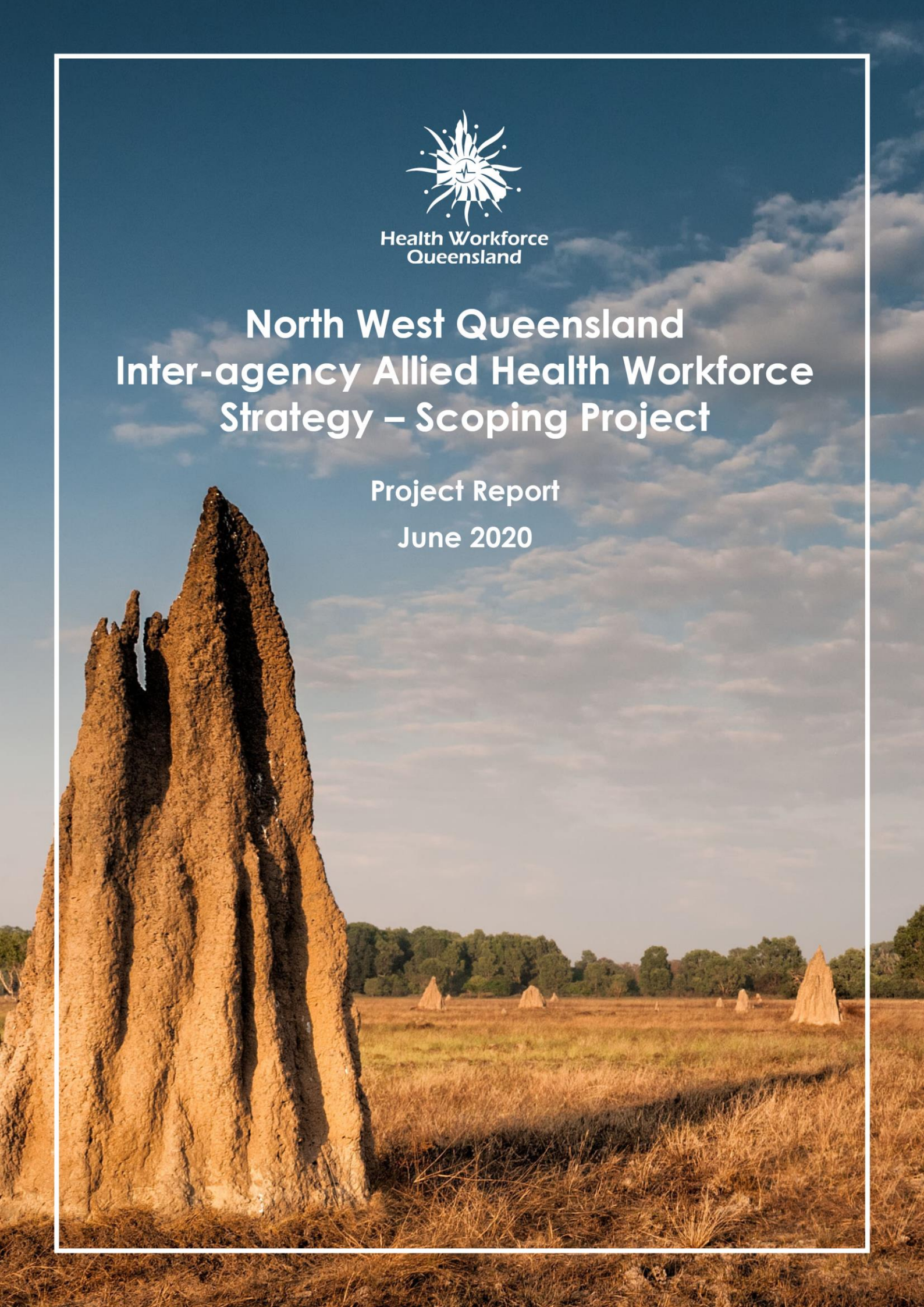

Health Workforce Queensland

North West Queensland Inter-agency Allied Health Workforce Strategy – Scoping Project

Project Report

June 2020

Executive Summary

North west Queensland health service providers and funders participated in a four-month scoping project that was led by Health Workforce Queensland and co-funded by the Allied Health Professions' Office of Queensland, Queensland Health, Queensland Government. The aim of the project was to work with key stakeholders to scope an inter-agency, collaborative, regional approach to allied health workforce development including recruitment, retention and capacity building in health services in north west Queensland.

The rationale for the project included reported challenges with:

- Allied health professional recruitment, particularly for experienced clinicians and leaders,
- Implementing sustainable work-based training, professional supervision and clinical governance processes, in small multi-professional teams, and
- Costs and service impacts associated with turnover and periods of vacancy in key positions.

As the current regional workforce profile was strongly weighted to early career allied health professionals, a strategy to provide high quality professional support, intensive training and recruitment and retention incentives for this group was prioritised. An inter-agency approach that optimally and efficiently used the senior allied health professional capacity available in all participating organisations was identified as an important component of the strategy.

Project Summary and Method

The primary partners in the project included North West Hospital and Health Service, North West Remote Health, Gidgee Healing, Centre for Rural and Remote Health, Western Queensland Primary Health Network, Health Workforce Queensland and the Allied Health Professions' Office of Queensland. The project was conducted over 20 weeks (17 February to 30 June 2020) and was managed by 0.5 FTE project manager/facilitator.

The project team worked with stakeholders to scope an inter-agency, collaborative, regional approach to allied health workforce development in health services in north west Queensland. The Allied Health Rural Generalist Pathway was used as the focus of the strategy.

Deliverables

The primary deliverable of the scoping project is a proposed inter-agency, collaborative allied health workforce strategy with a focus on the Allied Health Rural Generalist Pathway as a cross-agency approach to early career attraction and support and catalyst for collaboration on workforce objectives. The deliverable is presented as a draft implementation plan for endorsement by project partners (Attachment 1 – *Two-year Implementation Plan (2020-2022)*).

Project outputs also included:

- A final project report,
- A case for change document for internal stakeholders,
- A policy brief for external stakeholders (Attachment 2 – *Policy Brief*),
- Abstract submission to the Are You Remotely Interested Conference, and the Australian Journal of Rural Health special edition on health professional education.

Findings

The proposed strategy includes:

- The implementation of the Allied Health Rural Generalist Pathway as an inter-agency, collaborative approach to workforce development,
- Each participating healthcare organisation implementing one or more designated allied health rural generalist training positions,
- Development of an inter-agency cohort of rural generalist trainees supported by in kind resourcing from the University Department of Rural Health and a collaborative group of supervisors from participating organisations,
- A governance structure coordinated by Health Workforce Queensland,
- Resourcing for participating organisations through existing state and national Allied Health Rural Generalist Pathway funding schemes, and support from service commissioners.

Key findings in relation to the proposed strategy include:

- The Allied Health Rural Generalist Pathway is accepted as a structure for allied health workforce development for primary care and public sector health services,
- A commissioning model that enables workforce development and sustainability strategies for remote allied health teams is critical for primary care services,
- An inter-agency, collaborative approach to supporting early career allied health professionals can mitigate risks associated with vacancies in senior roles, and provide a breadth of training and supervision resources that individual organisations could not source independently, and
- The University Department of Rural Health is well placed to support a cohort of early career rural generalist trainees, with education expertise and infrastructure available.

Recommendations

Recommendation 1.

The scoping project partners endorse the project report and the sponsor and funders approve the completion report and deliverables.

Recommendation 2.

Collaboration partners support a 2-year initial phase of implementation of the inter-agency allied health workforce strategy scoped in this project including:

- Participating health services redesign one or more early career allied health roles into designated rural generalist training positions,
- That Western Queensland Primary Health Network work with relevant health services to integrate the strategy into service commissioning models,
- A training cohort is formed, through in-kind support from the Centre for Rural and Remote Health, that is supported by senior allied health professionals from each participating health service, and
- Allied health workforce / education funders, including the Allied Health Professions' Office of Queensland, Health Workforce Queensland, Services for Australian Rural and Remote Allied Health and Centre for Rural and Remote Health, provide funding or in-kind support for organisations implementing rural generalist training positions and participating in the inter-agency, collaborative workforce strategy.

Recommendation 3.

Health Workforce Queensland implement the dissemination strategy for the project completion report including highlighting:

- Outcomes and next steps information for project partners; and
- Advice for a range of state and national bodies on the outcomes of the project and potential opportunities for use of the model in other rural and remote locations.

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Background and overview

In November 2019, allied health service providers and commissioners in north west Queensland came together in Mount Isa to discuss the challenges and opportunities for workforce sustainability in the region. The meeting attendees were supportive of scoping an inter-agency, collaborative workforce strategy, with a primary focus on early career rural generalist recruitment, retention, training and support using the Allied Health Rural Generalist (AHRG) Pathway. Health Workforce Queensland (HWQ) led the scoping project, which was co-funded by the Allied Health Professions' Office of Queensland (AHPOQ).

Health Workforce Queensland (HWQ) is the rural workforce agency for health professionals looking to work in rural and remote parts of Queensland and is part of a broader national network of Rural Workforce Agencies.

Allied Health Professions' Office of Queensland (AHPOQ), Queensland Department of Health leads the development, implementation and evaluation of strategies to ensure an appropriately skilled allied health workforce meets the current and future health service needs of Queensland.

Context and rationale

The challenges of building and sustaining a stable, high performing allied health workforce in rural and remote areas are well known (Battye, Roufeil, Edwards, Hardaker, Janssen, Wilkins, 2019). Difficulties recruiting experienced allied health professionals, challenges providing supervision and work-based training for early career practitioners or releasing staff for professional development, and flat workforce structures contribute to the friability of small multi-professional rural teams. Recent research indicates that early career rural employment is the strongest predictor of a rural or remote career for allied health and nursing professions (Playford, Moran, Thompson, 2020). An 'own grown' workforce strategy that can produce, at a minimum, a modest extension to the average tenure of early career staff and translate into longer-term retention of some experienced practitioners, has the potential to generate substantial benefits for a service and a region.

A more detailed description of the national rural and remote allied health workforce context is provided in Appendix A – *Evidence Review and Context*.

The AHRG Pathway is designed to improve workforce sustainability through attraction, targeted training and support of early career professionals, along with a focus on service development and continuous improvement. It was selected as the basis of the strategy developed in this project as it aligns to the workforce and service development needs of the participating organisations. North west Queensland has a range of allied health service providers and a local University Department of Rural Health that have a history of working together on key activities such as the Lower Gulf Strategy (Queensland Health, 2019b). North west Queensland is well placed to develop a collaborative workforce strategy that leverages the resources, talents and strengths of each organisation in order to draw allied health professionals to the region and support them to address the demand for services.

Key Concepts

Allied Health Rural Generalist

The term 'rural generalist' refers to a service, or to a position or practitioner delivering the service, that can respond to the broad range of healthcare needs of a rural or remote community. This includes delivering services to people with a wide range of clinical presentations, across the age spectrum, and in a variety of clinical settings (inpatient, ambulatory care and community) (Services for Australian Rural and Remote Allied Health, n.d.). Rural generalists practice under the regulatory instruments of their specific allied health profession and the policies of their employer. The term 'rural generalist' should not be confused with the term 'generic health worker', that does not have a primary health professional qualification.

Allied Health Rural Generalist Pathway

The AHRG Pathway aims to support the growth, sustainability and value of the rural and remote allied health workforce and the proliferation of rural generalist service models that deliver accessible, safe, effective and efficient health services for rural and remote health consumers. The AHRG Pathway has three components:

1. Rural generalist service models that support and engage allied health professionals to implement innovative and effective solutions to the challenges of delivering care across geographically dispersed and culturally diverse populations,
2. Workforce policy and employment structures that align to development requirements and facilitate progression from entry-level competency to proficient rural generalist in the relevant allied health profession and into extended scope roles where this is required by the service, and
3. A formal education program that supports the development of the clinical and non-clinical rural generalist practice requirements of the relevant allied health profession.

Further details on the AHRG Pathway are provided in Appendix B – *Allied Health Rural Generalist Pathway*.

Project details

Aim and objectives

The aim of the scoping project was to work with key stakeholders to develop an inter-agency, collaborative, regional approach to allied health workforce development including recruitment, retention and capacity building, in health services in north west Queensland.

The outcome of the scoping project is a proposed strategy, including draft implementation plan, that describes for partner organisations:

- A cross-agency approach to implementation of the AHRG Pathway to support early career attraction and development, and to act as a catalyst for collaboration between organisations and
- The opportunities/benefits, enablers, risks and resources required to commence implementation of the proposed strategy.

Scope

The project focused on a regional approach to sustainable early career allied health attraction / recruitment, training, development, supervision and retention. The project examined:

- The AHRG Pathway implementation barriers, enablers and methods relevant to each of the organisations,
- The potential benefits and strategies to work collaboratively to support early career allied health professionals (rural generalist trainees), and
- Ways to support the capacity and capabilities of senior allied health professionals, particularly with regard to clinical leadership, supervision, work-based training and learning facilitation.

The options examined included:

- Development of designated allied health rural generalist training positions in two or more health services in the region,
- An inter-agency early career training cohort that uses inter-professional education, learning facilitation and peer learning to support trainees undertaking the AHRG Pathway,
- Cross-agency supervision and training facilitation arrangements to provide confidence in the continuity of supervision in the event that there is a period of vacancy in a senior professional role, and
- Funding opportunities to support the strategy.

Options not considered within the scoping project but noted to be potentially valuable to examine in the next phase were:

- Short-term secondment opportunities or clinical placement / work shadowing in other local services, and
- Recruitment pathways from pre-entry placements in Mount Isa to local training positions.

Professions

The professions primarily in scope of the strategy are the nine that can undertake the Allied Health Rural Generalist Program through James Cook University (JCU):

- nutrition and dietetics
- occupational therapy
- speech pathology
- pharmacy
- medical imaging
- social work
- podiatry
- physiotherapy
- psychology

Other professions could be considered but would require an alternative education program to be identified in the implementation planning.

Out of scope

The following were not in scope of the project:

- Joint or shared positions, due to known complexities and barriers related to differing wage rates / industrial frameworks, human resource requirements, entitlements, employer expectations e.g. travel, etc., and
- Funding/resource allocation over and above that which is already available in the partner organisations or from existing funding programs. In particular, the project did not examine additional (supernumerary) staffing and instead scoped the development of training roles through redesign of existing establishment.

Term

March 2020 – June 2020 (4 months)

Stakeholders

The main service providers in scope of the project were:

- North West Hospital and Health Service (NWHHS)
- Gidgee Healing
- North West Remote Health (NWRH)
- Centre for Rural and Remote Health (CRRH)
- Department of Education (DoE)

Other key partners in the scoping project were:

- Western Queensland Primary Health Network (WQPHN) – funder / commissioner of primary care services
- HWQ – training / workforce development funding for non-government organisations / primary care sector
- AHPOQ – training / workforce development funding for public sector.

Governance

A project governance group was formed to support the collaborative management of the project. Representatives were invited from HWQ, AHPOQ, CRRH, NWHHS Gidgee Healing, NWRH, WQPHN and DoE. Terms of reference were developed by HWQ in consultation with the membership. The group met approximately monthly during the project, initially in person and then virtually to accommodate COVID-19 restrictions.

Terms of reference for the Project Partners Group (PPG) were developed, endorsed by members and approved by the project sponsor. Refer to Appendix D – *Terms of Reference*.

Resourcing

The project was co-funded by HWQ and the AHPOQ. In-kind resourcing was provided by project partners in terms of the allocation of staff time to meetings, consultations and review of project documents.

Staffing resources were:

- 0.4 FTE Project Manager (Townsville)
- 0.1 FTE Project Manager (Mount Isa) – seconded from CRRH

Method and activities

The scoping project built on the outcomes of the November 2019 inter-agency meeting which had focused the scope on the AHRG Pathway including inter-agency collaboration to facilitate the pathway's implementation.

The project methods included:

- A desktop review of relevant published and grey literature,
- An opportunistic sample of the allied health workforce in key service providers in north west Queensland,
- Four stakeholder group meetings that progressively developed and refined the proposed strategy, and
- Multiple individual consultations with allied health clinical / professional leaders and service leaders to examine organisation-specific challenges, resources and implementation considerations for the emerging strategy.

Deliverables and outputs

The primary deliverable for the scoping project is a proposal in the form of a draft implementation plan for the 2-year preliminary phase of the inter-agency collaborative workforce strategy. This is presented as Attachment 1 - *Two-year Implementation Plan (2020-22),* to this report. The plan has been designed to align to the needs of local health service providers and evidence of allied health workforce development enablers. The plan will be presented to each partner organisation for endorsement following closure of the scoping project.

The plan describes:

- The strategy, activities, timeframes, outcomes and evaluation framework for a 2-year initial phase of the strategy's implementation,
- Inter-agency governance / collaboration structures for the strategy, and recommendations and drafts of governance / collaboration instruments (based on existing organisation examples for other purposes) e.g. service agreement, and
- A description of resource requirements and proposed sources (i.e. internal/in kind resources in each partner organisation; external resources e.g. HWQ, AHPOQ, Services for Australian Rural and Remote Allied Health (SARRAH) and WQPHN).

In addition to the primary deliverable, the project produced:

- A final project report,
- A case for change document for internal stakeholders,
- A policy brief for external stakeholders (Attachment 2 – *Policy Brief*), and
- Abstracts submission to the Are You Remotely Interested Conference and the Australian Journal of Rural Health special edition on health professional education.

Findings

Evidence from the published and grey literature indicates that a strategy to build a sustainable rural and remote allied health workforce should:

- Address modifiable factors that negatively impact recruitment and retention (Battye et al., 2019),
- Support allied health professionals in their first rural job (Playford et al., 2020),
- Match experiences with early career allied health professionals' expectations (Cosgrave, Maple, & Hussain, 2018),
- Provide support in early years of practice (Chisholm, Russell, Humphreys, 2011),
- Build and connect components or stages of the allied health professional workforce pipeline (Battye et al., 2019; Durey, Haigh, Katzenellenbogen, 2015),
- Provide support and governance structures (Nancarrow, Roots, Grace, Young, Barlow, 2015),
- Implement relevant rural service strategies (Nancarrow, et al., 2015),
- Include strategies to limit the cost of high turnover/recruitment (Chisholm et al., 2011; Russell, Wakerman, Humphreys, 2013), and
- Provide opportunities for innovation (Battye et al., 2019).

Summarised below and detailed in Appendix C – *Site Visit Issue Summary,* are challenges and enablers for workforce development and sustainability that were identified through extensive consultation with key stakeholders.

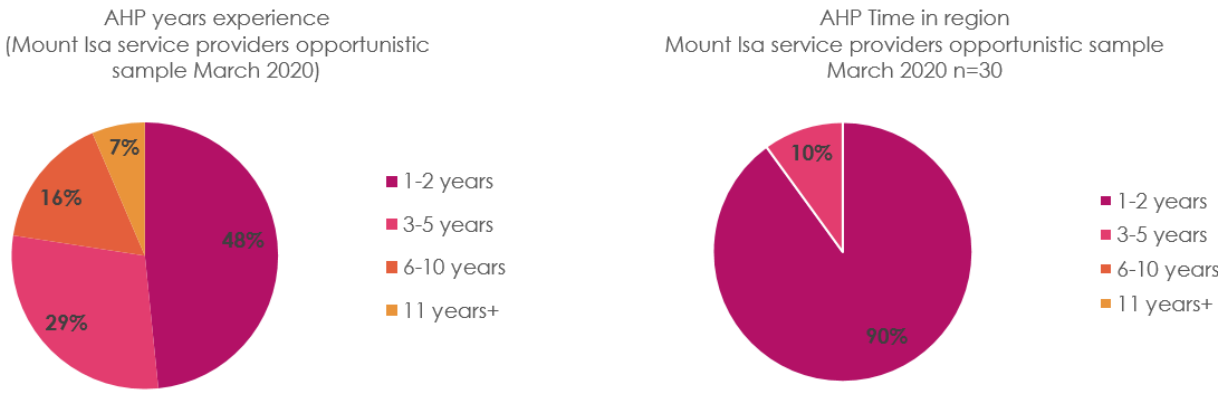
Table 1. Stakeholder perceptions of challenges and enablers of workforce development and sustainability in north west Queensland

Identified challenges	Identified enablers
Funding models for primary care do not have explicit workforce development and capacity building support. Senior supervision/leadership capacity including: • difficulty attracting and retaining senior staff with supervision and clinical leadership capabilities, and • conflict between meeting activity targets and time allocation to supervision and work-based training Financial and operational pressures that limit investment in workforce development activities. Lack of coordination and the time required to investigate and pull together disparate local, state and national funding for allied health training and support. Unclear professional progression and career development pathways for early career practitioners in their organisation and the north west region, which impacts retention. Intra-regional competition for workforce and difficulties attracting health professionals from other areas of the state/country, particularly experienced practitioners.	Resources and capabilities that may be leveraged for an inter-agency strategy include: • a local health teaching facility (CRRH) • a critical mass of allied health service providers and teams based in Mount Isa • local experience in establishing AHRG training positions and supporting AHRG trainees (NWHHS) Inter-agency collaboration experience, for example: • the Lower Gulf Strategy, and • inter-agency professional supervision agreements. State and national funding programs available to primary care and public sector services to support implementation of AHRG training positions. A shared stakeholder vision that north west Queensland can be a leader in allied health workforce and service outcomes, with the potential to increasingly attract high-quality allied health professionals through offering career enrichment opportunities that are uncommon in rural and remote areas including clinical leadership, education and research.

An opportunistic sample of 30 allied health professionals working in NWHHS, NWRH, Gidgee Healing and CRRH was collected in March 2020. Forty-eight per cent (48%) of allied health professionals in this sample had ≤ 2 years' professional experience, with 77% having ≤5 years' experience. Ninety per cent (90%) had been in the region for less than 2 years.

The workforce sample confirmed the need to focus on early career professionals and to develop a strategy that increases retention and transitions staff from early career to senior clinical and leadership roles.

Figure 1: Cross-agency sample of allied health professionals in Mount Isa, March 2020 by professional experience and time in the region



The AHRG Pathway was well accepted as a structure for workforce development by public and primary care service providers participating in the scoping project. Consultations recognised that the professional supervision component and some project requirements of the Pathway were already occurring for early career practitioners in local health services. Implementation of designated training positions requires limited additional investment in these components. Resource investment is required for:

- Direct costs of post-graduate study (university fees), and
- Offsetting the clinical activity impacts of a marginal increase in supervision and development time.

Health service representatives identified the loss of profession-specific supervision during a period of vacancy in a senior role as a risk to implementing AHRG training positions. Options for mitigating this risk and providing bridging support for trainees were identified including:

- Leveraging collaborative partnerships with other local services, and
- Using group-based, inter-professional, inter-agency support and supervision.

Participating health services identified the potential benefits of the AHRG Pathway as:

- Structured training and support for early career practitioners in rural generalist practice,
- Workforce development and clinical governance benefits for the organisation,
- Attraction benefits for advertised positions,

- Program completion timeframes (2-4 years) acting as a retention incentive for early career practitioners, and
- Opportunities for senior allied health professionals to further develop supervision and learning facilitation skills.

Outcomes

Proposed strategy

The proposed strategy, to span a 2-year initial phase (August 2020 – August 2022), includes each participating healthcare organisation implementing one or more designated allied health rural generalist training positions. Training positions are formed by redesigning existing establishment to conform with the specifications and support requirements of the training role as follows:

- 0.1 FTE (approximately 4 hours per weeks) development, supervision and project time,
- Profession-specific supervision, which is co-located for staff with less than 2-year's professional experience,
- Completion of an approved program of study in rural generalist practice for the relevant profession, and
- Participation in a work-based service development project that is designed to produce tangible benefits for clients, the community and organisation.

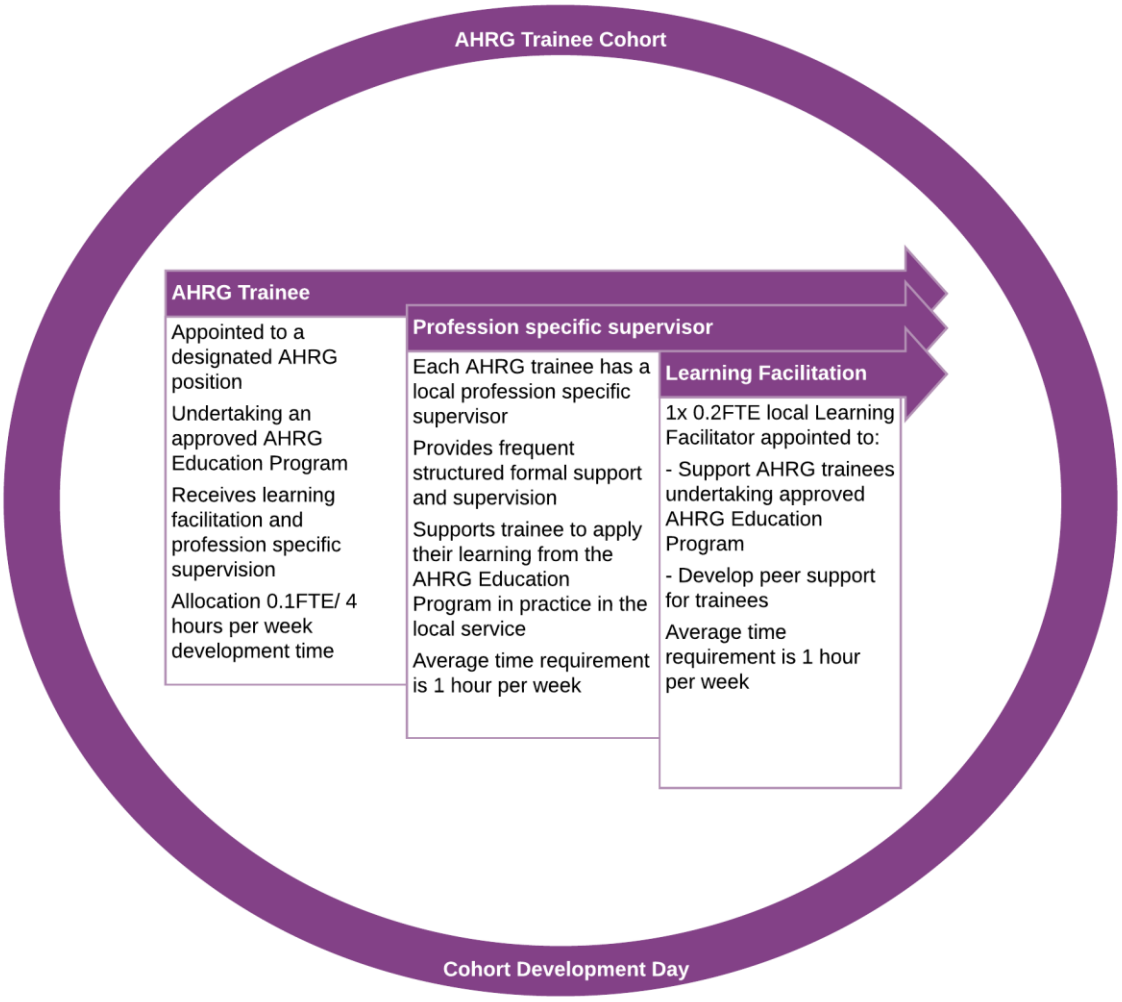
AHRG trainees will be employed by their health service and are subject to the employment terms, policies and work directions of the organisation. Training positions at the commencement of the strategy may be filled, with the current incumbent transitioning with the role to become a trainee or may be vacant and advertised as a training position to take advantage of demonstrated attraction benefits.

Profession-specific supervision and work-based training will be accessed in the employing organisation, or where not available, an inter-agency supervision arrangement may be negotiated with another partner organisation and reflected in an existing or new agreement between the services.

An inter-agency cohort of AHRG trainees will be formed that has a common 'development day' once a fortnight at the CRRH. The development day will include facilitated learning on key topics relevant to participants, peer learning and individual development time. Trainees will work on their post-graduate studies and projects.

The project partners identified the need to have a key driver and coordinator of the training cohort, including a fractional role (0.2 FTE is proposed). As the local health education provider, the CRRH is well placed to support the training cohort including providing a venue for trainees to meet and study.

Figure 2: Regional allied health workforce strategy key components



Resourcing

Resourcing to support the trainees' education fees and to provide organisational capacity was identified as critical to progressing the strategy. Health services indicated that funding solely for training fees would be inadequate to support the implementation of the AHRG Pathway. Externally sourced funding for the organisation was seen as imperative to enable the expansion and consolidation of supervision and senior leadership capacity, offset clinical activity impacts of development and supervision time, enable staff to engage in service development project activities and to address other implementation barriers. Resourcing to support the implementation of the strategy is described in further detail in Attachment 1 – *Two-year Implementation Plan (2020-22)*.

In summary, resources will be sourced from a number of organisations:

- For Primary Health Network (PHN)-funded services, the WQPHN have provided in principle support for amending the commissioning model to enable development time for trainees and supervisors.
- Funding sources specifically for the AHRG Pathway training fees and organisational capacity building including:
    - AHPOQ for the NWHHS through the existing Queensland Health AHRG Pathway funding support packages, and
    - SARRAH through the Allied Health Rural Generalist Workforce and Education Scheme (ARGHWES) for the primary care sector providers.
- In kind contribution from the CRRH – Mount Isa in the form of 0.2 FTE allied health teaching academic to function as a Cohort Learning Facilitator.
- In kind support from HWQ for the secretariat/coordination role of the Implementation Oversight Committee.

Governance and coordination

Governance of the collaborative implementation of the strategy will include two groups.

The Implementation Oversight Committee will be organised through a 'partnership governance' approach including health services and funding / commissioning agencies involved in the collaboration. HWQ will coordinate and provide secretariat support for the committee. The purpose of the committee will be to manage and monitor the implementation plan, identify and initiate restorative measures to address risks or variances from the plan and to coordinate the reporting to the executive of each partner organisation.

A Learning Facilitation Group will be formed that is coordinated by the CRRH Cohort Learning Facilitator and with one or more supervisors (senior allied health professionals) from each participating organisation. This group will plan and coordinate the learning program for the training cohort and provide an opportunity for collaboration and peer support for supervisors. Refer to Appendix E – *North West Queensland Allied Health Workforce Strategy Components.*

Evaluation

An evaluation plan will be developed and coordinated by HWQ in collaboration with participating organisations.

Implications

Stakeholders agreed that the scoping project identified underpinning characteristics of sustainable, high performing allied health services in the region. These characteristics include:

- A stable workforce that can deliver accessible, appropriate and valuable allied health services to communities in north west Queensland,

- A regional allied health staffing profile that has an appropriate blend of well supported early career professionals, developing senior clinicians/clinical leaders and experienced clinicians/leaders, with a clear pathway through these roles,
- An 'own-grown' approach shared by service providers with a focus on medium to long-term workforce development at a regional level,
- A supportive, regional approach to early career workforce development that promotes learning and cooperation, resulting in benefits for integrated care and health outcomes for consumers, and
- Funding and governance models within and between agencies that can maintain a focus on the 'long game' of workforce capacity building in the north west.

The scoping project also identified broader implications for the health system and may provide useful learnings for other rural and remote services and policy makers.

- Rural and remote practice is broader than the provision of clinical services. Career progression and retention incentives should reflect professional enrichment activities such as education and workforce development, leadership, quality improvement and research. These activities were also identified as integral to high quality, responsive health services.
- Collaboration can overcome funding, service and other barriers to the implementation of a structured training pathway for allied health professionals in the public and primary care sectors. An inter-agency approach can leverage resources available from multiple local service providers and the University Department of Rural Health, creating opportunities for rural generalist training that individual organisations would be unable to secure independently.
- Funding for the organisation is critical to enabling the development and ongoing support for training roles. The numerous and disparate 'funding buckets' for allied health services and training create a complex landscape that is difficult for rural and remote services to negotiate. Progress is being made through the current national trial of the AHRGWES that is administered by SARRAH. AHRGWES funding for organisational capacity building and education fees is integral to strategy developed in this project. However, further work is required to enable secure, coordinated resourcing of the AHRG Pathway at a national level and across sectors.
- Local education resources can be leveraged through collaboration with the local University Department of Rural Health, including clinical education expertise and training venue and resources.
- Further research and examples of the implementation of the AHRG Pathway are required, particularly in the primary care sector, to enable health services and commissioners to evaluate its potential application and value to their local context.

A policy brief has been developed to disseminate key findings that may be applicable in other settings and identify policy considerations (Attachment 2 – *Policy Brief*).

Dissemination Plan

The dissemination plan for the project report and policy brief is shown in Appendix F – *Dissemination Plan*.

Recommendations

Recommendation 1.

The scoping project partners endorse the project report and the sponsor and funders approve the completion report and deliverables.

Recommendation 2.

Collaboration partners support a 2-year initial phase of implementation of the inter-agency allied health workforce strategy scoped in this project including:

- Participating health services redesign one or more early career allied health roles into designated rural generalist training positions,
- That Western Queensland Primary Health Network work with relevant health services to integrate the strategy into service commissioning models,
- A training cohort is formed, through in-kind support from the Centre for Rural and Remote Health, that is supported by senior allied health professionals from each participating health service, and
- Allied health workforce / education funders, including the Allied Health Professions' Office of Queensland, Health Workforce Queensland, Services for Australian Rural and Remote Allied Health and Centre for Rural and Remote Health, provide funding or in-kind support for organisations implementing rural generalist training positions and participating in the inter-agency, collaborative workforce strategy.

Recommendation 3.

Health Workforce Queensland implement the dissemination strategy for the project completion report including highlighting:

- Outcomes and next steps information for project partners, and
- Advice for a range of state and national bodies on the outcomes of the project and potential opportunities for use of the model in other rural and remote locations.

Acknowledgments

Project Team

Health Workforce Queensland (HWQ)	Sarah Venn Robyn Adams
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List of appendices

Appendix A – Evidence Review and Context

Appendix B – Allied Health Rural Generalist Pathway

Appendix C – Site Visit Issue Summary

Appendix D – Terms of Reference

Appendix E – North West Queensland Allied Health Workforce Strategy Components

Appendix F – Dissemination Plan

List of attachments

Attachment 1 – Two-year Implementation Plan (2020-22)

Attachment 2 – Policy Brief

List of abbreviations

AH	Allied Health
AHP	Allied Health Professional
AHPOQ	Allied Health Professions' Office of Queensland
AHRG	Allied Health Rural Generalist
AHRGWES	Allied Health Rural Generalist Workforce and Education Scheme
CRRH	Centre for Rural and Remote Health
DoE	Department of Education
FIFO	Fly-In-Fly-Out
FTE	Full-time equivalent (staff)
HP3	Health Professional Level 3 (Allied health classification in Queensland Health)
HWQ	Health Workforce Queensland
JCU	James Cook University
NWHHS	North West Hospital and Health Service
NWRH	North West Remote Health
PHN	Primary Health Network
PPG	Project Partners Group
SARRAH	Services for Australian Rural and Remote Allied Health
WQPHN	Western Queensland Primary Health Network

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Appendix A – Evidence Review and Context

Despite numerous initiatives over recent decades, rural allied health workforce challenges remain a key factor limiting access to allied health services in rural and remote communities. Nationally, the rural allied health literature describes multiple factors that contribute to high turnover/low tenure of allied health professionals. Factors include lack of professional development opportunities, concerns for deskilling, perceived lack of local training opportunities and concern that time in a rural role will limit career progression (Schoo, Stagnitti, Mercer, & Dunbar, 2005).

Persistent geographic maldistribution of the allied health workforce (Department of Health, 2017) continues the disparity in access to allied health services for people in rural and remote communities. The challenges of allied health workforce sustainability in rural and remote areas are well known (Battye, et al., 2019; Durey, et al., 2015). Factors influencing recruitment and retention are extensively described in the rural allied health literature and recently summarised in a rapid review (Battye, et al., 2019). Modifiable factors influencing workforce stability identified in this review include supervision and professional support, rural training experience including education and qualifications in rural and remote practice, supportive work environments, capacity to work to full scope of practice and the role and recognition of allied health in the wider healthcare team. An important addition to the rural allied health literature since the publication of the rapid review found that the single most significant factor predicting long term rural practice was early career rural practice (Playford, et al., 2020).

A pipeline model has been proposed for building the rural and remote allied health workforce (Battye, et al. 2019; Durey et al., 2015), including early career entry to rural practice. Durey et al. (2015) describe pipeline components from school to university, new graduate and career professionals contributing to a rural health workforce that may also be supplemented by overseas trained professionals, locums and Fly-In-Fly-Out (FIFO) workers. Battye et al. (2019) differentiate the allied health professional career stages into early career, establishing career and mature career allied health professionals and describe the required elements and underpinning components for a rural allied health pipeline. While many of the components for a rural allied health pipeline are in place, further work is required to link the components to form a comprehensive pipeline (Battye, et al., 2019, p. 24). In summary, Battye et al. (2019) note that the pipeline offers significant opportunities for innovation through recognising the need to establish connected training, employment and career pathways, supervision and support and funding mechanisms for sustainable positions.

Estimated costs for allied health recruitment in recent studies reveal median allied health professional recruitment costs of $21,925 (Russell, et al., 2013) and $45,781 for remote areas (Chisholm, et al., 2011). The impact and costs of high staff turnover include a loss of service continuity and community access during periods of vacancy and ramp up time of incoming staff, lowered organisational expectations of attracting strong recruitment pools of allied health professionals with experience and expertise in rural generalist practice.

The costs of providing primary care and the cost impact of high staff turnover have been estimated in Northern Territory remote communities (Zhao, Russell, Guthridge, Ramjan, Jones, Humphreys, Wakerman, 2019). The authors found that the cost differentials between clinics were proportional to staff turnover and remoteness. High staff turnover exacerbates the already high costs of providing primary care in remote areas, costing approximately $50 extra per consultation. The key recommendation was for 'sustained investments in developing a more stable primary care workforce should not only improve primary care in remote areas, but also reduce the costs of excessive turnover and overall service delivery costs (Zhao et al., 2019, p. 689).

Appendix B – Allied Health Rural Generalist Pathway

The Allied Health Rural Generalist (AHRG) Pathway has been developed to connect formal education, workplace policy and employment structures and rural generalist service models. The AHRG Pathway recognises that rural practice requires a broad skillset and a strong reliance on teamwork, multi-disciplinary and inter-professional practice and the development of innovative service delivery models. A key focus of the AHRG Pathway strategy is to address issues that influence workforce recruitment and retention in rural and remote areas, including ensuring access to professional development and providing effective supervision and support (SARRAH, n.d.).

Evaluation of the 2014 implementation phase of the Pathway in Queensland Health found that it was a successful strategy for addressing challenges associated with recruitment and retention of rural and remote allied health practitioners (Nancarrow, et al., 2015). 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 (Nancarrow et al., 2015). Building capacity in allied health services through service development strategies was an opportunity for innovation identified by Battye and colleagues (Battye, et al., 2019, p. 44).

Service outcomes from the Queensland Health 2015-16 AHRG Pathway implementation phase included services provided closer to home, better use of support workers, the clinical effectiveness of telehealth services and reduced patient waiting times (Allied Health Professions' Office of Queensland, 2017). For example:

- A new physiotherapy telehealth service to remote facilities saved 2940km of client travel in a 12-month period,
- A new speech pathology telehealth clinic to a remote facility reduced average patient waiting time by over ten weeks,

Rural Generalist Service Strategies

The primary aim of rural generalist service models is to deliver high quality, safe, effective and efficient services as close to the client's community as possible.

There are a range of rural generalist service strategies that can be implemented by teams and individual allied health professionals to maximise local service access and quality. Training position incumbents will develop experience with one or more of these strategies whilst they are also adopted by experienced practitioners.

The primary strategies comprise:

- Telehealth.
- Delegation to clinical support workers (for example AH assistants).
- Extended scope of practice including skill sharing (trans-professional practice).
- Partnerships supporting the implementation of a 'generalist scope' for complex or low frequency clinical presentations, (including rural-urban, cross-agency and cross-sectoral partnerships that use shared care or collaborative practice models).

(SARRAH, n.d.)

- Utilisation of allied health assistants for delegated physiotherapy tasks increased by 35% between 2014 and 2016 in one rural hospital, and
- Clinical outcomes from a rural physiotherapy telehealth clinic supported by allied health assistants were at least equivalent to traditional face-to-face services.

Workforce outcomes for the same period included improved attraction and retention, for example:

- Recruitment pools generally out-performed regular [HP3] roles,
- Training positions provided a local development pathway that supported an 'own grown' workforce strategy,
- Retention during the 1 or 2-year temporary appointments to the rural generalist training positions was 100% for the 22 position holders in the 2014 - 2016 cohorts, and
- Employment destinations 6 months after separation from the temporary rural generalist training positions showed employees most commonly remained in rural or remote practice or secured a position in the regional centre nearest to their training position.

[Note: following the 'proof of concept' trial phases 2014 -18, AHRG implementation by Queensland public health services has used positions within an organisation's existing establishment rather than supernumerary positions].

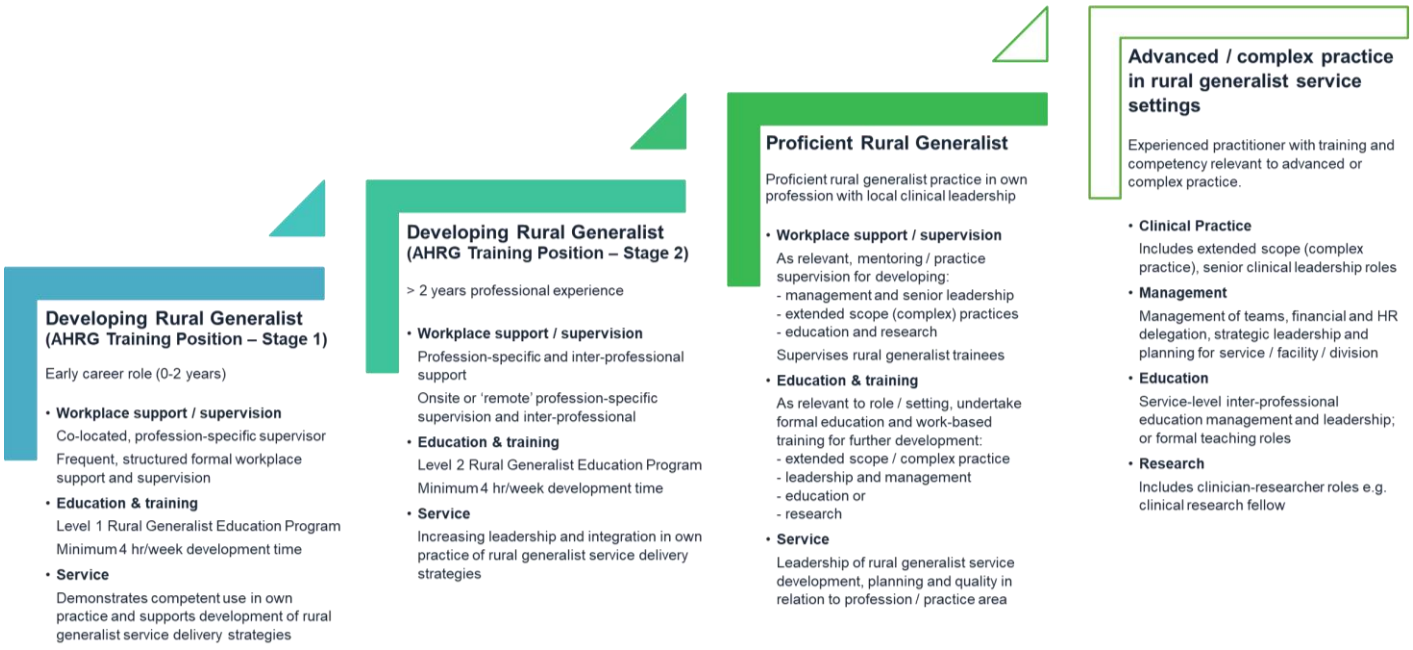
Information on the AHRG Pathway is available at https://sarrah.org.au/ahrgp. Key resources detailing the development, implementation phases and evaluation of the pathway in Queensland Health are available at https://www.health.qld.gov.au/ahwac/html/rural-remote.

The information sheet provides an overview of the Pathway including the early career component and senior allied health component of the Pathway: https://www.health.qld.gov.au/__data/assets/pdf_file/0038/839189/ahrg-pathway-information.PDF.

Rural generalist trainees undertake the JCU Rural Generalist Program. Information is available at:

- Level 1 Program: https://www.jcu.edu.au/rgp, and
- Level 2 Program: https://www.jcu.edu.au/courses-and-study/courses/graduate-diploma-of-rural-generalist-practice.

Figure 3. Allied Health Rural Generalist Pathway



Queensland Health (2019a).

Appendix C – Site Visit Issue Summary

	AHRG Training Position & Education	AHRG Trainee Development & Supervision	AHRG Trainee Cohort	AHRG Learning Facilitation	AHRG Trainee Employing Organisation
Description	*Stage 1 AHRG Training position* Early career role (0-2 years) New to rural practice *Stage 2 AHRG Training Position* >2 years professional experience Greater independence in complex decision-making Increasing clinical leadership	0.1 FTE development time (Approximately four hours per week) Frequent structured formal support and supervision is provided Support for AHRG trainee to apply their learning from the formal education program to practice	Established to encourage a collaborative and supportive learning environment for AHRG trainees An interagency approach provides the opportunity for shared supervision and learning facilitation reducing the 'load' on each participating agency.	Supports AHRG trainee to progress through development pathway A 'lead learning facilitator' will be beneficial to assist with coordination, planning, delivery and support of the AHRG trainee cohort.	Designate new or existing position/s as AHRG training position/s Allocate (or approve from another organisation), a profession specific supervisor for AHRG trainee Commitment to interagency collaborative AH workforce model
Investment	*University fees* **Level 1**- Rural Generalist Program : $9600 over 1-2 years; **Level 2**- Graduate Diploma of Rural Generalist Practice : $25,240 over 2 years *(or $18,930 over 1.5 years for AHPs who have completed Level 1)*	Minimum O.1 FTE development time Senior AHP supervisor* for AHRG trainee-approx. 1 hour /week Trainee to attend cohort learning sessions *Note: Cross agency supervision is possible within local interagency collaborative model*	In cohort model, development time is allocated as one day per fortnight O.2 FTE Cohort Learning Facilitator AHRG development day venue	Senior AHP input to the learning facilitation group on average 1 hour per week	Enable trainee to attend scheduled AHRG cohort learning facilitation sessions (x1/fn) Maintain organisational commitment for 0.1 FTE development time
Resources	*Primary Care Services* AHRGWES* Trainee education fee grants of up to $8,000 for Level 1 and up to $28,00 for Level 2; Health Workforce Scholarship Program (HWSP) ** up to $10,000 per 12-month period for up to 24 months for a postgraduate course. *Public sector services* AHPOQ $30, 000 p.a. per trainee	*0.1 FTE trainee development* ARHGWES Employer grants of up to $16,000 for Level 1 and up to $32,000 Level 2. AHPOQ (as noted left) PHN –to be confirmed *Senior supervisor* No additional costs - consistent with current clinical governance processes in each organisation	*Cohort Learning Facilitator* 0.2 FTE in-kind contribution by CRRH-MI *Venue:* In-kind contribution by CRRH-MI	ARHGWES Employer grants of up to $16,000 for Level 1 and up to $32,000 Level 2 (as noted left). AHPOQ (as noted left)	Access funding through relevant AHRG workplace training packages

* SARRAH provide grants under the Commonwealth-funded AHRGWES.

** AHPOQ funding allocation must be used to fund 100% of trainee fees, with the residual able to be used flexibly by the HHS to support implementation and capacity building.

Appendix D – Terms of Reference

Project Partners Group – North West Queensland Inter-agency Allied Health Workforce Strategy Scoping Project

Background

The challenges of allied health workforce sustainability in rural and remote areas are well known. The Office of National Rural Health Commissioner's recent *Discussion Paper for Consultation: Rural Allied Health Quality, Access and Distribution (2019),* described building a "sustainable rural allied health workforce, applying the internationally recognised 'three-legged stool', by

1. creating opportunities for rural origin students;
2. enhancing structured rural training and career pathways and
3. creating sustainable jobs."

Locally, Allied Health service providers and commissioners in north west Queensland came together in Mount Isa on 5 November 2019 to discuss challenges and opportunities for workforce sustainability in the region.

The meeting attendees were supportive of scoping an inter-agency, collaborative workforce strategy, with a primary focus on early career rural generalist recruitment, retention, training and support using the AHRG Pathway.

Aim

The aim the scoping project is to work with key stakeholders to develop a strategy that supports an inter-agency, collaborative, regional approach to allied health workforce development including recruitment, retention and capacity building, in health services in north west Queensland.

Outcomes

The outcomes of the scoping project will be:

- A proposed inter-agency, collaborative allied health workforce strategy with a focus on the AHRG Pathway as a cross-agency approach to early career attraction and support and catalyst for collaboration on workforce strategies, and
- Clear guidance for partner organisations regarding opportunities/benefits, enablers, risks and resources required to trial the proposed strategy.

Role of Project Partners Group

The role of the Project Partners Group (PPG) is to:

- Enable collaboration and sharing of knowledge of allied health workforce management and development, service delivery and funding in project partner organisations (service provider and funding organisations),

- Identify barriers, enablers and considerations relevant to project partner organisations that will influence the project outcome/deliverable,
- Identify and leverage the strengths, resources, organisational capabilities and individual talents of allied health clinicians and managers in project partner organisations that can support the project outcome/deliverable, and
- Contribute to the scoping and design of a plan for trialling the strategy that will be presented to each partner organisation for endorsement.

Role of Individual Project Partners Group members

- Participation in teleconference meetings and review of materials tabled for each meeting,
- Appreciation of the significance of the project for many stakeholders and maintenance of confidentiality where required, and
- A HWQ representative will Chair meetings and email the Agenda one week prior to each meeting.

Proposed Project Partners Group members (to be specified through consultation)

- North West Hospital and Health Service (NWHHS) x1
- Gidgee Healing x1
- North West Remote Health (NWRH) x1
- Centre for Rural and Remote Health (CRRH) x1
- Department of Education (DoE) x1
- Western Queensland Primary Health Network (WQPHN) x1
- Health Workforce Queensland (HWQ) x2
- Allied Health Professions' Office of Queensland (AHPOQ) x2

Timeframe and Frequency of Meetings

The reference group will operate from March to June 2020. It is anticipated a maximum of five meetings will be held in the following weeks:

- Week of 2 March 2020 (teleconference)
- Week of 6 April 2020 (teleconference)
- Week of 5 May 2020 (face to face meeting in Mount Isa)
- Week of 1 June 2020 (face to face meeting in Mount Isa)
- Week 8/15 June 2020 (teleconference)

Quorum Requirements

A quorum for teleconferences will be the Chair and a minimum of four project partner organisations. If a quorum is not secured, the meeting may progress, with a log of advice and recommendations from members to be circulated and confirmed out of session. Attendance of all PPG members at the face to face meetings is encouraged. Members can nominate a suitably brief proxy if unable to attend a meeting, by contacting the chair prior to the meeting.

Appendix E – North West Queensland Allied Health Workforce Strategy Components

8 key components		North west Queensland inter-agency collaborative allied health strategy implementation
1.	Partner organisations implement one or more designated AHRG training positions.*	• The positions will be within the existing establishment. • The role is redesigned to conform to the mandatory AHRG position specifications and support requirements* that have been demonstrated in national trials of the Pathway to be necessary for successful implementation.
2.	AHRG trainee employment	• AHRG Trainees will be employed by the relevant health service, subject to the employment terms, policies and work directions of the organisation.
3.	Profession-specific supervision	• Profession-specific supervision will be accessed in the employing organisation, or • Where not available, an inter-agency supervision arrangement to be negotiated with another partner organisation and reflected in an existing or new agreement between the services.
4.	Workplace-based training	• In addition to formal profession specific supervision, workplace-based training provided by members of the team is also required for early career practitioners. • This would be broadly consistent with current processes and time investment in teams.
5.	AHRG trainee cohort & development day	• An inter-agency cohort of AHRG trainees will be formed that has a common 'development day' once a fortnight at an agreed venue. • The development day will include self-directed learning time (work on university studies), peer learning / teaching, facilitated learning sessions and potentially, collaboration on quality and service development projects.
6.	Commissioning model	• Support to be negotiated with the PHN for a commissioning model that enables allocation of time for development activities for trainee and supervision.

7.	Funding	• Funding (or in-kind resourcing) to be sourced for:
		  o Training fees and organisational support for training from relevant sources (AHPOQ, HWQ or AHRGWES), and
		  o Cohort Learning Facilitator (0.2 FTE) to assist all trainees with development activities and coordinate the fortnightly development days.
		• Supervisors from partner organisations will also contribute to learning support through a program developed by a collaborative committee.

8.	Collaborative governance	• The Implementation Oversight Committee will provide inter-agency coordination of the strategy, including forward planning of learning support activities, identifying issues and solutions and submitting reports.

***Note to Appendix E:** The Allied Health Rural Generalist training position role requirements are:

- Dedicated development and supervision time of at least 0.1 FTE (approximately 4 hours per week),
- Funded participation in a formal, post-graduate allied health rural generalist education program such as the Rural Generalist Program offered by JCU in collaboration with Queensland University of Technology,
- A formal development plan aligned with a level 1 or level 2 allied health rural generalist program relevant to the profession (where available) and the requirements of the employing service,
- Profession-specific supervisor, which for graduates (0-2 years professional experience) should be co-located, and
- Contribution and increasing leadership with experience of rural generalist service development project/s that improve client care and service outcomes.

Appendix F – Dissemination Plan

Organisation	Department / Branch
Commonwealth Department of Health	Health Training Branch
	Rural Access Branch
	Primary Care, Dental & Palliative Care
	Chief Allied Health Officer
Office of the National Rural Health Commissioner	National Rural Health Commissioner
Ministers	The Honourable Mark Coulton MP, Minister for Regional Health, Regional Communications & Local Government
	The Honourable Dr Steven Miles, Deputy Premier and Minister for Health and Minister for Ambulance Services
Queensland Health	Office of Rural and Remote Health
Australian Allied Health Leadership Forum including member organisations	Allied Health Professions Australia
	Australian Council of Deans of Health Sciences
	Indigenous Allied Health Australia
	National Allied Health Advisors and Chief Officers
	Services for Australian Rural & Remote Allied Health
Other	Australian Healthcare and Hospital Association

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