Allied Health Rural Generalist Training Positions

2014 Implementation Report

September 2015

Queensland Government

Allied Health Rural Generalist Training Positions: 2014 Implementation Report
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Summary

Overview of Allied Health Rural Generalist Training Positions initiative 2014

The Allied Health Rural Generalist Training Positions (AHRGTP) initiative provided funding from the Allied Health Professions' Office of Queensland (AHPOQ) to rural and remote teams in Queensland Hospital and Health Services (HHS) to implement supernumerary graduate / early career positions. The initiative commenced in January 2014. The AHPOQ evaluated the first year of implementation through an external evaluation study of stakeholder experiences and views conducted by Southern Cross University (SCU), and compilation of outputs and outcomes from the AHRGTP host sites. The AHPOQ funding commitment to the AHRGTP implementation in HHSs in 2014 was $922,062.

Host sites for the positions were selected through an expression of interest process in 2013. Eleven Health Practitioner Level 3 (HP3.1) positions (10.6FTE) received non-recurrent funding. Positions were implemented in nine HHSs and five professions: nutrition and dietetics, radiography, physiotherapy, occupational therapy and pharmacy. The funding agreement required sites to implement and report on the workforce and service development objectives of the initiative.

Workforce development objective

Create and implement a full-time graduate / early career position:

- located in and providing services to rural and remote locations,
- in a team with a co-located practitioner of the same profession to provide local support and professional supervision,
- with mandatory allocation of 0.2FTE to training, supervision and participation in service development activities of the team, and
- with a structured development plan aligned to the clinical and non-clinical (professional / service skills) requirements of a rural generalist practitioner of the relevant profession.

Service development objective

Scope, develop, implement and evaluate rural generalist service development strategy/ies relevant to the local setting and community. Specifically:

- delegation and better use of support workers (e.g. allied health assistants),
- extended scope of practice including
  - skill sharing and shared practice between allied health professions,
  - primary contact roles, or extended scope clinical functions such as prescribing, imaging and pathology ordering and interpretation.
- telehealth, and
- new services (including partnerships) that move care from larger centres to rural / remote facilities where safe and appropriate to do so, and that expand the range of services available locally to rural and remote consumers.

Outcomes and findings from the evaluation of the 2014 AHRGTP implementation

The AHRGTP has demonstrated adequate outcomes and stakeholder acceptability in the initial implementation year to support continuance and a transition from the trial phase to an established workforce program with ongoing evaluation and monitoring.

The 2014 AHRGTP implementation indicated that employment of graduates in rural and remote HP3 positions is feasible, appropriate and valuable if systems and processes are in place to support the employee and co-located profession-specific supervisor.

The AHRGTP initiative has demonstrated positive outcomes for:

- graduates/early career professionals in terms of increased opportunities for employment in rural and remote areas, and an employment, development and support model that is consistent with the needs of this workforce group,
- existing staff in terms of improved job satisfaction, reduced fatigue and increased opportunities for collaborative practice with colleagues of the same profession,
- services in relation to stimulating and supporting implementation of rural generalist service strategies, particularly telehealth, delegation and improved use of support workers, and the introduction of new services, and
- rural and remote communities through increased service access and activity, improved timeliness of care, and moving services closer to clients.

Further development or changes to the following aspects of the AHRGTP initiative are indicated by the evaluation:

- greater definition and awareness raising of rural generalist service and workforce models is required to support HHSs to achieve the initiative's aims,
- a formal rural generalist training program for AHRGTP incumbents is required,
- the employment term and funding duration for sites should be amended,
- more resources and guidance should be provided to assist rural and remote teams to plan, manage and evaluate the AHRGTP implementation.

Actions

The AHPOQ, in collaboration with HHSs, the Cunningham Centre and other stakeholders, will implement the actions below in response to the outcomes and findings from the 2014 implementation.

1. Continue implementation of the AHRGTP initiative and examine opportunities for growth through partnerships with HHSs and other jurisdictions and agencies. In particular, designation of new or existing (vacant) HHS roles as AHRGT positions should be explored and promoted.
2. Operational management of the AHRGTP initiative will move to the Cunningham Centre, Darling Downs HHS from January 2016. The Cunningham Centre possesses expertise in managing allied health development-focussed programs, and the customer service infrastructure required for ongoing implementation of the statewide AHRGTP initiative.

3. Implement the following changes to the AHRGTP initiative for future implementation rounds:
    - Two-year non-recurrent funding cycle for AHRGTP implementation sites. The next funding cycle will commence in January 2017, with recruitment of the host sites commencing in the second quarter of 2016. The implementation planning and reporting process, which is currently completed annually by sites, will be extended to two years to align with the term of the funding allocation.
    - The employment term for graduates / early career practitioners in the AHRGT positions will be extended from one to two years. This will commence with an optional extension of the 2015 incumbents in current positions through to December 2016 (at the discretion of the employing HHS) and become the preferred model from 2017 to align with the term of funding allocation to host sites.
    - An evaluation and monitoring plan for the ongoing phase of the AHRGTP implementation will be implemented including entry and exit surveys, service impacts/outputs minimum data set, and longitudinal tracking of training position incumbents.
4. Develop a structured, formal rural generalist training program for AHRGTP incumbents, encompassing clinical and non-clinical development requirements and including profession-specific and inter-professional learning topics. The training program, although targeted to AHRGTP incumbents, should address rural generalist workforce and service capacity building more generally in order to distribute benefits of the initiative on a wider scale.
5. Enhance AHRGTP local (HHS) implementation processes and supports
    - The AHPOQ will re-design implementation planning and reporting templates, guides and support processes for host sites including integration of a minimum data set in the evaluation plan template.
    - Evaluation findings with regard to successful strategies for management of service development projects and early career practitioner training and support will be disseminated to stakeholders.
    - Evaluation findings will inform the recruitment and selection process for the 2017-18 AHRGTP cohort. In particular, the process should seek to identify teams with strong local leadership, governance, education / graduate support capacity and change readiness.

Overview: Allied Health Rural Generalist Training Positions initiative

Background

The Allied Health Rural Generalist Training Positions (AHRGTP) initiative is a rural and remote workforce strategy sponsored by the Allied Health Professions' Office of Queensland.

The AHRGTP was developed in 2012/13 through the reallocation of funds from the Queensland Health Allied Health Rural Scholarship Scheme and a number of other smaller workforce programs. Reduced investment in incentive programs targeting pre-entry students was driven by the outcomes of the Allied Health Pre-Entry Scholarship Schemes review[1, 2] and a combination of escalating pre-entry student numbers and decreasing demand from rural and remote health services to recruit graduates, particularly to sole and isolated allied health positions. The Queensland Health Director-General approved the funding reallocation in May 2012 to a trial implementation of supernumerary graduate allied health positions in rural and remote services. The Directors of Allied Health Professions' Advisory Committee endorsed a concept paper for the AHRGTP initiative in March 2013. In April 2013 the Deputy Director General, Health Services and Clinical Innovation Division approved the recruitment of host sites for the 2014 AHRGTP trial via an expression of interest process.

Purpose

The AHRGTP was initially conceived as primarily a workforce development strategy for rural and remote services. Prior to the finalisation of host site selection in 2013, the initiative's scope was broadened to include an equal emphasis on allied health rural generalist service development. This change was driven by concurrent work in a number of agencies including Queensland Health[3], the Greater Northern Australia Regional Training Network[4] and Health Workforce Australia[5] to develop generalist service and workforce models for the allied health professions. The reorientated AHRGTP initiative retained a focus on increasing opportunities for graduates to commence their professional careers in a rural or remote service. Rural experience as students or graduates has been associated with future career decisions of health professionals[6, 7]. The resource provided to the AHRGTP sites, in the form of a supernumerary graduate position, was also to assist teams implement or expand use of key allied health rural generalist service strategies:

- delegation and better use of support workers (e.g. allied health assistants),
- extended scope of practice including
  - skill sharing and shared practice between allied health professions,
  - primary contact roles, or extended scope clinical functions such as prescribing, imaging and pathology ordering and interpretation.
- telehealth, and
- new services (including partnerships) that move care from larger centres to rural / remote facilities where safe and appropriate to do so, and that expand the range of services available locally to rural and remote consumers.

Aims

The aims of the AHRGTP initiative in 2014 were:

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

Strategy

The AHRGTP initiative in 2014 implemented eleven (10.6FTE) allied health positions in nine Hospital and Health Services. Workforce and service development aims of the initiative were actioned through a funding agreement between the AHPOQ and AHRGTP host Hospital and Health Service.

Workforce development

Host site requirements with regard to the workforce aims of the AHRGTP were:

- employ a graduate / early career practitioner (less than one year professional experience),
- generate, implement and evaluate a development plan for an early career rural or remote generalist in the relevant profession,
- implement 0.2FTE designated development time for the AHRGTP incumbent to complete the development plan and participate in service development activities, and
- provide local supervision / mentoring to the AHRGTP 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*.

Service development

Host site requirements with regard to the service aims of the AHRGTP were:

- increase access to services of the relevant profession in the nominated rural or remote area, and
- develop, implement and evaluate rural and remote generalist service development / re-design strategies relevant to the profession and setting, that enhance healthcare access and health outcomes of the community, and the productivity, efficiency and sustainability of the service.

Resourcing

The AHPOQ funding allocation to support the implementation of the AHRGTP in HHSs was $922,062. The AHPOQ allocated additional resources from core funding to support administration, coordination and evaluation of the statewide AHRGTP initiative. HHSs received non-recurrent funding to implement the AHRGTP in the location and profession identified in the funding agreement. Funding was provided in separate transfers for the periods January to June and July to December 2014. The funding model was:

- Salary at HP3.1 for 52 weeks + 25% oncosts
- Rural or remote allowance (as relevant to position location)[*]
- Professional development funding [†]
- Other (one site was provided with funding for accommodation support).

All Hospital and Health Services contributed resources to support the AHRGTP 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 2014

Recruitment and selection of host sites

Recruitment of host sites for the AHRGTPs was through an expression of interest (EOI) process that concluded on 31 May 2013. Twenty-four EOIs were received.

A selection panel assessed EOIs and provided a recommendation to the Chief Allied Health Officer of merit order. The panel included an AHPOQ representative, two senior allied health leaders from HHSs with rural or remote services and a senior allied health leader from a public health system outside Queensland. The panel undertook their assessment against the criteria in the EOI information document and template. The criteria were:

- Position: clarity of plan for recruitment and rationale for prioritisation of the nominated profession
- Service: demonstrated local service demand particularly unmet demand, consistency of the service model with the rural generalist focus of the initiative
- Location: proposed position was located in and would provide all or the majority of services to rural or remote locations[‡]
- Professional support and clinical governance: mandatory co-location of a position of the same profession (the 'local supervisor'), description of a clear professional and operation management structure, and the team/unit's demonstrated track record of providing strong clinical and professional governance to allied health employees

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[*] Queensland Health *Human Resource Policy C15: Allowances*

[†] Although temporary employees, and therefore ineligible for Professional Development Allowance under Queensland Health *Human Resource Policy C42: Health practitioners - professional development allowance and leave*, equivalent funding was provided to host sites to support the development of incumbents.

[‡] Defined as Category A (rural) or Category B (remote) locations in Queensland Health *Human Resource Policy C15: Allowances*

- Training and development: incumbent in the 'local supervisor' role had demonstrated experience or capacity to provide supervision and support for early career practitioners, the development plan outlined in the EOI included an appropriate range and mix of clinical and non-clinical training activities relevant to a rural generalist role of the nominated profession, and the team / unit possessed a demonstrated track record of supporting training for staff and / or students.
- Funding/budget proposal.

The outcome of the site selection process is shown in Table A.

Table A: AHRGTP sites and professions 2014

HHS	Location	Profession
Cairns and Hinterland	Innisfail	Physiotherapy
Cairns and Hinterland	Atherton	Dietetics & Nutrition
Central Queensland	Emerald	Pharmacy
Central West	Longreach	Radiography
Darling Downs	Kingaroy	Physiotherapy
Darling Downs	Chinchilla	Occupational Therapy
Mackay	Moranbah	Radiography (sonography trainee)
North West	Mount Isa	Dietetics & Nutrition
South West	St George	Physiotherapy
Torres and Cape	Weipa	Radiography
Wide Bay	Gayndah	Physiotherapy

AHRGTP host site 'induction' and planning

A face-to-face forum was held in Brisbane in November 2013 with local site operational managers, supervisors and HHS-level sponsor (e.g. Executive Director of Allied Health, Director of relevant profession) invited. Nine of eleven implementation sites provided participants, with one additional site attending via videoconference. Travel and accommodation for face-to-face participants was funded by the AHPOQ (note: this cost is not included in the Resourcing section above as it was a one-off expense associated with the initial implementation). The one and a half day forum provided presentations on the organisational context, purpose and aims of the initiative and facilitated sessions on scoping and planning service development priorities, role development and recruitment to AHRGTPs, developing a training plan for the incumbent, evaluation planning and reporting requirements.

AHRGTP host site networking and support

The AHPOQ coordinated a statewide AHRGTP host site network that met four times during 2014. The network terms of reference was approved by the Chief Allied Health Officer on 22 May 2014 (see Appendix 1). Several less formal sub-groups were also formed including an HHS-driven group of sites implementing physiotherapy positions, and a group for sites implementing telehealth strategies. The latter included participants from the AHPOQ and the Telehealth Support Unit, Clinical Access and Redesign Unit.

AHRGTP host site implementation activities

Hospital and Health Services managed the local implementation activities of the AHRGTP initiative in their nominated location/s. The planning and reporting requirements of HHSs to the AHPOQ in 2014 were:

- Local Site Implementation Plan due 31 March 2014 including
  - 12-month development plan for the incumbent
  - service development plan
  - indicators and evaluation plan for workforce and service development objectives
- Implementation Progress Report due 31 July 2014
- Implementation Completion Report due 28 February 2015

Recruitment and management of AHRGT Position incumbent

Hospital and Health Services managed the recruitment to the AHRGT positions as per usual processes. A role description template was provided to all sites, though its use was not mandatory. The position title was "Graduate (Profession)", and the role description template included reference to the AHRGTP initiative.

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

Professional support and development for the AHRGT Position incumbent

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 implementation plan in March 2014. A template for the development plan was provided that included major clinical and non-clinical development topics. Limited guidance was provided by the AHPOQ regarding development programs and activities, particularly for profession-specific clinical areas. The operational manager and local supervisor were responsible for monitoring and reporting on the implementation of the development plan and professional support agreement to the AHPOQ as part of the progress and completion reports.

Service development strategies

AHRGTP host sites were responsible for the development, implementation and evaluation of one or more rural generalist service development strategies. The strategies were outlined in a Local Site Implementation Plan approved by the HHS sponsor and endorsed by the Chief Allied Health Officer in March 2014. The Local Site Implementation Plan included a description and rationale for each strategy, performance indicators and evaluation plan, as well as governance and stakeholder engagement plan. Progress against the nominated indicators and status of each strategy were reported in the progress and completion reports. Host sites were able to develop strategies that were most relevant to their context, service model and community needs. This allowed tailoring of the implementation to local demands but limited the guidance provided by the AHPOQ to sites in the scoping and development stages, beyond requiring a focus on the rural generalist service strategies (see p1).

Evaluation process and outcomes dissemination

External evaluation

The AHPOQ conducted a request for offer process and engaged Southern Cross University (SCU) to undertake an external evaluation. The evaluation commenced in August 2014 and was finalised in May 2015. The summary of the evaluation report is provided in Appendix 2. The full report is presented in Attachment A.

HHS outcomes reporting

AHRGTP host sites reported outcomes against their performance indicators in the 2014 implementation completion reports. Outcomes / outputs information was collated and summarised, with the draft summary provided to host site managers and Directors of Allied Health (or equivalent) for checking prior to publication in Appendix 3.

Outcomes dissemination

1. AHRGTP 2014 Implementation Showcase

The AHRGTP 2014 Implementation Showcase was held via videoconference on 17 February 2015. All AHRGTP host sites provided a 10 minute overview of their workforce and service development strategies, outcomes/outputs, resources developed and learnings. Thirty-five videoconference sites from Queensland HHSs and Department of Health, and Northern Territory Health Services attended the Showcase. A summary of presentations is published on the AHPOQ QHEPS site at http://qheps.health.qld.gov.au/ahwac/content/hp3_hp4_ruraldevpath.htm.

2. Statewide Rural and Remote Clinical Network (SRRCN) Forum

The SRRCN Forum in Cairns on 5 June 2015 featured presentations from the Atherton, St George and Chinchilla AHRGTP host sites on their service development work and outcomes.

3. Directors of Allied Health Professions Advisory Group

Summary outcomes from the external evaluation and AHRGTP host site reports were presented in a brief to the Directors of Allied Health Professions' Advisory Group (DAHPAG) June 2015 meeting.

4. E-News publications

Short reports on the AHRGTP statewide initiative and individual host site implementations have been included in the Allied Health E-News, and the Health Services and Clinical Innovation Division (now Clinical Excellence Division) electronic newsletter.

Outcomes, key learnings and actions

Performance against AHRGTP initiative aims

Aim 1: Increase employment opportunities for early career allied health professionals (AHPs) in rural and / or remote health services

This aim was achieved.

Eleven (10.6 FTE) supernumerary positions were created in rural and remote areas. This was an increase in Queensland Health rural and remote HP3 allied health FTE of approximately 8%.[§] For individual professions the increase in HP3 FTE located in rural or remote areas was:

- Physiotherapy 16%
- Occupational Therapy 5%
- Pharmacy 9%
- Radiography 43%
- Nutrition & Dietetics 25%

The growth in HP3 positions indicates the initiative was successful in increasing opportunities for graduate employment in these allied health professions in rural and remote services.

Nine of eleven host sites successfully recruited to the positions. Incumbents commenced in these positions between mid-January and early March 2014. All incumbents remained in the position until December 2014. All allied health professionals recruited to AHRGT positions in 2014 were graduates or had qualified for full registration / entry to their profession less than one year prior to appointment.

Aim 2: Establish and evaluate a model for early career employment in rural and remote areas including training, development, and on-going support.

This aim was achieved. Evaluation findings should be used to refine the model for future AHRGTP implementations.

The SCU evaluation indicated positive feedback on the concept of the AHRGTPs as an early career workforce development strategy for rural and remote teams. Evaluation findings generally supported the employment model used in the 2014 AHRGTP implementation, with some minor suggested amendments.

- Explicit allocation of 0.2FTE development time in the funding model was supported by evaluation findings to be a key enabler for maintaining the strong training focus of the positions. This aspect of the AHRGTP should be continued. Although not mandatory, some sites reported on hours the incumbent engaged in professional development activities, and these were found to conform to the time allocation. Some stakeholders identified challenges for the management of AHRGTP incumbents' absences from the workplace for training (e.g. clinical placements) and allocation of time to development activities, particularly in periods of high clinical service demand. However this was balanced by the added workforce capacity available from the supernumerary position.

[§] FTE comparison using DSS payroll data for pay date 13/10/13, MOHRI Occupied FTE, all allied health professions, HP Level 3, Category A (rural) and B (remote) locations.

- New graduates (or post-professional development year) were recruited to all positions in 2014, but stakeholders identified that opening recruitment to early career practitioners (up to two years professional experience) may continue to support the workforce growth aims while enlarging the recruitment pool.
- All AHRGTP incumbents demonstrated completion of a locally-generated development plan. Completion reports from AHRGTP sites indicate a wide range of development strategies and programs were implemented. There was limited consistency between positions in the development approaches and topics addressed, even for positions of the same profession. This reflects some variation in development needs and practicalities (e.g. remoteness) between service settings and individual practitioners, but also that a clear description of the clinical and non-clinical competency / capability requirements of rural generalist practitioners is lacking in the allied health professions. Stakeholders strongly supported the development of a more structured and formal training program.
- Although not formally reported in 2014, informal feedback indicated that AHRGTP sites fully expended the professional development funding allocated as part of the resourcing model, and generally provided additional HHS funds.
- Most sites had a profession-specific supervisor (senior clinician) "on-site" (i.e. co-located and easily accessible for approximately 50% of work hours or more) for the duration of 2014. Two sites had staff turnover and periods of vacancy in the local supervisor role. AHPOQ was notified and sites implemented alternative support strategies including sourcing supervision from a senior manager available locally who was of the same professional background as the AHRGTP incumbent, or support from staff in the regional hub facility. Stakeholders confirmed the local supervisor is a critical component of successful employment of a graduate / early career practitioner in a rural or remote team. Some sites strengthened local supervision and training with connections to inter-professional new graduate networks and profession-specific clinical educators in the closest regional centre.
- The SCU evaluation and host site completion reports identified that AHRGTP incumbents participated in allied health rural generalist service development strategies implemented by the local team. Evaluation findings indicate this was a valuable learning experience for the incumbents. However a lack of clarity regarding the incumbent's expected role in the management of service development projects was evident in some sites. The findings of the SCU evaluation indicated that some incumbents expressed concerns about the level of responsibility they felt for the service development projects. Experiences of the AHPOQ staff engaging with AHRGTP sites indicated early confusion between the workforce (employment and training for an early career practitioner) and service development (implementation of rural generalist service model/s) aims of the AHRGTP. Vacancy and short-term appointments in the local supervisor position also lead to the graduate taking on greater responsibility for the service development work in two sites, although additional support was provided through other senior staff members in the team. Ongoing work with sites in 2014 differentiated the service and workforce components of the AHRGTP initiative. This distinction between service and workforce aims of the initiative should be incorporated into future communication with current or prospective AHRGTP host sites.

The evaluation identified some sites experienced challenges associated with the establishment of a new HP3 position particularly in the initial implementation phase. These included establishing professional and operational governance structures, administrative

management of the professional development funding allocation, recruitment delays, building supervision and training skills of the local supervisor, pressures on clinical space, vehicles and other resources, and adjusting workload / caseload allocation and management processes.

Two radiography sites failed to recruit to the positions. The Chief Allied Health Officer approved alternative implementation plans for each site. One site seconded an early career practitioner from Metro North HHS for approximately three months and utilised the residual funds to support the service development project. The other site used the funding to release capacity of the senior team member to complete the service development work.

AHRGT positions as a proportion of existing statewide rural and remote HP3 FTE was substantially higher for radiography than for other professions (see page 7). This relates to the low proportion of rural and remote radiography positions in the existing workforce that are at HP3 level, and also to the allocation of three AHRGT positions to radiography in 2014, more than all other professions except physiotherapy. The relatively large proportional increase in post-PDY employment opportunities for this profession may have contributed to the observed recruitment issues. Limited awareness raising of the new positions with potential applicants was possible in 2013 due to timeframes between funding approval and implementation. The timing of the release of job advertisements in these sites and relevance of the term "graduate" (included in the AHRGTP role description template) for radiography are also suspected to have contributed to the recruitment problems.

Aim 3: Enhance opportunities for exposure to rural and / or remote service, incentivise rural and remote practice for early career professionals, and support sustainability of the rural and remote allied health workforce.

This aim was mostly achieved, though the scope of a one-year evaluation cannot adequately investigate the impact on workforce sustainability.

Ten allied health professionals gained exposure to rural or remote practice through the AHRGTP 2014 implementation.

Incentivisation of rural and remote practice was partially achieved. The qualitative data from the SCU evaluation indicated AHRGTP incumbents provided generally positive statements on the AHRGTP, including indications that the positions support a preference for future rural practice. Of the nine early career professionals appointed for the duration of 2014, six months after separation from the AHRGTP role payroll data (05/07/15) indicated work locations were:

- Remote (Category B locations): 2 employees
- Rural (Category A locations): 3 employees [**]
- Regional: 2 employees
- Metropolitan: 1 employee
- Not employed by Queensland Health: 1 employee

Of these, two employees secured a position within their AHRGTP host team. A further two moved to the regional centre closest to the AHRGTP site in which they were employed.

[**] Includes the radiographer / trainee sonographer AHRGTP that has a two-year employment term to accommodate the duration of the sonography training program.

The SCU evaluation identified that processes are required to translate learnings and experiences from one AHRGTP cohort to the next, including building strategies for previous AHRGTP incumbents to promote rural and remote practice. The development of the AHRGTP as a recruitment and retention incentive for early career allied health professionals will require further development of supporting strategies and a longer term evaluation approach, particularly to investigate the impact on workforce sustainability.

Aim 4: Trial the development of rural and remote allied health generalist models of care in AHRGTP sites which may include implementation or expansion of telehealth services or other forms of service re-design, and / or workforce re-design including delegation and skill sharing / trans-disciplinary practice.

This aim was mostly achieved, though extended scope/skill sharing was not investigated by sites in the 2014 implementation.

Eleven AHRGTP sites examined changes to their service to integrate rural and remote generalist service strategies. Sites varied in the extent to which the changes were implemented in 2014, with some flowing into 2015 due to either a staged approach to implementation extending beyond 2014 (for larger scale change projects) or due to implementation delays. A small number of strategies were scoped but did not proceed to development and implementation stages. These were generally projects that were supplementary to the major focus of the implementation plan. Of the four key allied health rural generalist service strategies, multiple AHRGTP sites examined delegation and support functions (including X-ray operator-delivered services), telehealth and/or the development of new services through partnerships with local stakeholders, other agencies or larger facilities. No sites examined the fourth rural generalist service strategy, extended scope of practice including skill sharing. The SCU evaluation did note feedback from AHRGTP sites that the additional capacity of the graduate role allowed senior practitioners to work more to full scope. An example is the development of an 'early contact' emergency department / outpatient triage clinic physiotherapy service model.

AHRGTP site completion reports and the SCU evaluation identified a range of service outcomes from the 2014 implementation. The service development focus of each site is presented in summary in Table B below. The strategies and outputs / outcomes are presented in more detail in Appendix 3.

Outcomes can be broadly summarised as those directly related to the addition of supernumerary FTE and 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 AHRGTP's non-recurrent funding model, but the latter has the potential to produce ongoing benefits for host teams.

The main outcomes in relation to the addition of supernumerary FTE were described in terms of:

- waiting list reductions (or waiting time reductions),
- activity increases (occasions of service),
- improved capacity to manage on-call and fatigue leave, and improved service continuity during periods of leave (recreation leave, professional development leave), particularly where the permanent establishment for the profession is 1FTE, and
- less frequent and shorter periods of diminished service capacity (e.g. fewer days without a clinician onsite or decreased days with inpatient services limited to urgent cases only).

Inconsistency in the indicators used for reporting and a wide range of confounding factors such as vacancies in other positions in the team or other service providers (e.g. Medicare Local staffing), changes in referral patterns and changes in data recording systems or errors/gaps in data collection, make it difficult to synthesise outcomes or to attribute reported changes solely to the AHRGTP implementation. However, all AHRGTP sites demonstrated some degree of improvement in service access during the 2014 implementation.

Outcomes in relation to service changes enabled by the AHRGTP resource varied between sites as each one implemented the service development strategies most relevant to their community and HHS needs. This flexibility was viewed as a strength of the AHRGTP by stakeholders. Examples of outcomes from successful strategies included

- a 140% increase in telehealth clinical service hours in the Darling Downs HHS Western Cluster occupational therapy services,
- an increase in dietetics service access in western Cairns and Hinterland HHS rural and remote centres from infrequent outreach to timely telehealth-supported consultations on referral,
- net annual savings of $7,143 to the service (revenue and reduced costs) associated with the implementation of in-house medication packing in Woorabinda,
- a 64% increase in total physiotherapy inpatient occasions of service in Nanango through the implementation of delegation to allied health assistants, and
- access to new group-based physiotherapy services in South West and Wide Bay HHSs.

Table B: AHRGTP host sites' service development focus 2014

Location	Profession	Service development areas planned in 2014
Innisfail	Physiotherapy	Delegation to AHAs
Atherton	Dietetics & Nutrition	Telehealth
Emerald	Pharmacy	Telehealth, new generalist service (drop-in clinic, in-house medication packing)
Longreach	Radiography	X-ray operator delivered services
Kingaroy	Physiotherapy	Delegation to AHAs, telehealth, new generalist services (sub-acute services outside hub facility, pulmonary rehabilitation)
Chinchilla	Occupational Therapy	New generalist services (paediatrics), telehealth
Moranbah	Radiography/sonography	X-ray operator delivered services
Mount Isa	Dietetics & Nutrition	New services (maternity & paediatrics), food service, culturally appropriate services and resources through local partnerships.
St George	Physiotherapy	Delegation to AHAs, new generalist services ('early contact' physiotherapy in emergency department, group-based interventions)
Weipa	Radiography	X-ray operator delivered services
Gayndah	Physiotherapy	Telehealth, delegation to AHAs, new generalist services (sub-acute services outside hub facility, group-based interventions)

The SCU evaluation and reporting from the AHRGTP sites identified a number of issues and challenges with regard to implementing rural generalist service development projects.

- Lack of clarity regarding allied health rural generalist service models
  This was likely impacted by implementation timeframes in 2013 and limited and inconsistent descriptions of the "rural generalist" concept at a national level with regard to the allied health professions[4]. The Queensland Health concept of rural generalist service development priorities was not fully developed in 2013 when teams were undertaking planning. It was developed throughout 2014 by the AHPOQ and stakeholders including the Statewide Rural and Remote Clinical Network, and with contributions from the AHRGTP sites themselves.
- Implementation scoping and planning timeframes
  Sites had approximately three months from the date of the AHRGTP sites face-to-face planning forum in Brisbane (21 November 2013) to the submission of a locally approved implementation plan (28 February 2014). The Christmas period was reported to have impacted on planning, as did the graduate orientation and induction process early in 2014. Greater scoping and development time should be integrated into subsequent AHRGTP site selection and implementation timeframes.
- Project and change management capacity varies between rural teams and influenced service development outcomes.
  The capacity to manage service development projects, including the evaluation and reporting requirements, was impacted in some sites by vacancies / turnover in the local team leader / manager and local supervisor positions. A small number of sites experienced problems with project governance due to changes in organisational structures and reporting lines, or failure to establish a shared understanding of responsibilities for the service development strategy in the planning phase. Individuals responsible for leading or contributing to service development projects also had different levels of experience and skills in this area, as is to be expected in small rural and remote teams. Informal feedback to the AHPOQ and the SCU evaluation findings indicated that the resources provided to support scoping, planning and evaluation of service development projects (i.e. templates, recommended evaluation strategies/indicators) did not adequately meet the needs of staff, particularly those with limited previous project management experience.

Summary of key findings and learnings

The external evaluation findings and recommendations, compilation of HHS completion reports, informal feedback from AHRGTP host sites and experiences of the AHPOQ staff involved in the initiative have informed the following summary findings and learnings.

1. Overall value, benefits realisation and continuance

The AHRGTP has demonstrated adequate outcomes and stakeholder acceptability in the initial implementation year to support continuance and a transition from the trial phase to an established workforce program with ongoing evaluation and monitoring.

The 2014 trial demonstrated the viability and value of employing graduates and early career practitioners in rural and remote health services, if they have access to a co-located experienced practitioner of the same profession, and have a comprehensive development plan established and actively supported and monitored by the local work unit including

allocation of time to training and supervision activities. The AHRGTP initiative demonstrates that if coupled with an explicit focus on rural generalist service development, benefits of the approach can be accrued to the service and consumers, in addition to the position incumbent.

Expansion of the AHRGTP initiative beyond the existing AHPOQ funding allocation will require HHS support. This may be possible through the redesign of existing positions into HP3 AHRGT positions, such as those with a history of recruitment problems, or where a vacancy provides an opportunity to examine the current workforce structure in a rural or remote facility. HHSs could also consider an AHRGT position in workforce planning for new services. HHS-funded AHRGT positions would not have the AHPOQ reporting requirements of the supernumerary positions, but to maintain the integrity of the emerging AHRGTP 'brand' in the allied health workforce market, would need to integrate the service and workforce development aspects of the current positions (i.e. co-located position of the same profession, allocated training time, participation in a service development initiative etc). Sustainability and growth of the AHRGTP initiative may also be effected through further developing partnerships with other jurisdictions (particularly the Northern Territory and Western Australia through the collaboration with the Greater Northern Australia Regional Training Network) and potentially with organisations in the primary healthcare, community-controlled and non-government sectors.

2. AHRGTP employment model

Evaluation findings support the employment model used in the 2014 AHRGTP implementation including 0.2FTE allocation of "development time", professional development funding consistent with a permanent employee in the same location, mandatory co-location with a practitioner of the same profession to provide local supervision and support, mandatory involvement in a rural generalist development plan addressing clinical and non-clinical training needs, and involvement in the implementation of a rural generalist service development project in the team. Continued targeting of new graduates (or post-PDY) was supported by the evaluation, but recruitment of early career practitioners (up to two years post-professional entry) should be permitted for future AHRGTP implementations.

The employment term of the AHRGTP incumbent should increase to two years to support greater exposure to rural and remote service settings and a more comprehensive development program.

3. Rural generalist training program for AHRGTP incumbents

A structured, formal rural generalist training program is required for AHRGTP incumbents, encompassing clinical and non-clinical development requirements and including profession-specific and inter-professional learning topics. The training program, although targeted to AHRGTP incumbents, should address rural generalist workforce and service capacity building more generally in order to distribute benefits of the initiative on a wider scale.

4. Rural generalist service development and quality improvement strategies

The AHRGTP initiative demonstrated reasonable success as an enabler of service development in host teams. The SCU evaluation identified the AHRGTP as a "system disruptor", stimulating and supporting changes to the local service delivery model. In 2014, the AHRGTP supported local teams to implement or enhance delegated service models, x-

ray operator services, telehealth, a range of new services that moved care closer to rural and remote clients, and also assisted teams to complete quality improvement activities.

5. AHRGTP local (HHS) implementation processes and supports

Evaluation findings demonstrated that all AHRGTP sites produced positive outcomes in 2014. Differences in local capacity and organisational readiness to plan, manage and evaluate workforce and service development projects was demonstrated in the SCU evaluation findings, host site completion reports and in feedback to the AHPOQ. These differences were primarily manifest in variations in the challenges and time/resource investment required to implement and report on the AHRGTP. The 2014 AHRGTP implementation was impacted by tight lead-in timeframes in 2013, adjustments to the aims of the initiative concurrent with the site recruitment process, and the uniqueness of rural training positions for allied health, making some issues difficult to anticipate. For current AHRGTP sites, many of the challenges were fully addressed in the 2014 implementation and will not require revisiting in 2015 e.g. establishing governance structures, adjustments to workload organisation to accommodate the change in FTE. Greater guidance and support for planning, managing and evaluating service development initiatives is required for the current AHRGTP sites in 2015. Learnings should also be integrated into recruitment / selection and support processes for new AHRGTP sites in future funding rounds.

Action plan

The action plan to guide the further development of the AHRGTP initiative is presented below, and with brief reporting on the status of actions at 31 July 2015 in Appendix 4.

1. Continue implementation of the AHRGTP initiative and examine opportunities for growth through partnerships with HHSs and other jurisdictions and agencies

- The AHPOQ will continue to fund the AHRGTP initiative. Funding of AHRGTP sites will remain non-recurrent in order to capitalise on the “system disrupter” effects of the funding for the development of local service models.
- All 2014 AHRGTP sites were offered funding to implement in 2015 while the outcome of the evaluation was pending.
- Most current AHRGTP sites were offered funding allocations for 2016 and all accepted. Funding of these AHRGTP sites will conclude in December 2016. The three-year funding term recognises that current sites have contributed to the initial work up and trialling of the initiative.
- From 2017 a 24-month funding round will be implemented (commencing January and concluding in December the following year). Site selection will occur in the second quarter of the previous calendar year (to provide adequate recruitment and service development lead-in times for successful sites). Consequently, selection of the 2017-18 sites will be undertaken in the second quarter of 2016.
- Operational management of the AHRGTP initiative will move to the Cunningham Centre, Darling Downs HHS form January 2016. The Cunningham Centre possesses expertise in managing allied health development-focussed programs, and the customer service infrastructure required for ongoing implementation of the statewide AHRGTP initiative.

- Recommendations from the Southern Cross University evaluation team are to be implemented including
  - additions to the data set collected from sites in 2015 progress and completion report templates, and
  - entry and exit surveys to be developed for implementation from 2016.
- Opportunities for expansion of the AHRGTP initiative to improve impacts and sustainability should be explored through designation or development of HHS positions, and through partnerships with other agencies. Further development of the concept of HHS-funded AHRGT positions and collaboration with rural and remote allied health teams is required to progress the growth of the strategy in Queensland.

2. Amend the AHRGTP employment model

- The term of employment for all AHRGTP incumbents from 2017 will be two years. Sites will be able to recruit an individual with up to two years professional experience to the role.
- AHRGTP 2016 funded sites may elect to appoint the 2015 incumbent for a second year, or to recruit a new early career professional for a twelve month term.

3. Develop a rural generalist training program for AHRGTP incumbents

- A formal rural generalist training program will be developed targeting the needs of current and proposed AHRGTP professions. A rural generalist pathway, incorporating the training program and the supporting employment structures (AHRGT positions and the existing HP3 to HP4 Rural Development Pathway) shall be developed.

4. Amend the term of the service development strategy/ies implementation and reporting

- From 2017 service development plans will have a two-year term, mirroring the duration of the funding cycle and the development plan of the AHRGTP incumbent.

5. Improve AHRGTP local (HHS) implementation processes and supports

- The AHPOQ will re-design project planning templates and develop project planning guides for telehealth, delegation, extended scope including skill sharing and new rural generalist services. Progress and completion report templates are to be tailored to each AHRGTP site and align to the site's implementation plan. The AHPOQ is to also offer assistance to all 2015 AHRGTP sites with regard to implementation planning and evaluation, either through directly providing support from AHPOQ staff or though linking to individuals with the required skill set (e.g. research fellows).
- SCU evaluation findings with regard to successful strategies for management of service development and incumbent training and support will be disseminated to stakeholders.
- Findings from the 2014 evaluation are to be used to inform the development of the recruitment and selection process for the 2017-18 AHRGTP cohort. Selection should have strong focus on assessing local leadership, governance, education/graduate support capacity and change readiness. The AHPOQ and Cunningham Centre are to collaboratively develop the recruitment and selection process in 2015.

Abbreviations

AHA(s)	Allied Health Assistant(s)
AHPOQ	Allied Health Professions' Office of Queensland
AHRGTP	Allied Health Rural Generalist Training Positions
EOI(s)	Expression(s) of interest
FTE	Full time equivalent
GNARTN	Greater Northern Australia Regional Training Network
HHS(s)	Hospital and Health Service(s)
PDY	Professional Development Year, meaning the period between university graduation and the allied health professional completing all requirements to obtain full/unrestricted registration or ability to practice independently.
QH	Queensland Health, meaning the Department of Health and both prescribed and non-prescribed Hospital and Health Services.
SCU	Southern Cross University
XO(s)	X-ray Operators(s)

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Appendix 1: Terms of reference AHRGTP Collaborative Network

Name

Allied Health Rural Generalist Training Positions Implementation Collaborative Network

Purpose

The purpose of the Network is to support the implementation of the Allied Health Rural Generalist Training Positions initiative and facilitate communication and shared problem-solving between stakeholders including host services, the Allied Health Professions' Office of Queensland (AHPOQ), and the Cunningham Centre.

Background

The AHRGTP initiative commenced in 2013-14. The initiative is funded by the Allied Health Professions' Office of Queensland, Department of Health. The purpose of this initiative is to support the provision of safe and applicable healthcare for rural and remote areas of Queensland by:

- supporting Hospital and Health Services (HHSs) to invest in training and support of graduates in rural and remote areas;
- increasing opportunities and incentivising rural and remote practice for graduates in allied health professions; and
- facilitating the implementation of new generalist models of care in rural and remote allied health services to increase access for clients and efficiency for health services.

Role

Support collaboration between services implementing the AHRGTP initiative

Facilitate communication and shared problem-solving between stakeholders including rural and remote teams in Hospital and Health Services (HHSs), the Allied Health Professions' Office of Queensland (AHPOQ) and the Cunningham Centre.

Support implementation and sustainability of the initiative through collaborative planning, and progress monitoring.

Membership

Stakeholder	Positions
HHSs hosting AHRGT positions	AHRGTP operational manager and/or delegate AHRGTP professional supervisor / site senior professional AHRGTP incumbent Director of Allied Health (or equivalent senior professional leaders)
AHPOQ	Principal Workforce Officer
Cunningham Centre	Senior Program Coordinator

Chair

The AHPOQ member will act as the chair.

Membership eligibility

Membership is by positions held.

Induction

An induction process for new members will be provided by the Chair.

Meeting arrangements and conduct

Frequency

- The Network will meet quarterly at dates and times to be determined by members.
- An extraordinary meeting may be called by the Chair for emergent issues.
- Meetings will be via video-conference.

Secretariat

- Coordinate logistics of the meetings (teleconference/venue, agenda, guests).
- Disseminates the agenda and briefing papers to members seven business days prior to the meeting
- Document and disseminate minutes to all network members within five working days of the meeting and maintain other documentation relevant to resolutions and/or recommendations made by the network.

Attendance and quorum

Each AHRGTP host site will be represented at each meeting to ensure information efficient flow of information between all stakeholder organisations in the Network.

As the Network is not a decision-making body, a quorum is not required to proceed with a meeting. In the event of low attendance those present will determine if the meeting proceeds.

Proxies

Members should nominate a suitably briefed proxy if unable to attend a meeting.

Guests

Guests may be invited to attend the meeting on an ad hoc basis to contribute information to specific agenda items. The Chair will coordinate arrangements for inviting guests.

Confidentiality

Network members may from time to time be in receipt of information that is regarded as 'in confidence'. Members acknowledge their responsibility to maintain confidentiality of all information that is not in the public domain.

Governance and authority

- The Network is sponsored by and reports to the Chief Allied Health Officer, Queensland Department of Health.
- The Network is a collaboration and advisory group and does not possess financial or legislative authority or decision making responsibilities in relation to the AHRGTP initiative.
- The reporting, communication and collaboration relationships are shown in Attachment 1.
- Subgroups may be formed to support more intensive collaborative activities between AHRGTP implementation sites e.g. profession-specific subgroups or project-related subgroups. Subgroups will determine operational arrangements that meet their objectives (e.g. meeting frequency, coordination, objectives) and can request support from AHPOQ including teleconference or videoconference arrangements. Subgroups will provide brief updates to the Chair and Network on activities and outputs.

Approval

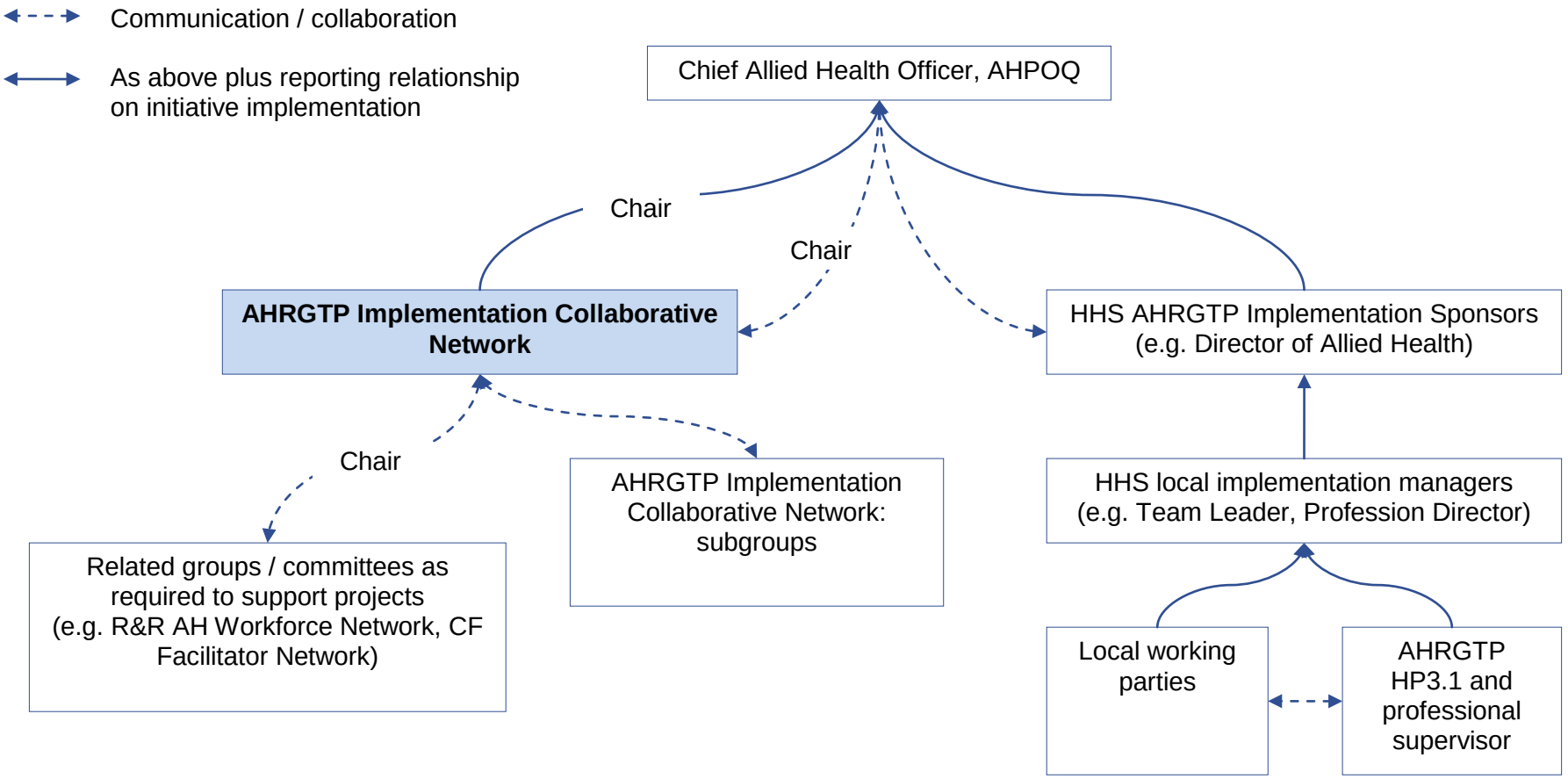
Julie Hulcombe

Chief Allied Health Officer

Allied Health Professions' Office of Queensland, Department of Health

22 / 05 / 2014

TOR ATTACHMENT 1: Collaboration, communication and reporting structure



Appendix 2: External evaluation summary

Evaluation overview

The scope of the Southern Cross University evaluation related to examining stakeholder views on the 2014 AHRGTP implementation, including barriers, issues, benefits and outcomes. The purpose of the external evaluation was to inform decision-making on the AHRGTP initiative, including providing information on benefits realisation and changes required to maximise service and workforce outcomes to the system. The evaluation report was accepted by the Chief Allied Health Officer in May 2015.

The evaluation team was headed by Professor Susan Nancarrow and included Dr Alison Roots, Dr Sandra Grace and Ms Kegan Barlow of the School of Health and Human Sciences, Southern Cross University, and Ms Gretchen Young of Young Futures.

The summary of the evaluation report is provided in this section. The full report is presented in Attachment A available at https://www.health.qld.gov.au/ahwac/html/rural-remote.asp.

Methods

A mixed methods approach to the data collection was used which included review of available literature on the allied health rural generalist role, documentary analysis, in-depth stakeholder interviews, and an online survey of staff who work with the AHRGTP in each context. Data were analysed using inductive logic reasoning. Ethics approval was obtained from the Gold Coast HHS Human Research Ethics Committee (HREC) (HREC/14/QGC/168), and Southern Cross University HREC (ECN-14-218), and approval was obtained for the evaluation study from all HHS delegates (e.g. Executive Director of Allied Health).

Results

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

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

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

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

1. Delegation (vertical task substitution) to allied health assistants (AHA) and other support workers or delivery of support functions by other practitioners (e.g. radiographers training X-ray Operators);

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

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

Impacts of the AHRGTP

The impacts of the AHRGTP were:

1. The new role was seen as a 'disrupter' to the status quo. From a service perspective, the AHRGTP facilitated new discussions and enabled organisations to implement change.
2. Increased staff satisfaction by reducing personal stress, reducing extended periods of on-call or extended work hours, and increasing collaboration.
3. Reduced travel times for patients and staff, particularly through the use of increased outreach services delivered via telehealth.
4. Enhanced team and organisational training capacity by capitalising on the additional professional development (PD) time available to the incumbent and using this to provide training to the team.
5. Development of rural and remote practitioners by developing, in situ, a relevant skill set and support structures for new graduates.
6. Improved service integration by improving communication within and between multidisciplinary teams; enhanced referral and service pathways; and the creation of networks with regional and metropolitan services.
7. Increased service development opportunities due to the establishment of clearer data collection processes and the need for an explicit focus on service development in the projects.
8. Increased service capacity by providing more rural and remote services (e.g. through telehealth), through new models of care (such as group services), and the use of AHAs.
9. Improved service quality, such as: increased continuity of care for patients; increased service access due to longer opening hours; increased multidisciplinary input to patient care.

Key findings from the external evaluation project

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

To optimise the implementation of the AHRGTP:

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

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

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

Conclusions

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

New graduates in these roles built capacity in terms of training support and development for the whole team, fostered integrated inter-professional relationships and established networks to benefit the wider service. This trial has demonstrated that well developed rural and remote positions can be established as sought after roles for graduate AHPs. The roles and frameworks established through this initiative have formed a foundation for further work on the development of rural generalist service and workforce models for selected AHPs.

The AHRG role is a complex concept that was implemented rapidly through this program, and the requirements of teams evolved and expanded in the early stages of implementation. Consequently, the way that the services understood, interpreted and implemented the AHRGTP model was inconsistent and often lacked clarity. An improved description and general agreement regarding a framework for allied health rural generalism is required to

progress the initiative. Additionally, the initiative needs to be supported by a clearly articulated rural generalist training pathway which incorporates clinical and non-clinical skills. This project also has wider implications for the training of AHPs (role evolution), and support for new graduates generally.

Recommendations

Recommendation 1: Clarify and clearly articulate a rural allied health generalist training framework to participating services

Recommendation 2: Facilitate early recruitment and profession-specific marketing of AHRGTP positions

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

Recommendation 3: Design rural generalist service development projects that are tightly focused, well scoped and realistic

Projects linked to the roles should have a tight focus, be well scoped and realistic with data systems in place to support the evaluation requirements for the project. Projects should include one or more of the following strategies:

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

Recommendation 4: Support and governance structures for the AHRGTP are implemented and monitored by the HHS sponsor and stakeholders, and by the funding provider

The support processes for the AHRGTP should be reported to the funding provider and implemented by the host service from the commencement of the role. Specifically:

- professional, clinical, and personal/pastoral support networks for the incumbent are established,
- lines of accountability (including formal supervision and operational management) are clearly defined,

- financial and administrative accountabilities are made clear and accessible to AHRGTP incumbents to limit the barriers to accessing professional development,
- a formal governance process for service development projects is defined in the implementation plan and monitored by the HHS sponsor and funding provider, and
- a formal handover to the new incumbent is implemented by sites where possible, to create mechanisms to build capacity from the incumbent's learnings.

Recommendation 5: Align the length of the AHRGTP with the goals of increasing exposure to rural practice while optimising capacity building

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

Recommendation 6: Establish a formal training pathway that outlines the key skills and pathways required for rural practice

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

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

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

Appendix 3: HHS-reported outcomes / outputs summary

Cairns & Hinterland HHS Implementation component	Atherton Implementation objectives	Dietitian Outcomes (summary)
Workforce development	Recruit and maintain AHRGTP on establishment in rural / remote location for 12 months	Graduate dietitian employed in AHRGT position for the duration of 2014.
	Supervision and support provided to AHRGTP incumbent	**Development plan implemented** Clinical focus areas - malnutrition, maternal nutrition, nutrition for specific populations e.g. cancer care, older persons, palliative care, new models of practice including hospital in the home and a range of other topics. Non-clinical focus areas: evidence-based practice, peer supervision, telehealth, cultural capability, documentation, time management and a range of other skills.
	Development time (0.2FTE) implemented.	
Increased local establishment / service capacity	Service model and activity change associated with 1 FTE supernumerary AHRGT position located in Atherton Hospital. Previous service model: fractional / outreach service	**Increased dietetics occasions of service (OOS) at Atherton Hospital** 39% increase in total inpatient OOS in 2014 (compared to 2013) 16% increase in total outpatient OOS in 2014 (compared to 2013).
		Decreased dietetics outpatient waiting list at Atherton Hospital 17% decrease in average number of patients on outpatient waiting list in 2014 (compared to 2013).
		Staff satisfaction High satisfaction with implementation of an onsite dietetic service in Atherton Hospital (staff survey).

Cairns & Hinterland HHS Implementation component	Atherton Implementation objectives	Dietitian Outcomes (summary)
Service redesign / development	Develop, implement and evaluate telehealth services for Croydon, Forsayth and Georgetown. Previous service model was (limited) outreach services.	**Dietetics telehealth service implemented for Croydon, Forsayth and Georgetown** Telehealth OOS 2013 = 0; 2014 = 19 High satisfaction with telehealth services (staff and clients) Initiated joint telehealth service with outreach pharmacist (continue development of this service in 2015).
	Dietetics service model developed for new clinical areas / populations in Atherton	**New / expanded dietetics services implemented** for chemotherapy clinic, pulmonary and cardiac rehabilitation groups, and child health group for new mothers. Commenced dietetic input to weekly gestational diabetes case conference.
Implementation management	Complete a research project to evaluate outcomes of the AHRGTP implementation in this site	Research project completed.

Cairns & Hinterland HHS Implementation component	Innisfail Implementation objectives	Physiotherapist Outcomes (summary)
Workforce development	Recruit and maintain AHRGTP on establishment in rural / remote location for 12 months	Graduate physiotherapist employed in AHRGT position for the duration of 2014.
	Supervision and support provided to AHRGTP incumbent.	**Development plan implemented** Clinical focus areas: orthopaedics and musculoskeletal, paediatrics, neuro-rehab, falls prevention, aged care, general medical and cardio-respiratory. Non-clinical focus areas: cultural capability, safety & quality.
	Development time (0.2FTE) implemented.	
Increased local establishment and service capacity	Service model and activity change associated with 1 FTE supernumerary AHRGT position	**Increased physiotherapy occasions of service (OOS) at Innisfail Hospital** 76% increase in total physiotherapy OOS in 2014 (compared to 2013) 95% increase in total inpatient physiotherapy OOS in 2014 (compared to 2013) 20% increase in total outpatient physiotherapy OOS in 2014 (compared to 2013)
		Decreased physiotherapy waiting list at Innisfail Hospital 25% decrease in average number of patients on outpatient waiting list at the end of 2014 (compared to same period in 2013)
Service redesign / development	Improve delegation model of physiotherapy team	Implementation postponed to 2015.
Implementation management	Complete a research project to evaluate outcomes of the AHRGTP implementation in this site	Research project completed.

Central Queensland HHS Implementation component	Emerald Implementation objectives	Pharmacist Outcomes (summary)
Workforce development	Recruit and maintain AHRGTP on establishment in rural / remote location for 12 months	Graduate pharmacist employed in AHRGT position for the duration of 2014.
	Supervision and support provided to AHRGTP incumbent	**Development plan implemented** Clinical focus areas: medicines management, general hospital pharmacy. Non-clinical focus areas: supervision, telehealth, rural and remote practice.
	Development time (0.2FTE) implemented.	
Increased local establishment / service capacity	Service model and activity change associated with 1 FTE supernumerary AHRGT position	**Increase pharmacy clinical services in Emerald, Blackwater, Woorabinda, and Springsure** Total occasions of service increased 330% in 2014 compared to 2013 (including change from 0 to 102 in aggregated data from smaller centres of Woorabinda, Blackwater and Springsure) Medication Action Plan completions (across all service sites) increased 250% compared to 2013 Number of Discharge Medication Records completed increase 36% in 2014 compared to 2013
		Medicines safety-related NSQHSS Accreditation standard achieved
Service redesign / development	Develop, implement and evaluate telepharmacy services to Springsure in 2014	**Telepharmacy service implemented** Workflow documents developed to support telehealth implementation: - Weekday Admissions Medication Action Plan Process - Weekday Discharge Medication Review Process - Springsure Telepharmacy Patient Assessment Baseline Medication Action Plan data collected - for further development in 2015.

Central Queensland HHS Implementation component	Emerald Implementation objectives	Pharmacist Outcomes (summary)
	Develop and implement new services for the rural / remote location	**Scoping of drop-in service at Woorabinda completed** To be progressed by Woorabinda Pharmacist (new position) in 2015.
	Improve efficiency and quality of medication services in Woorabinda	**In-house medication packing in Woorabinda implemented** Evaluation conducted: annual saving of $7,143 to the service (revenue and reduced costs).

Central West HHS Implementation component	Longreach Implementation objectives	Radiographer Outcomes (summary)
Workforce development	Recruit and maintain AHRGTP on establishment in rural / remote location for 12 months	Failed to recruit. Alternative plan focussed on service development goals was approved by the AHPOQ and implemented.
Increased local establishment / service capacity	Service model and activity change associated with 1 FTE supernumerary AHRGT position	**Reduce wait times for non-urgent sonography** Reduced from three weeks to one week during alternative staffing implementation period.
	(Funding repurposed to achieve service development and activity objectives - Sonography FTE was temporarily increased from 0.6 FTE to 1FTE from Jul-Dec 2014)	**Governance and standards of CWHHS Medical Imaging services enhanced** Birdsville and Bedourie Primary Healthcare Centres absorbed into CWHHS radiation safety licence. X-ray operator costing exercise completed to inform workforce and business planning decisions.
Service redesign / development	Implement and evaluate a training and supervision model for X-ray operators and increase number and frequency of radiographer site visits	**X-ray operator training and supervision increased** Radiographer site visits increased from 3 visits across 2 sites in Jan-June 2014 to 27 visits across all 6 HHS sites in July to December 2014.

Darling Downs HHS Implementation component	Chinchilla Implementation objectives	Occupational Therapist Outcomes (summary)
Workforce development	Recruit and maintain AHRGTP on establishment in rural / remote location for 12 months	Graduate occupational therapist employed in AHRGT position for the duration of 2014.
	Supervision and support provided to AHRGTP incumbent	**Development plan implemented** Clinical focus areas: chronic disease, rehabilitation, equipment prescription, home assessment and modifications, paediatrics, hands, oedema management, vascular, burns, scar management. Non-clinical focus areas: evidence-based practice, supervision, telehealth, documentation.
	Development time (0.2FTE) implemented.	
Increased local establishment / service capacity	Service model and activity change associated with 1 FTE supernumerary AHRGT position	**Increase occupational therapy clinical services, with specific focus on outreach sites (Miles, Taroom, Wandoan)** Total occasions of service in outreach sites increased 94% in 2014 (204 in 2013; 396 in 2014).
Service redesign / development	Identify and implement a consistent range of occupational therapy rural generalist services and caseload management processes across all Western Cluster sites to improve access and timeliness of services for rural clients.	**Paediatric occupational therapy services reviewed** including service gaps identified and preliminary development completed for a 'drop-in' clinic for implementation in 2015.
		Service demand review completed to inform planning Referral mapping: 25% hands, 65% home assessment/modifications, assistive aids, home safety, 10% other.
		Occupational Therapy screening tool developed and implemented (adult outpatient and inpatient clients) 100% outpatients and 90% inpatients screened. Further impact and outcome evaluation of screening required.

Darling Downs HHS Implementation component	Chinchilla Implementation objectives	Occupational Therapist Outcomes (summary)
	Identify a rural generalist occupational therapist clinical 'skill set' aligned to the service model (above) and trial an associated development program across Western Cluster occupational therapists.	**Generalist clinical skill set developed and trialled** Skill set includes 19 training elements across the following clinical functions: hands, paediatrics, seating, wheel chair prescription, pressure care/aids, home modifications, oedema / lymphoedema, cognitive assessment and interventions.
	Review, further develop and evaluate telehealth occupational therapy services in Western Cluster sites.	**Telehealth clinical service hours increased by 140%** 104 hours in 2013; 250 in 2014

Darling Downs HHS Implementation component	Kingaroy Implementation objectives	Physiotherapist Outcomes (summary)
Workforce development	Recruit and maintain AHRGTP on establishment in rural / remote location for 12 months	Graduate physiotherapist employed in AHRGT position for the duration of 2014.
	Supervision and support provided to AHRGTP incumbent	**Development plan implemented** Clinical focus areas: rehabilitation, paediatrics, musculoskeletal. Non-clinical focus areas: evidence-based practice, supervision, telehealth / e-health.
	Development time (0.2FTE) implemented.	
Increased local establishment / service capacity	Service model and activity change associated with 1 FTE supernumerary AHRGT position	**Physiotherapy outpatient waiting lists remained stable** with 5.6% increased referrals.
		Inpatient occasions of service (OOS) increased in Kingaroy Hospital by 15% (2001 in 2013, 2301 in 2014)
Service redesign / development	Implement physiotherapy step-down rehabilitation model for Nanango Hospital.	**Scoping and preparation work completed.** New service for implementation in 2015. Recruitment of Advanced AHA, training and competency assessment completed. OOS for inpatient physiotherapy in Nanango Hospital increased by 64% in 2014 (44 OOS in 2013; 77 OOS in 2014).
	Increase physiotherapy emergency department OOS in Kingaroy Hospital	OOS data unavailable.
	Scope, and if indicated, develop and implement changes to the Cherbourg physiotherapy outpatients service	Scoping completed. Findings did not support prioritisation of this service development strategy due to the presence of other providers.

Darling Downs HHS Implementation component	Kingaroy Implementation objectives	Physiotherapist Outcomes (summary)
	Increase use of telehealth by South Burnett physiotherapy team.	Data on telehealth clinical service activity not available. Increased use of telehealth for professional support was noted.
	Scope, and if indicated, develop and implement a pulmonary rehabilitation service linked to current cardiac rehabilitation services in Kingaroy	Scoping completed. Findings did not support prioritisation of this service development strategy.

Mackay HHS Implementation component	Moranbah Implementation objectives	Radiographer / trainee sonographer Outcomes (summary)
Workforce development	Recruit and maintain AHRGTP on establishment in rural / remote location for 12 months	Post-PDY radiographer employed in AHRGT position for the duration of 2014. Incumbent enrolled in 2-year sonography training program.
	Supervision and support provided to AHRGTP incumbent	**Development plan implemented** Sonography training program.
	Development time (0.2FTE) implemented.	
Increased local establishment / service capacity	Service model and activity change associated with 1 FTE supernumerary AHRGT position	**Increased access to full x-ray service at Moranbah Hospital** Days of 'full service' (i.e. access to radiographer) increased to 250 days in 2014 (additional 42 days compared to 2013)
		Increased access to sonography service at Moranbah Hospital Days of 'full service' (i.e. access to trained sonographer) increased to 225 days in 2014 (additional 17 days compared to 2013); plus an additional 8 days limited / trainee service in 2014.
Service redesign / development	Improved x-ray operator (XO) supervision, training and service quality	**XO support and training strategies implemented** Film critique and feedback (100% films taken by XOs in 2014 in the two rural satellite sites were reviewed). Additional training and supervision implemented for XOs.

North West HHS	Mt Isa	Dietitian
Implementation component	Implementation objectives	Outcomes (summary)
Workforce development	Recruit and maintain AHRGTP on establishment in rural / remote location for 12 months	Graduate dietitian employed in AHRGT position for the duration of 2014.
	Supervision and support provided to AHRGTP incumbent	**Development plan implemented:** Graduate Certificate Remote Health Practice (Allied Health) completed. Clinical focus areas: food service, paediatrics and maternal nutrition. Non-clinical focus areas: time management, telehealth, supervision skills, delegation, cultural capability, rural and remote allied health services. Contributed to the development of the national Network of Emerging Australian Dietitian (NEAD) group.
	Development time (0.2FTE) implemented.	
Increased local establishment / service capacity	Service model and activity change associated with 1 FTE supernumerary AHRGT position	**Increase access to dietetic services at Mt Isa Hospital** 32.5% increase in occasions of service (OOS) in 2014 compared to 2014, with main increases in maternity, baby development clinic and paediatrics.
Service redesign / development	Improve food services at Mount Isa Hospital	**QLD Health Nutrition Standards for Meals and Menus at Mt Isa Hospital nearing implementation** Majority of development activities completed and awaiting implementation at end of 2014.
	Demonstrate culturally competent dietetics service provision	**Identify, design and develop culturally competent model of service and resources to support that service** Cultural advisors engaged for menu review and development of culturally appropriate cook book for nutritionally high risk client groups.
	Develop and implement new services	**Gestational Diabetes outpatient group education sessions** were developed and implemented.

South West HHS	St George	Physiotherapist
Implementation component	Implementation objectives	Outcomes (summary)
Workforce development	Recruit and maintain AHRGTP on establishment in rural / remote location for 12 months	Graduate physiotherapist employed in AHRGT position for the duration of 2014.
	Supervision and support provided to AHRGTP incumbent	**Development plan implemented:** Clinical focus areas - Musculoskeletal and orthopaedics, women's health, neurology and rehab / sub-acute.
	Development time (0.2FTE) implemented.	
Increased local establishment / service capacity	Service model and activity change associated with 1 FTE supernumerary AHRGT position	**Increased inpatient physiotherapy services in St George** including supporting earlier step-down transfers from Roma (linked to implementation of SWHHS sub-acute service): Days without inpatient coverage (due to outreach / leave) in 2014 reduced by more than two-thirds compared to 2013. Total inpatient occasions of service in 2014 increased by 11%.
		Increased outreach physiotherapy services Dirranbandi: visits increased from 9 in 2013 to 26 in 2014; and occasions of service doubled. Bollon: visits increased from 2 in 2013 to 8 in 2014; and occasions of service increased by 160%. Mungindi: visits increased from 10 in 2013 to 34 in 2014; and occasions of service tripled.
Service redesign / development	Improve delegation model of physiotherapy team	**Task delegation to AHAs increased** 58% per physiotherapy FTE in 2014 compared to 2013. AHA total occasions of service increased 65% in 2014.

South West HHS	St George	Physiotherapist
Implementation component	Implementation objectives	Outcomes (summary)
	Develop and implement new services	**Strength & balance group** developed and implemented (93 participants in 2014)
	Develop and implement expanded scope services	**'Early contact' physiotherapy service model in emergency department** (ED) developed and implemented. 2014 ED Physiotherapy occasions of service: 42 Number of patients requiring follow-up: 17 Number of patients seen in ED residing >100km from St George: 14 (previous service model would have necessitated client return to St George at a later date for physiotherapy review in the outpatient clinic). Positively evaluated by healthcare team members.

Torres & Cape HHS	Weipa	Radiographer
Implementation component	Implementation objectives	Outcomes (summary)
Workforce development	Recruit and maintain AHRGTP on establishment in rural / remote location for 12 months	Graduate radiographer employed in AHRGT position for 12 weeks in 2014 (recruitment difficulties).
	Supervision and support provided to AHRGTP incumbent, and development activities implemented.	Due to term of AHRGTP incumbent, a limited development program was implemented including exposure to sonography and radiographer commenting and experience quality reviewing XO images in IMPAX.
Increased local establishment / service capacity	Service model and activity change associated with 1 FTE supernumerary AHRGT position	Due to term of AHRGTP incumbent, service development activities were prioritised for the implementation and activity changes were not captured.
Service redesign / development	Development and implementation of the TCHHS x-ray operator (XO) training and supervision framework	**Telehealth-delivered training and supervision of XOs developed and implemented** Feedback on images implemented through IMPAX. 17 % of XO examinations assessed under 'Every Image, Every day' initiative in 2014 and 100% while AHRGT position was filled.
		Training materials for XOs developed and implemented (linked to existing statewide resources and legislation requirements). Resources at http://qheps.health.qld.gov.au/torres-cape/html/radiography-xray.htm.
		Radiation safety audits and competency assessments of XOs completed through site visits to primary healthcare centres
	Improve workforce planning for medical imaging in the HHS	Baseline data collected for TCHHS X-ray operator sites (OOS). For further development in 2015.

Wide Bay HHS	Gayndah	Physiotherapist
Implementation component	Implementation objectives	Outcomes (summary)
Workforce development	Recruit and maintain AHRGTP on establishment in rural / remote location for 12 months	Graduate physiotherapist employed in AHRGT position for the duration of 2014.
	Supervision and support provided to AHRGTP incumbent	**Development plan implemented** Clinical focus areas: Musculoskeletal and orthopaedics, women's health. Non-clinical areas: rural and remote practice (various topics), cultural practice, delegation, telehealth, service improvement and quality improvement.
	Development time (0.2FTE) implemented.	
Increased local establishment / service capacity	Service model and activity change associated with 1 FTE supernumerary AHRGT position	**Reduce waiting times for physiotherapy clients** Average waiting time from referral to initial appointment decreased 7 days between January and December 2014.
		Increased physiotherapy occasions of service Total physiotherapy occasions of service (OOS) approximately doubled in 2014 compared to 2013.
Service redesign / development	Develop, implement and evaluate telehealth services	**Telehealth-delivered services implemented** Group preadmission clinic (7 sites, occurring weekly) and balance and mobility clinic. Total telehealth OOS 2013 = 0; 2014 = 21 Total group telehealth OOS 2013 = 5; 2014 = 55
	Develop and implement new inpatient step-down sub-acute care in Gayndah facility	**Access to physiotherapy increased for Gayndah Hospital sub-acute inpatients** Daily (weekday) service available for Gayndah Hospital sub and non-acute patients, Gayndah Hospital physiotherapy sub-acute OOS increased from 34 in 2013 to 210 in 2014.

Appendix 4: AHRGTP initiative action plan

Action	Status at 31 July 2015
1. Continue implementation of the AHRGTP initiative and examine opportunities for growth through partnerships with HHSs and other jurisdictions and agencies	
• The AHPOQ will continue to fund the AHRGTP initiative. Funding of AHRGTP sites will remain non-recurrent in order to capitalise on the "system disrupter" effects of the funding for development of local service models. • All 2014 AHRGTP sites were offered funding to implement in 2015, pending the outcome of the evaluation. • Most current AHRGTP sites were offered and accepted funding allocations for 2016. Funding of these AHRGTP sites will conclude in December 2016. The three-year funding term recognises that current sites have contributed to the initial work up and trialling of the initiative. • From 2017 a 24-month funding round will be implemented (commencing January and concluding in December the following year). Site selection will occur in the second quarter of the previous calendar year (to provide adequate recruitment and service development lead-in times for successful sites). Consequently, selection of the 2017-18 sites will be undertaken in the second quarter of 2016.	All sites were advised in March 2015 of the intent to conclude the present non-recurrent funding arrangements at the end of 2016, allowing time to plan for service transition and embedding of service development strategies.
• Operational management of the AHRGTP initiative will move to the Cunningham Centre, Darling Downs HHS form January 2016. The Cunningham Centre possesses expertise in managing allied health development-focussed programs, and the customer service infrastructure required for ongoing implementation of the statewide AHRGTP initiative.	Agreement secured with Darling Downs HHS to commence management of the initiative from January 2016. Transition of responsibilities in progress.

Action	Status at 31 July 2015
• Recommendations from the Southern Cross University evaluation team are to be implemented including o additions to the data set collected from sites in 2015 progress and completion report templates, and o entry and exit surveys to be developed for implementation from 2016.	Changes to the 2015 progress and completion report templates actioned including the addition of new reporting items: number of applicants for the position, expenditure on development activities (course fees, travel to clinical placement etc), variance from planned governance structures for workforce and service development objectives and mandatory service activity data reporting across all sites (e.g. occasions of service).
• Opportunities for expansion of the AHRGTP initiative to improve impacts and sustainability should be explored through designation or development of HHS positions, and through partnerships with other agencies. Further development of the concept of HHS-funded AHRGT positions and collaboration with rural and remote allied health teams is required to progress the growth of the strategy in Queensland.	Meeting with inter-jurisdictional stakeholders in May 2015 (Greater Northern Australia Regional Training Network, Western Australia Department of Health and Western Australia Country Health Services, Northern Territory Department of Health, Services for Australian Rural and Remote Allied Health).
2. Amend the AHRGTP employment model	
• The term of employment for all AHRGTP incumbents from 2017 will be two years. Sites will be able to recruit an individual with up to two years professional experience to the role. • AHRGTP 2016 funded sites may elect to appoint the 2015 incumbent for a second year, or to recruit a new early career professional for a twelve month term.	AHRGTP 2016 funded sites were advised in June 2015 of recruitment options for 2016.

Action	Status at 31 July 2015
3. Develop a rural generalist training program for AHRGTP incumbents	
• A formal rural generalist training program will be developed targeting the needs of current and proposed AHRGTP professions. A rural generalist pathway, incorporating the training program and the supporting employment structures (AHRGT positions and the existing HP3 to HP4 Rural Development Pathway) shall be developed.	The Cunningham Centre has been funded by the AHPOQ to undertake the Allied Health Rural Generalist Pathway Scoping Project (March to September 2015).
4. Amend the term of the service development strategy/ies implementation and reporting	
• From 2017 service development plans will have a two-year term, mirroring the duration of the funding cycle and development plan of the AHRGTP incumbent.	
5. Improve AHRGTP local (HHS) implementation processes and supports	
• The AHPOQ re-design project planning templates and develop project planning guides for telehealth, delegation, extended scope including skill sharing and new rural generalist services. Progress and completion reporting templates are to be tailored to each AHRGTP site and align to the site's implementation plan. The AHPOQ is to also offer assistance to all 2015 AHRGTP sites with regard to implementation planning and evaluation, either through directly providing support from AHPOQ staff or though linking to individuals with the required skill set (e.g. research fellows). • SCU evaluation findings regarding successful strategies for management of service development and incumbent training and support will be disseminated to stakeholders. • Findings from the 2014 evaluation are to be used to inform the development of the recruitment and selection process for the 2017-18 AHRGTP cohort. Selection should have strong focus on assessing local leadership, governance, education/graduate support capacity and change readiness. The AHPOQ and Cunningham Centre are to collaboratively develop the recruitment and selection process in 2015.	Re-designed reporting templates and support documents were implemented in 2015. Feedback session provided by SCU evaluation team via videoconference to AHRGTP sites and other stakeholders on 27 July 2015. The AHPOQ provided information sessions via videoconference in the project planning phase (January – March 2015), including offers of one-on-one support for individual sites. Development of the recruitment and selection process for the 2017-18 funding round has commenced.

Allied Health Professions' Office of Queensland
Department of Health

Allied Health Rural Generalist Training Positions – 2014 Implementation Report