRG Training Position incumbents.	
Development time (0.2FTE) and individual development plan implemented	Development plan implemented in 2015 including: • Clinical focus areas: image interpretation, exposure to sonography • Non-clinical focus areas: provision of support/education to X-ray operators, radiation safety Development plan implemented in 2016 including: • Clinical focus areas: radiographer commenting, introductory sonography training • Non-clinical focus areas: cultural competence, provision of support/education to X-ray operators, supervision, telehealth	
Service development objectives		
Increase access to services 'closer to home'	Increased medical imaging service activity in Weipa: • 14% increase in X-ray examinations per month in 2015 (compared to 2014). • 11% increase in X-ray examinations per month in 2016 (compared to 2015). • 23% increase in ultrasound examinations per month in 2015 (compared to 2014). • 15% increase in ultrasound examinations per month in 2016 (compared to 2015). • Total OOS (X-ray and ultrasound) provided at Weipa Integrated Health Service: 3917 in 2016; 3660 in 2015; 3120 in 2014.	

Torres and Cape HHS	Site: Weipa	Profession: Medical imaging
Local implementation objectives	**Outcomes (summary)**	
Implement service development projects: 1. Develop X-ray operator training and supervision role, including telehealth-delivered supervision/support (2015-2016)	Telehealth-delivered supervision/support to X-ray operators in TCHHS: • 24% increase in X-ray operator OOS in 2015 (compared to 2014). Minimal change in X-ray operator OOS between 2015 and 2016. • TCHHS X-ray operator training and assessment toolkit developed. • 'Every image, every day' program implemented to assess quality of images taken by X-ray operators. • Annual visits to ensure compliance with radiation safety requirements at all sites. • Monthly education sessions delivered to X-ray operators in 2016.	
2. Identification of options for ongoing provision of radiography/sonography services to remote communities in the TCHHS (2016)	Proposed model of ultrasound service-delivery for Aurukun developed to offer visiting ultrasound services on a monthly basis for non-urgent presentations. This would represent significant savings in patient travel and eliminate the need for residents to travel to Cairns for examinations. Concept brief developed to ensure ongoing service provision in Weipa and appropriate support to be provided to X-ray operators at TCHHS sites. AHRG Training Position extended for 6 months to cover the period of workforce planning.	

Wide Bay HHS	Site: Gayndah	Profession: Physiotherapy
Local implementation objectives	**Outcomes (summary)**	
Workforce development objectives		
Recruit and maintain AHRG Training Positions on establishment in rural/remote location during 2015 and 2016	Graduate physiotherapist commenced in AHRG Training Position January 2015 and continued in position until December 2016	
Supervision and support provided to AHRG Training Position incumbent	Co-located practitioner of same profession with supplementary profession-specific support from the regional service and inter-professional support of local team members during periods of locum staffing / vacancy in supervisor role. Professional supervision agreement in place for AHRG Training Position incumbent.	
Development time (0.2FTE) and individual development plan implemented	Development plan implemented including: • Clinical focus areas: Cardio-respiratory, orthopaedics, paediatrics, women's health, musculoskeletal, chronic disease management. • Non-clinical focus areas: primary health care, quality improvement, evidence-based practice, workload management, collaborative practice, student supervision, delegation, telehealth.	
Service development objectives		
Increase access to services 'closer to home'	• 26% increase in total physiotherapy OOS in 2015 (compared to 2014). • 5% decrease in total physiotherapy OOS in 2016 (compared to 2015) due to vacancies in other positions within the service. • 12% increase in outpatient OOS in 2016 (compared to 2015). Outpatient waiting list outcomes varied, influenced by staffing and service changes: • Decreased Category 2 and 3 waiting lists during 2015 (compared to 2014), but Category 1 waiting list increased from six in December 2014 to 17 in December 2015. • Decreased Category 1 and 3 waiting lists during 2016 (compared to 2015), but Category 2 waiting list increased from 31 in December 2015 to 78 in December.	

Wide Bay HHS	Site: Gayndah	Profession: Physiotherapy
Local implementation objectives	**Outcomes (summary)**	
Increase access to services 'closer to home' (cont.)	• Wait times across all clinical categories reduced by 40-87% in 2015 (compared to 2014). • Wait times for Category 2 and 3 patients reduced by 68-87% in 2016 (compared to 2015). Wait time for Category 1 patients increased by 45% in 2016 due to new primary contact role generating increased referrals.	
Implement service development projects: 1. Expand telehealth-supported physiotherapy clinic model for rural facilities (AHAs supporting telehealth use at recipient sites) (2015)	Increased telehealth OOS provided to rural sites • 496 telehealth OOS provided by entire rural allied health team in 2015 (compared to 89 in 2014), an increase of 457%. • 182 telehealth OOS provided by physiotherapists in 2015 (compared to 33 in 2014), an increase of 451%. • 314 telehealth OOS were supported by allied health assistants in 2015 (compared to 56 in 2014). This outcome was linked to both the employment of more AHAs in rural sites of WBHHS and to implementation of the telehealth-supported delegation model including clinical task training of AHAs. New falls and balance groups delivered via telehealth • 76% decrease in the Category 2 waiting list number in 2015 was linked to the implementation of telehealth groups for which many patients in this category were eligible. High levels of staff and client satisfaction with telehealth service. 117 revenue-generating telehealth OOS captured during 2015/16 financial year compared to 0 in 2014/15 financial year. Travel time for clinicians was not reduced as planned with the telehealth implementation due to staff vacancies during the project roll-out period.	
2. Further expand telehealth-supported physiotherapy clinic model for rural facilities (AHAs supporting telehealth use at recipient sites) (2016)	New service model integrated into 'usual business' and team rosters. Increased telehealth OOS provided to rural sites: • 712 telehealth OOS provided by the entire team in 2016 (increase of 44% compared to 2015 and 700% compared to 2014). • 10% of the total telehealth OOS in Wide Bay HHS were provided by Gayndah physiotherapy staff; and 25% of the HHS total by the Gayndah allied health team.	

Wide Bay HHS	Site: Gayndah	Profession: Physiotherapy
Local implementation objectives	**Outcomes (summary)**	
Further expand telehealth-supported physiotherapy clinic model for rural facilities (AHAs supporting telehealth use at recipient sites) (2016) (cont.)	Average travel time for allied health professionals in the team reduced from 18.2 hours per fortnight prior to the implementation of the telehealth / AHA model (2014) to 1.5-8 hours per fortnight (2016). Clinical outcomes raw scores for telehealth-delivered / AHA supported falls and balance program were equivalent or better than the same program delivered face-to-face (measures included Timed Up and Go, Berg Balance and falls efficacy scale). High satisfaction recorded in the client survey, and one formal compliment received by the HHS for the telehealth service.	
3. Expand delegated service model using allied health assistants for clinic in rural facilities (2016)	Increased OOS delivered by allied health assistants (AHAs): • 2682 OOS delivered by allied health assistants in 2016 (14% increase from 2015, but impacted by vacancies in two AHA positions). New clinics offered to patients at rural sites: • Rolling rehabilitation, pre-admission clinics, falls and balance clinics implemented weekly. • Chronic pain clinic implemented (multidisciplinary clinic). • Inpatient physiotherapy services via telehealth offered using AHAs at recipient sites. Resources to support the service model were developed and implemented including clinical task instructions, training rosters, and an Allied Health Assistant Framework audit tool.	