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South Australian Allied Health Rural Generalist Pathway Evaluation: Phase 1

December 2019

Flinders University

South Australian Allied Health Rural Generalist Pathway Evaluation

Phase 1 Report, December 2019

This report was completed as a result of a partnership between SA Health and Flinders University, with funds provided by the Rural Health Workforce Strategy (Government of South Australia)

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Flinders and Upper North Local Health Network
Limestone Coast Local Health Network
Riverland Mallee Coorong Local Health Network
Yorke and Northern Local Health Network

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Abbreviations

ACL	Advanced Clinical Lead
AHP	Allied Health Professional
AHRGP	Allied Health Rural Generalist Pathway
FTE	Full time equivalent
JCU	James Cook University
LHNs	Local Health Networks
RSS	Rural Support Service
SA	South Australia
SA Health	Department for Health and Wellbeing, South Australia
SARRAH	Services for Australian Rural and Remote Allied Health

Executive Summary

Introduction

In 2019 Rural Health Workforce Strategy funding, provided by the Government of South Australia, supported the introduction of the Allied Health Rural Generalist Pathway (AHRGP) as a strategy for improving allied health workforce and quality outcomes for rural and remote South Australians.

This pathway was originally developed through a collaboration between the Allied Health Professions Office of Queensland, Services for Rural and Remote Allied Health (SARRAH), Australian state and territory healthcare sectors, and other stakeholders including universities and the Australian Healthcare and Hospitals Association.

The education component of the AHRGP is provided by James Cook University in two levels for newly qualified and more experienced Allied Health Professionals (AHPs). Rural generalist trainees enrolled in the program undertake course work and work-based projects throughout the program. They have protected time within their workload to study as well as dedicated profession specific supervision.

Aims

The aims of this research are to evaluate the impact of the AHRGP for key stakeholders and to explore rural and remote allied health workforce challenges and opportunities in South Australia (SA).

Methods

Flinders University was contracted by SA Health to complete a formal evaluation of the implementation of the AHRGP in SA. This research will use a mixed methods approach to explore and describe the experience and perspectives of trainees, supervisors, line managers, Advanced Clinical Leads (ACLs), the project management team and consumer representatives.

The research will be in four phases from pre-pathway to midpoint, endpoint and follow up with data collected and analysed at each phase. Research participants will be interviewed and surveyed throughout the research project phases, collecting both quantitative and qualitative data. This report forms the basis of phase 1.

Summary

In the first 6 months of implementation, the AHRGP in SA has been positively received by stakeholders. Thirteen AHPs commenced the AHRGP in 2019 and with minor changes, 11 are expected to continue into 2020. Thirteen trainees have participated in this first phase of the evaluation, including two AHPs who are not continuing in 2020. Eleven supervisors, seven line managers, four ACLs and five consumer representatives have also participated in this phase.

A range of enablers and barriers for success of the pathway were described with time and support structures being the major factors anticipated to impact on success of the pathway. Challenges and opportunities of living and working in a rural and remote SA are diverse and relate to personal and organisational factors.

Recommendations

This report outlines preliminary emerging recommendations:

- Continue to invest in the AHRGP due to the overwhelmingly positive experience of all stakeholders to date
- Ongoing support be provided to AHRGP trainees to have protected time and dedicated supervision throughout the training process
- Line managers to offer regular support, advice and guidance and work with trainees to identify projects that are relevant and beneficial to their Local Health Network and more broadly
- Rural Support Service continues to provide oversight and support to all stakeholders throughout the AHRGP implementation
- Regional Local Health Networks to advocate for and support retention strategies that are relevant to their local AHPs.

Introduction

Allied health is a broad term encompassing a wide range of health professions excluding medicine and nursing who are involved in enhancing and maintaining function with individuals, groups and communities (1). These professions include but are not limited to; dietetics, exercise physiology, occupational therapy, physiotherapy, podiatry, social work, speech pathology, psychology, pharmacy and medical radiation.

Allied health professionals (AHPs) working in rural and remote areas provide vital and wide-ranging services to local communities (2). Allied Health rural generalists have a broad range of clinical and non-clinical skills and competencies, relevant to rural practice within their profession. They provide services to a broad range of consumers working across settings and service models, working collaboratively in interdisciplinary teams to meet the needs of their local community. AHPs in rural and remote Australia have been working as rural generalist specialists for many years but have had no formal recognition of their unique skill set and no training pathway to support early career professionals to develop the skill set more rapidly.

In 2019 according to the SA Health Rural Support Service (RSS) there were approximately 500 AHPs employed across the six state government funded regional Local Health Networks (LHNs) in Rural and Remote SA. Data collected from RSS between 2014 and 2018 indicated the average annual turnover of allied health staff across rural and remote SA was 22%.

The Allied Health Rural Generalist training program, delivered by James Cook University (JCU), provides specialist training to support clinicians working in rural and remote areas, incorporating work based clinical supervision and quality improvement activities (3).There are two stages of training. Level 1 is designed for AHPs with up to 3 years of experience (to be completed over 1-2 years part time); Level 2, designed for AHPs with more than 2 years of experience, provides a graduate diploma qualification on completion and is completed over 2-3 years part time. Nine allied health professions are included in the training pathway including; dietetics, medical radiation, occupational therapy, pharmacy, physiotherapy, podiatry, psychology, social work and speech pathology.

The Allied Health Rural Generalist Pathway (AHRGP) was initiated by the Queensland Department of Health, who in 2014 introduced allied health rural generalist training positions in rural and remote health services with the aim of improving recruitment and retention of AHPs, increasing access to health services for rural and remote communities, and improving the quality and sustainability of health service delivery (4). The program evolved and developed to now include the formal rural generalist education program delivered by JCU, alongside targeted clinical supervision and support to complete service development activities relevant to the local health service. Evaluation of the program pilot in 2015 and further evaluation of the program implementation in 2017 found a range of benefits and improvements for all stakeholders (4,5). Job satisfaction improved and skills and capacity of the trainees increased as they undertook the training. Further it was noted that communication and coordination within multidisciplinary teams improved and service development opportunities increased. All clinicians who participated in the program from 2014-2016, remained in the rural and remote areas for at least the duration of the program (12 – 24 months) and six months after completing the training most participants (70%) remained working in rural or remote locations (4). There were also a range of benefits for clients including the decreased need to travel for services, quicker access to health services and improved quality and continuity of care (4,5). These results are very promising and the implications for health services and communities cannot be underestimated.

Following the Queensland trial, the AHRGP was subsequently introduced in other states and territories including New South Wales, Tasmania and Northern Territory. Services for Australian Rural and Remote Allied Health (SARRAH) has been instrumental in supporting the introduction of the AHRGP to other states and territories, to promote consistent and quality services for rural and remote communities (6).

In 2019, following a successful funding submission to the Rural Health Workforce Strategy Steering Committee, the Minister for Health and Wellbeing approved the allocation of funds to introduce the AHRGP in rural and remote SA for the first time. This funding also provided for project manager support for the initiative and included funding allocation to contract the Flinders University to undertake research and complete a formal evaluation strategy.

Although the AHRGP has been evaluated in Queensland, there is a need for more broad research questioning and exploration as well as considerations of the needs of the South Australian context. The purpose of this research is to evaluate the effectiveness, appropriateness, suitability and success of the program in rural SA, and to also research more broadly a range of workforce and health service delivery outcomes that result. This report has been produced to meet the first project milestone required of this evaluation partnership agreement.

This research will describe and measure the effectiveness of the AHRGP as a suitable strategy for improving workforce and clinical outcomes for rural and remote SA. Retention, recruitment, career and service development are key areas requiring improvement in rural and remote SA and the significant investment in this pathway is unlikely to be sustained without the demonstration of clear, measurable and positive outcomes. The outcomes of this research will inform SA Health regional LHNs about the needs of AHPs, their supervisors, line managers and consumers, and will assist in planning recruitment, retention and career development strategies for the future.

Funding for this research has been provided through the Rural Health Workforce Strategy, and ethics approval was received from the Southern Adelaide Local Health Network Human Resource Ethics Committee.

Research Aims

The overarching aim of the research is to investigate the outcomes of the AHRGP in SA Health regional LHNs.

The specific aims include:

1. To explore workforce challenges and opportunities for AHPs in rural and remote SA
2. To explore the experience of the AHPs participating in the AHRGP and the impact on their skills, abilities and knowledge for practice
3. To understand the impact and perceptions of the AHRGP on supervisors, clinical leads and line managers working with rural generalist trainees
4. To explore how the AHRGP has impacted consumers perceptions, access and quality of allied health service delivery and development
5. To identify where the rural generalist program works, which professions, locations and individual characteristics are particularly suited to the AHRGP
6. To explore the costs and benefits of the AHRGP.

Methods

The SA AHRGP will be evaluated in several phases. The first phase is the focus on this initial evaluation. A mixed methods approach will be used to explore qualitative and quantitative outcomes of the program using interview and survey. Kirkpatrick's (7) four levels of evaluation will guide the structure and logical approach of the evaluation as it is well recognised as a robust and comprehensive model for training evaluation and ensures all levels of impact are considered (8). Qualitative data will explore the intended and actual experiences of the participants, their line managers, supervisors, Advanced Clinical Leads (ACLs), consumer representatives and the program coordinators. Quantitative data will describe the costs and potential benefits of the program, workforce statistics, participant demographics, trainee personality types and satisfaction, competence and confidence ratings. The evaluation phases and methods are described in table 1.

Participants were recruited from five of the six regional Local Health Networks in SA. Four allied health professions were included in the 2019 South Australian cohort including; occupational therapy, physiotherapy, podiatry and speech pathology.

Table 1. Methods

Phase 1 2019 Pre-Program	Trainee survey	Trainees completed an online survey once they had consented to participate which collected their demographic information, intentions for the training and rating of confidence as a rural generalist clinician in the early stages of the AHRGP. Participants also completed The Temperament and Character Inventory (9).
	Trainee interviews	Trainees were interviewed between September and November 2019 to explore their reasons for participating in the program, their perceptions of rural and remote practice and the support they required during the AHRGP.
	Line manager, Supervisor and ACL interviews	Trainee's line managers, supervisors, and ACLs were interviewed between September and November 2019 to explore their initial impressions of the AHRGP and their experience of working with early career AHPs.
	Project management team interview	The project management team was interviewed in November 2019 to give the research team a thorough insight into the AHRGP and to discuss costs, workforce patterns and long-term plans of the pathway.
	Consumer representative focus group	Six consumer representatives from four participating regional LHNs accepted an invitation to meet in November 2019 to discuss their perceptions of allied health services and to describe what quality service provision was from their perspective.
Phase 2 2020 Mid-Point	Trainee survey and interview	At the approximate mid-point of their progress through the AHRGP, the trainees will participate in a survey and interview exploring their initial impressions of the training, their experience in the pathway and the impact it has had on their practice

	Line manager, Supervisor and ACL interviews	Following their trainees' mid-point interview, trainees' line managers, supervisors and ACLs will be interviewed to explore their impressions of the program to date, what is has been like supporting a trainee, what the challenges and opportunities have been and what impact it has had on their services.
	Project management team interview	The project management team will be interviewed in May/June 2020 to discuss the AHRGP progress and to ascertain broadly what has been working well, what has been challenging and to explore the financial implications of the program
Phase 3 2021/2022 End point	Trainee survey and interview	Post training, trainees will be surveyed and interviewed to explore their experience of the AHRGP, what outcomes they achieved and how the AHRGP impacted on their practice overall.
	Line manager, Supervisor and ACL interviews	Once trainees have completed the AHRGP their supervisors, line managers and ACLs will be interviewed to discuss final perceptions and perceived outcomes.
	Project management team interview	The project management team will be interviewed once the trainees have finished the AHRGP to review their thoughts regarding the outcomes of the program revisiting the questions covered in the midway interview to ascertain any further achievements or challenges in the later stages of the project.
	Consumer representative focus group	In 2021 after the first group of participants have completed the AHRGP, consumers will be invited to participate in a second focus group to explore and discuss the outcomes of the AHRGP that have been achieved and to revisit their initial impressions of quality allied health services and if these have been impacted by the AHRGP.
Phase 4 2022-2023 Follow up	Trainee interview	6 months after completion of the training AHRGP, trainees will be followed up via email or phone call to explore where the training has led them and if they intend to remain in a rural or remote area.

This report will summarise phase one of the evaluation.

Results and Discussion

Demographic information

In July 2019 12 AHPs working in rural and remote SA commenced the AHRGP. Early changes resulted in two trainees withdrawing within their first and second study period. As a result, replacement AHPs were provided with the opportunity to participate, and one level 1 trainee will be supported to transfer to level 2 from 2020, meaning a total of 13 trainees commenced the program in 2019. Table 2 outlines the number of trainees in 2019 and 2020.

All thirteen trainees who commenced the training including the two who will not continue beyond 2019, consented to participate in the evaluation. Pre-program interviews and surveys were completed between September and November 2019.

Six consumer representatives from four regional LHNs gave their consent, and five participated in the phase 1 focus group. Eleven supervisors, seven line managers and four ACLs consented to participate and were interviewed. Two of the ACLs were also supervising trainees, so their comments are sometimes included in these results from a supervisor perspective. The term 'line manager' encompasses participants who were in team leader, manager and director roles who were responsible for at least one trainee in their organisation, in most circumstances they were working with more than one. Supervisors were working with one or two trainees and one level 2 trainee was also supervising a level 1 trainee and so was interviewed for both roles.

Employment type

Of the 13 trainees included in this evaluation, eight were employed with their regional LHN on a permanent basis and five were employed on a contract (see Table 2). The level 2 trainee currently employed on a contract had relocated from one regional LHN to another for a promotion but did have permanent employment in her substantive role. Contract length varied from 3 to 9 months and all trainees were working full time in 2019.

Table 2. Trainee demographics

	Number of trainees commenced in 2019	Number of trainees on a permanent contract	Number of trainees on a fixed term contract	Number of trainees continuing in 2020
Level 1 trainees	9	5	4	6
Level 2 trainees	4	3	1	5
Total	13	8	5	11

AHP and LHN distribution

Three occupational therapists, three physiotherapists, four podiatrists and three speech pathologists participated in the AHRGP in 2019 from five regional LHNs across SA. Table 3 outlines the number of trainees who participated in 2019 and those who plan to continue in 2020.

Table 3. Trainee distribution by LHN

	Commenced in 2019	Continuing in 2020
Eyre and Far North LHN	1	1
Flinders and Upper North LHN	4	4
Limestone Coast LHN	1	1
Riverland Murray Coorong LHN	4	3
Yorke and Northern LHN	3	2

Allied and Scientific Health Transition to Professional Practice Program

Ten of the 13 trainees had completed or were currently participating in the Allied and Scientific Health Transition to Professional Practice Program which is a graduate support and education program offered by the Rural Support Service. Three level 2 trainees had not participated in the program for unknown reasons. The trainees who had been involved in the Transition to Professional Practice Program generally reported it did not influence their choice to participate in the AHRGP.

Aim 1: To explore workforce challenges and opportunities for AHPs in rural and remote SA.

In order to understand the context of allied health practice in rural and remote SA, participants were asked to discuss a range of workforce challenges and opportunities relevant to newly qualified clinicians. The trainees' individual circumstances and perceptions were also explored:

Rural background and intention to stay

Of the 13 initial trainees included in this evaluation, seven grew up in a rural or remote setting, five in a metropolitan area and one was raised in both rural and metropolitan areas.

Trainees who had grown up in a rural or remote area discussed the desire to move back to a similar setting on graduation, "I knew the city was not for me" and "I didn't even apply for any metro jobs" were common responses. They wanted to work with a community, improve the health and wellbeing of rural and remote people and reduce inequities. These trainees reported enjoying the rural lifestyle, being close to family and friends and the pace of work in rural areas.

"Adelaide was never for me, I think. All my family, all my friends, everyone that I kind of grew up with are all here so for me it was always probably going to be that I'd come back here, regardless of whether I was with my partner or not. I think I'm just more suited to country lifestyle." Participant 13.

Trainees who had grown up in Adelaide had a range of reasons for taking a job in a rural area. For some, the opportunity to work in the public health system as a new graduate was a major draw card. They had wanted to work in a public hospital or health service but had encountered limited opportunities in Adelaide. Some trainees had rural placements at university which had given them an interest in rural practice on graduation. Others reported they had come for the generalist opportunities that they perceived would be available compared with the more specialised positions in a metropolitan setting.

"I've always sort of had a bit of a passion to work in a rural area, starting from when I was at uni, and my last placement being in a rural area. I've had family and friends work in country areas and live in country areas and was always taken aback by how kind people were and how welcoming it was and a real community feel so it's something I wanted to be a part of and thought that this was a good time to test the waters and try it out." Participant 10.

Interestingly some of the rural raised participants were not working in their place of origin but were working in a new town or region. Further, of the five trainees raised in a metro area, only one was working more than two hours from Adelaide, the others were working relatively close to Adelaide and some were commuting from Adelaide to work each day. One of the trainees who left within the first two modules was raised in a metropolitan area and the other in a rural area.

Almost half of the trainees had been working in a rural or remote location for less than a year. There was a wide range of time that trainees intended to stay in a rural or remote location and two people had already left when completing the survey. Interestingly, of the six who intended to stay more than five years, only one had a metropolitan upbringing.

Table 4. Trainees length of stay and intention to stay in a rural or remote area

	Number of years worked as a rural or remote AHP	Number of years intending to remain working in a rural or remote location
Less than a year	6	1
1-2 years	2	3
2-3 years	2	1
3-4 years	2	0
4-5 years	0	2
5-10 years	1	3
More than 10 years	0	3

Intentions to stay factors

Trainees reported a range of factors that were impacting on their intention to stay including:

1. ***Short contracts*** confounded by slow recruitment processes and short notice about contract extensions were significant issues for some trainees. Longer or permanent contracts would positively impact on intention to stay for these trainees.
2. ***New job opportunities, potential for career advancement and leadership*** are factors that would potentially result in trainees remaining in a rural area for longer. Working in rural and remote areas may have earlier and better opportunities than metropolitan which is highly valued by early career clinicians.
3. ***Manager support***, if trainees felt unsupported by management or not involved in decision-making at an operational level, then they may not want to remain working in the organisation.
4. Some trainees reported ***staff vacancies*** as being a significant factor in their intention to remain in the organisation. If they were consistently working in teams with positions unfilled or with limited cover arrangements, then they were unlikely to want to stay. Some trainees reported working in services that had been short staffed for extended periods of time and this being particularly stressful.
5. ***Supervision arrangements*** and the availability of regular, onsite support from a senior clinician was an important factor for many trainees.
6. ***Team dynamics and relationships with colleagues*** was a factor in trainees' willingness to remain in their current role.
7. ***Desired clinical roles*** were also reasons for remaining longer in a rural area. Although some early career AHPs see the generally narrower scope of practice in metropolitan areas as being undesirable, others find it appealing, especially if they were feeling unsupported in their generalist roles.
8. ***Personal factors,*** some trainees from metropolitan or other rural areas would like to return to be closer to family or a partner when an opportunity arises or when they want to have children. Generally, those from a metropolitan area see returning home as a long-term plan.

Supervisors, managers and ACLs experience working with early career AHPs

In their interviews, supervisors, line managers and ACLs generally reported that supporting early career AHPs is a positive experience and many of them felt it was one of the best aspects of their job. They commented that it is rewarding working with newly graduated clinicians and seeing them grow and develop over time. They felt new clinicians came with enthusiasm, energy and a desire to learn.

Some line managers and supervisors commented on a shift in the attitudes of recent graduates with a trend towards being in the job for personal gain and experience rather than for consumer benefit. The apparent sense of entitlement was reported to diminish once clinicians are embedded in the rural setting and if they remain in a rural location for a significant amount of time.

In discussion with ACLs, it was felt that particular people were more suited to rural and remote practice. These include; individuals with a rural upbringing or who had adjusted to new settings previously i.e. moved schools. New AHPs with a sense of resilience, open and flexible thinking and those who recognised the value of generalist skills were likely to suit rural and remote practice. A sense of community, perseverance, wanting to make a difference and the ability to solve problems were also important factors for rural professionals to have. These will be important factors to consider in future phases of this research.

Challenges & opportunities for early career AHPs

The line managers, supervisors and ACLs interviewed discussed a range of opportunities for early career clinicians in rural and remote areas:

1. ***Opportunity to work in a broad range of clinical areas where early career clinicians can develop skills across multiple service areas and client groups.*** These skills can be transferable to other regions, clinical areas and metropolitan practice. AHPs in rural areas work in multidisciplinary teams to support the needs of clients in collaborative ways rather than working in silos or independently. Generally, the multidisciplinary teams are supportive, welcoming and collaborative with everyone pitching in to help as needed.
2. ***Opportunity to work with a broad range of consumers, to get to know the community and understand how they can have an impact***. Trainees can embed themselves in a new community and get to know community needs much more than a metropolitan clinician would.
3. ***Opportunity to develop problem solving skills, flexible thinking and innovative practices*** as a result of the unique nature of rural practice and the need to think outside the box.
4. ***Good clinical governance structures to support early career AHPs with a strong commitment to supervision, support and professional development***. Access to training and supervision has improved with technology and funding but there continue to be barriers for rural and remote clinicians. One such barrier mentioned was the costs associated with professional development (travel and accommodation) which are higher for rural and remote clinicians than their metropolitan colleagues.
5. ***Warm, welcoming, supportive teams***. Teams with several early career AHPs can be appealing for new staff to enable friendships and networks to grow organically. Having lots of new people around at the same time is fun and everyone is in the same boat. Having too many new clinicians and not enough senior support was also reported as a challenge.
6. ***Opportunities for career advancement***, leadership and quality improvement activities for early career professionals is potentially quicker in rural and remote areas than in a metropolitan service.

A range of challenges were also discussed;

1. ***Living out of home or living in a rural or remote location for the first time***. Some early career AHPs experience home sickness being away from family or a partner or they want to maintain their social lives at home while working in a new rural location. The tiring nature of working 5 days a week in a new environment and then travelling several hours each weekend to go home is thought to be unsustainable long term.
2. ***Professional isolation and remote supervision***. Some professions are large enough to ensure each site has onsite senior support available, while others have smaller numbers and are more likely to rely on remote supervision. Depending on recruitment and retention issues and the configuration of local services, this can be variable. Remote supervision can be challenging especially when early career professionals are working away from the office or where they had significant gaps in their knowledge and skills. Line managers and supervisors identified that new clinicians are often 'thrown in the deep end' and experienced a 'steep learning curve' in rural and remote areas. AHPs who can think on their feet, find short term solutions and work flexibly are most likely to thrive in a rural location. New clinicians need to be able to recognise their own scope of practice and how to problem solve though a situation until support is available. They also need to know when, where, and how to get support.

   "that opportunity to develop that flexibility of thinking, I think is a huge asset because I think then you don't see things in black and white. You don't go in, you know and see a problem, and think you've got to go and solve it. You've got that sort of raft of skills and experiences" Participant 26.

3. ***Complexity of clients, funding streams and service types*** is a significant challenge in rural and remote areas. This is especially so for clinicians working in generalist roles where their clients are funded by a broad range of funders with their own reporting requirements, paperwork and stipulations. One line manager reported preferring to start the new clinicians in one clinical area or one funding stream initially to prevent them from getting overwhelmed but often this was not possible with the need to work across the region on outreach visits.

   "I do try and start them in one program, so they get their heads around documentation, how you do your data entry online, how you work with clients. Get that up to speed a bit first and then branch out into some of these other programs where you need to know those nuanced things." Participant 33.

4. ***Short term contracts*** are a significant challenge for newly qualified professionals. Those on short contracts were reported to be less likely to embed themselves in a community or the workplace and find suitable housing if they are not given an indication that their job will be available long term. A lack of incentives for new clinicians to move to a rural or remote location is also a barrier especially as other industries offer financial, accommodation or relocation incentives in some areas.
5. ***Workload, leave cover and service gaps in small teams and services*** are challenging for early career AHPs. New clinicians who are left on the ground to provide a service without adequate staff is particularly difficult. In some locations it is difficult to recruit certain professions compared with others and it is currently challenging to recruit experienced AHP2/AHP3 clinicians into specialised or supervision roles. Burnout amongst early career AHPs is a significant issue.

6. ***Retention and opportunity to grow career locally*** can be a challenge when AHPs do not have the opportunity to specialise or advance their career in a rural or remote area. If organisations can be flexible to cater to the evolving needs of their staff they may be able to keep them longer.
7. ***Information Technology (IT) Infrastructure in remote locations*** is sometimes a challenge, especially when clinicians travel to remote locations where access IT is limited. AHPs sometimes find it difficult to use their outreach visit time constructively when they don't have adequate IT access.
8. ***Awareness and understanding of rural practice expectations and requirements*** can sometimes be a challenge. Some new AHPs don't know what to expect in rural or remote practice and find the broad scope of practice overwhelming, which can lead to an experience of burnout. It was also reported that often, early career clinicians require significant support to develop effective communication skills, cultural safety and clinical skills relevant to their local community. Awareness of confidentiality issues and blurring of social and professional lines is also challenging for some new clinicians.

It is hoped that trainees' involvement in the AHRGP will assist trainees to overcome some of these challenges.

Aim 2 - To explore the experience of the AHPs participating in the AHRGP and the impact on their skills, abilities and knowledge for practice

Reasons for participating in the AHRGP

Trainees reported participating in the AHRGP for a range of reasons:

1. A desire to develop knowledge and understanding of rural and remote practice
2. To develop their skills in various areas including; specific and generalist clinical skills, project management, leadership and management skills
3. An opportunity to do further study in a relevant field
4. The scholarship opportunity and allocated time to study in work hours
5. The potential to improve career progression and job opportunities
6. To be able to better serve their community and to improve the quality of service provision to rural and remote consumers.

Job Satisfaction

Trainees were asked to rate their overall job satisfaction from 0 being not at all satisfied to 100 being extremely satisfied. Level 1 and 2 trainees were almost equal in their rating of job satisfaction. The trainees who left the program early are not included in this data.

Table 5. Trainee Job Satisfaction

Overall job satisfaction	Level 1 Average satisfaction	Level 2 Average satisfaction
78/100	78/100	79/100

Goals

The trainees were working towards a range of goals as part of their involvement in the AHRGP including:

1. To develop clinical, generalist and leadership skills
2. To develop knowledge about rural health, about rural generalism and specific clinical areas
3. To improve services for local communities
4. To contribute to quality improvement activities
5. To enhance confidence
6. To extend scope of practice
7. To be able to educate others about rural practice
8. To work towards a promotion

Confidence and Competence

Trainees were asked to rate their confidence in 3 different areas of rural generalist practice**,** and supervisors and line managers were asked to rate their trainee's competence in the same 3 areas. It was acknowledged that it was unreasonable to expect early career AHPs to rate their own competence**,** which is why they were asked about their confidence instead of competence. For ease of comparison, trainees and their supervisors and line managers were then asked to rate the trainees' *overall* confidence as a rural generalist (Table 6 and 7). These ratings will be reported on and compared in future phases of the evaluation:

Table 6. Confidence and competence of level 1 trainees

0 – not at all confident/competent 90 – extremely confident/competent	Level 1 Trainees Average **confidence** rating	Supervisors Average **competence** rating	Line managers average **competence** rating
Working with clients across the age spectrum (e.g. infants, children and adolescents, adults and older people)	66	59	70
Delivering a large variety of health services (e.g. health promotion, early intervention, acute hospital-based services, sub-acute and ambulatory care services, chronic disease management, aged care, palliative care)	65	60	76
Working across a large variety of health settings (e.g. hospitals, health centres and clinics, patient homes, community venues)	65	60	73
Confidence as a rural generalist (an overall rating of the trainee's confidence)	66	52	83

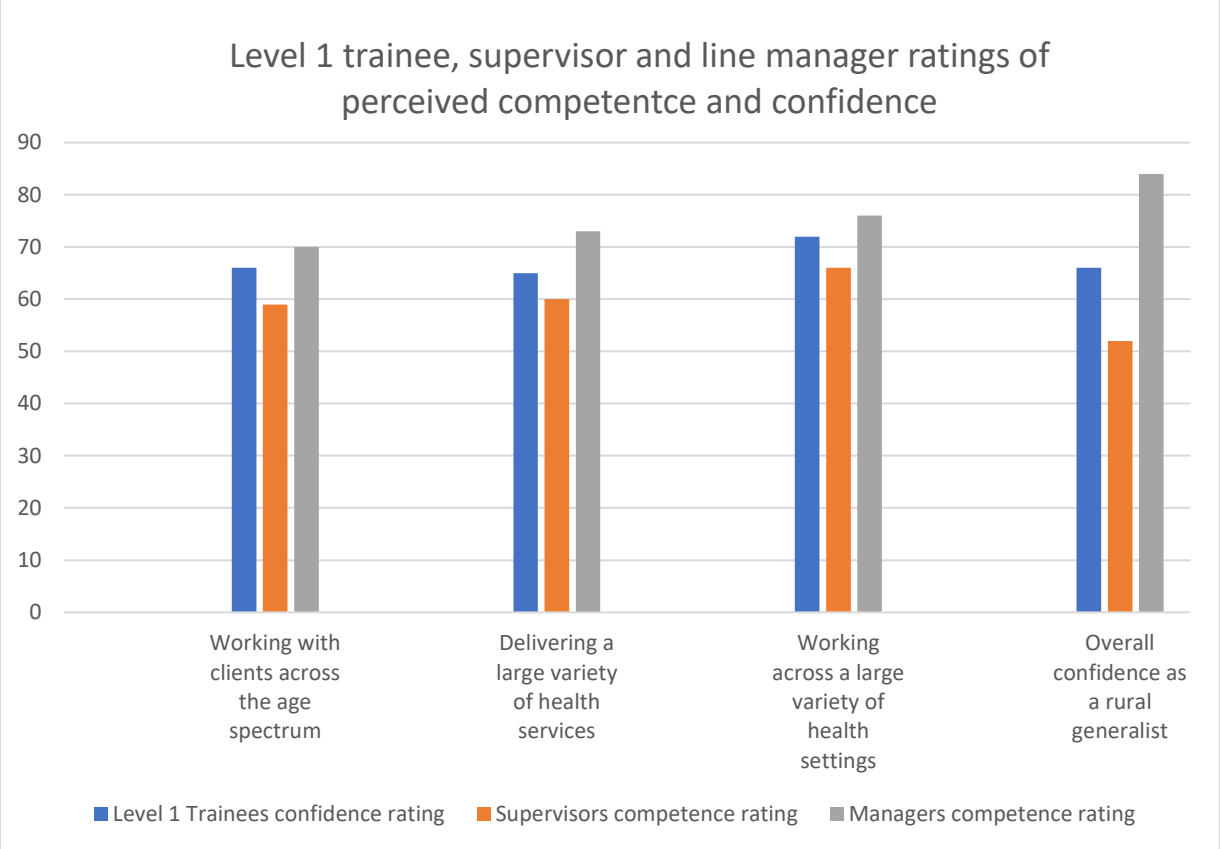
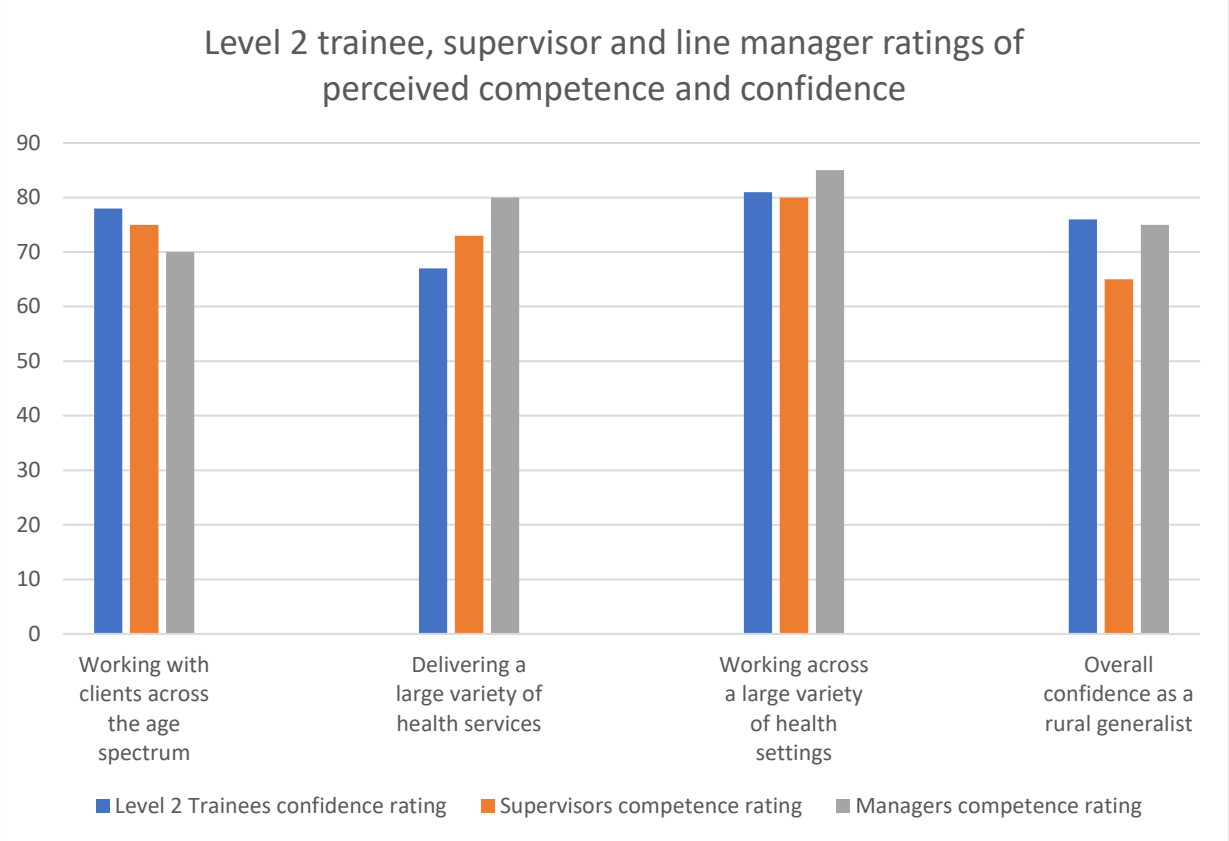


Table 7. Confidence and competence of level 2 trainees

0 – not at all confident/competent 90 – extremely confident/competent	Level 2 Trainees Average **confidence** rating	Supervisors Average **competence** rating	Line managers average **competence** rating
Working with clients across the age spectrum (e.g. infants, children and adolescents, adults and older people)	78	75	70
Delivering a large variety of health services (e.g. health promotion, early intervention, acute hospital-based services, sub-acute and ambulatory care services, chronic disease management, aged care, palliative care)	67	70	70
Working across a large variety of health settings (e.g. hospitals, health centres and clinics, patient homes, community venues)	67	73	80
Confidence as a rural generalist (an overall rating of the trainee's confidence)	76	70	70



On average trainees were quite confident about working as a generalist across a range of ages, settings and service types. The level 2 participants were more confident than the level 1 trainees, although when delivering a variety of service types and working across settings, their confidence was very similar.

On average, line managers and supervisors rated the trainees' competence and confidence highly considering they were early career AHPs with generally less than 5 years experience, and they had just started the training. Supervisors generally felt the level 2 trainees were more competent than the level 1s but the line managers rated these similarly for both the level 1 and 2 trainees. It is interesting to note that the line managers rated the trainees more highly than the supervisors did in 6 of the 8 domains across the two groups. These ratings will be monitored for trends and changes over time.

Barriers & enablers for success

Time was the most significant barrier trainees were anticipating in succeeding in the AHRGP. Clinical roles are seen to be a higher priority than study and protected study time is often interrupted by urgent clinical work. This is particularly problematic when trainees work in small teams with limited cover or where there is a significant vacancy problem. Trainees recognised that they will need to do part of their study at home in their own time and some reported they found it difficult to find the time and energy for this alongside fulltime work.

Trainees are aware of a range of enablers to their success in the AHRGP:

- Having permission to do study in work time
- Being able to study at home or in a quiet space at work
- Supportive supervisors are instrumental in giving the trainees advice, guidance, ideas and support in the early stages of the program
- Supportive managers and teams, especially for providing information and ideas for assignments.

Anticipated support requirements

Trainees have access to a range of support arrangements as part of this AHRGP. Trainees generally anticipated that the support they received from their clinical supervisors was going to be adequate in enabling them to be successful in the AHRGP. A small number of trainees had limited clinical supervisor support, but generally this was adequate and highly valued. Most trainees were receiving weekly or fortnightly clinical supervision, and in many cases, this was provided remotely.

Support from management was reported to be variable across the LHNs. Some trainees perceived their line managers to be supportive and interested in the training, offering guidance and advocating for their time. Other trainees perceived their line managers to be more indirectly involved and providing limited direct support and guidance.

Protected study time

It is a requirement of the Allied Health Rural Generalist training program that a minimum of 0.1-0.2FTE is allocated by the workplace for trainees to complete the program. Trainees were very appreciative of the time that had been allocated within their work time to undertake study. The amount of time allocated to each trainee varied between 0.1-0.2FTE and was determined by management locally. Interestingly the time allocated did not always correlate with the number of topics being undertaken at the time, with some trainees completing two topics each study period while others were doing one. In most instances this time was routinely rostered off by a senior

clinician however some trainees were responsible for their own rostering and were consistently booking study time out in their diary.

Concerns with participation

Trainees were excited about the prospect of undertaking study, however there were a few concerns raised. As discussed, time was the major concern reported with participants managing high clinical priorities in their allocated study time. Some trainees were worried they may not get the most out of the training or put in 100% if they were particularly busy in the future. This will be explored further in the next phase of the evaluation.

A couple of trainees were concerned that the training was not starting at the right time in terms of their career development and they emphasised the importance of technical and clinical skill development as a newly qualified clinician. There were also some participants who were wondering whether it was the right course for them. These perceptions and initial concerns will be further explored and reflected on next year when the trainees are further into the course.

Early reported experiences in the program

Although the pre-evaluation did not focus on the experience of the training, anecdotally the trainees reported the first modules had been interesting, engaging and applicable to their job roles. A wide range of modules had been initiated, including those with clinical and project management focuses. Trainees had chosen topics they thought would be most appropriate and interesting in the early stages of the program. They were looking forward to future topics and were pleased with the range of options available to them.

Aim 3 - To understand the impact and perceptions of the AHRGP on supervisors, clinical leads and managers working with rural generalist trainees

Anticipated outcomes

ACLs, supervisors and line managers were optimistic about the outcomes that could be achieved through the AHRGP. These were explored in terms of how the trainees, their teams, the regional LHNs and consumers would be impacted by the training.

Anticipated impact on trainees:

1. ***Trainees will become more confident*** rural generalists with improved skills and knowledge relevant to rural practice
2. **Trainees will develop a broad understanding** of health systems that new clinicians would not otherwise understand early in their career
3. **Trainees will develop critical and flexible thinking** with an ability to think outside the square, solve problems more easily, take on challenges, work with limited resources and be able to more easily consider others' perspectives and views
4. They will also develop an ***appreciation and understanding of rural and remote practice*** and the needs of their local community
5. By having a core group of trainees undertaking the training together, they will ***develop new networks to support each other and be able to work on projects together***
6. ***Trainees will feel valued and appreciated*** as they are given time and funding for training, they will also benefit from a recognised pathway for developing rural and remote generalist skills
7. Trainees involvement in the AHRGP will allow them ***to progress their careers in rural and remote areas*** rather than having to move for a promotion.

> *"I think it's acknowledgement of the specialty. I think it will gain a potential way of like retaining staff once we have them and also allow clinicians to work their way up the levels as well."* Participant 24.

Anticipated impact on the allied health workforce:

1. The workforce will be able ***to learn from the trainees*** if there is the opportunity to share relevant learnings both formally and informally
2. Allied health staff may benefit having ***clearer processes, better communication between staff, more transdisciplinary care and relevant resources developed to support their roles***
3. This first group of trainees will hopefully be able ***to mentor future trainees*** and be able to promote the AHRGP
4. ***The voice of allied health may be strengthened*** with trainees in each regional LHN achieving outcomes and making positive changes
5. Possibly the broader workforce may not understand the purpose of the training or the dedicated study time and may come to ***resent the trainees or be jealous of their study opportunities.***

Anticipated impact on the regional LHNs

1. ***Informing workforce planning*** and impacting on future directions of the organisation
2. ***Retention will improve with trainees having the ability to develop their careers in situ*** rather than moving to another location
3. ***Happier, more passionate and more productive*** staff in the organisation
4. ***Easier recruitment*** if potential new staff knew they may have the opportunity to undertake the AHRGP in the future

5. ***More skilled workforce*** will result in higher quality service provision
6. ***Developing a broad culture of learning*** amongst staff in the organisation
7. ***A stronger focus on evidence based practice*** and innovative practice.

Anticipated impact on consumers

1. Trainees will have ***better skills and be more knowledgeable*** and as a result will be able to more effectively meet the needs of their consumers
2. Trainees will be able to ***better cope with complex consumer needs***
3. Trainees will deliver ***a higher standard of care*** and better understand the needs of their community
4. Consumers should be able to receive ***high quality services closer to home*** and with better retention they should notice ***more consistent and higher levels of care*** from AHPs.

   "….if we are a place that's providing supportive education, structured and formal education for our staff, would we not then attract a higher level of (AHP) to our organisation if we are able to provide that? Of course that's going to have a good impact for the clients" Participant 23.

Enablers and barriers for achieving outcomes

ACLs, supervisors and line managers anticipated a range of enablers and barriers that may impact on the success of the AHRGP. Many of the factors were discussed as being enablers or barriers depending on the context:

1. ***Protected time*** is a significant enabler but as the trainees reported, clinical priorities often interrupt study time with high workloads and small teams covering large caseloads. Line managers and supervisors were supportive of trainees studying in work time and were open to flexible options to enable this to happen. They were aware of the clinical pressures and were supporting trainees to find time in their schedules.
2. The extent to which ***regional LHNs value the AHRGP*** and recognise the benefits and impact it has on workload is a potential enabler or barrier.
3. ***Adequate time at work to study*** is important so that trainees don't need to do most of the work at home.
4. ***Collaboration and communication across teams*** that trainees work in is important to ensure they feel supported and that workload reflects competing demands of generalist roles.
5. ***Support from supervisors and line managers*** is an enabler when available; supervisors appeared to be providing regular, scheduled clinical supervision, with line managers meeting with trainees when requested in most cases.
6. ***The availability of timely support, resources and information*** for assignments and projects is also important for success:

   "We've got an understanding that she's able to contact me or come and find me and we can talk through something because there's no point in having a whole day set aside for study and if your mind gets stuck on something or if you're losing track you're better to get that back on and make the most of the day" Participant 23.

7. ***Support from the Rural Support Service*** is an enabler for trainees, supervisors and line managers through scheduled meetings and informal support. The extensive support the project team had provided to all stakeholders was described as pivotal to the AHRGP being established and maintained over time.

8. ***The trainees supporting each other*** through the process is helpful in building networks and working on projects together.
9. ***Formally evaluating the AHRGP*** is an important enabler in measuring and reporting the impact and outcomes achieved and to support sustainability of the program.
10. ***The establishment of six regional LHNs is a potential barrier*** for the AHRGP. As the AHRGP was introduced, rural services in SA were restructuring into separate regional LHNs. There is the potential for each regional LHN to choose how much they invest in the program in the future, and they may provide different degrees of support, time and resources for trainees. Benefits and outcomes for each regional LHN need to be visible to promote ongoing investment. This will be further explored in the second phase of this evaluation.
11. ***Retention is a potential barrier*** for the success of the program, if trainees do not continue to work in a rural or remote area then the benefits of the program may not be reached for stakeholders.
12. ACLs, supervisors and line managers have ***limited access to information about the topics*** available to trainees. If there was more information about the content they may be help trainees to select the relevant topics.

Anticipated impact on workload

Although it is anticipated by line managers, supervisors and ACLs that the AHRGP will impact on their workload, at this early stage of the training the impact had not been significant, and all participants were very positive about supporting trainees and were not concerned about impact on their own workload. Support roles, strategic planning, service development and supervision is their core business. They anticipated that the trainees would produce resources, develop processes and guidelines and evaluate practice that the whole profession or LHN could benefit from. One ACL had already noticed some benefits in the early stages:

"For someone to have the time put aside to do that is so valuable because, you know, the whole profession is just working to keep seeing clients in the community and doing a bit of their own quality improvement activities at their site, not kind of having the time and ability to go 'what could we produce that would impact more broadly?" Participant 27.

Aim 4: To explore how the AHRGP has impacted consumers' perceptions, access and quality of allied health service delivery and development.

The consumer representatives explored their perceptions of allied health services in rural and remote areas in the focus group for this phase of the research. Their experiences and perceptions are described and summarised under the following headings.

The right professions

Quality allied health services were described as services that were accessible to consumers with a wide range of professions available to meet the varying needs of the community.

Generalist skills

Consumer representatives thought rural and remote AHPs should have experience and skills to work across a wide range of clinical areas rather than specialised skills in one area. They should have a good understanding of rural practice and match the service to the needs of the community.

Communication and Confidence

AHP confidence in relation to service delivery and awareness of when they need to ask for help was felt to be very important attributes. AHP's need to have excellent communications skills to work with a wide range of colleagues and consumers and they need to have a good understanding of their role and what they can offer consumers.

Timely

Allied health services should be available in a timely manner as people shouldn't have to wait just because they live in a rural or remote location. Consumers waiting for National Disability Insurance Scheme (NDIS) services and My Aged Care seemed to be waiting the longest time for services.

Client centred

The consumer representatives reported consumers would like AHPs to be client centred, they should focus on the problems the client is concerned about rather than what they think is important or what their discipline usually focuses on.

Teamwork

Health professionals should communicate effectively between themselves to avoid duplication for consumers and to improve the effectiveness of the care provided. They should not work in siloes, they should work closely within a multidisciplinary or interdisciplinary team. Consumer representatives felt that this teamwork was important in rural and remote areas because the health professionals were working across such broad clinical areas and locations that collaboration and communication is essential for consistent consumer care.

Complexity

Consumer representative felt AHPs should know how to work with consumers with multiple or complex needs and when there are competing priorities, these should be discussed as a team with the consumer to ensure the consumer is not marginalised or left out of the process. Case management should be considered when there are multiple needs to manage and the AHPs should have skills in how to case manage well.

Knowledge

Health professionals should have good understanding of the health system and what is available to consumers because it was reported that most people don't know what services are available to them or what they need. They should also work with other professional groups to let them know

what they can offer so that everyone can offer consumers the best possible services, for example sometimes doctors don't know what allied health services are available, so they don't refer.

Perceptions of rural versus metropolitan services

The consumer representatives reported it is often quicker and easier to get an appointment with an AHP in a metropolitan centre than in rural and remote areas. They felt this was inequitable and that service access should be the same, regardless of where someone lives. They reported in some areas in SA there was only one AHP for each profession covering a large geographical area and they felt this was not sustainable. They also noted this was professionally isolating and it is difficult for AHPs to build their skills and confidence when they are not working closely with others. They recognised that for some country areas there were private options available locally but this was unaffordable for many people and not all professions had private options available. As a result long wait lists were common in their local areas and sometimes people missed out on services or had to travel to access the service they needed.

Retention

The consumer representatives were aware of the high turnover of AHPs in country SA. They recognised that some AHPs experienced burnout as a result of high workloads and too many areas to cover or if they were not adequately prepared for the role they were employed to do. Job security was also highlighted as an issue which results in health professionals leaving for longer contracts in a different location. They noted that retention may always be an issue in rural and remote areas and felt health services should develop better systems of supporting new clinicians to smoothly transition into their roles and continue to provide good services to consumers.

Continuity and consistency

Continuity of services are a significant problem when there is high turnover of staff. Consumers are frustrated by the lack of consistency and continuity of treating clinicians which results in them having to retell their story at each appointment which wastes their time. They felt better retention, team communication and documentation could reduce this challenge. Sometimes consumers are waiting a long time for follow up from AHP's or they are not sure what is happening next. AHPs should make sure their consumers understand the plan and when they will be seen again.

Training

It was agreed that AHPs should be taught about rural practice and the reality of what it is like to live and work in a rural area before they come. They need to learn the practical aspects, not just the theory. AHPs should have the opportunity to study and work in rural areas while they are at university with good support structures for their learning, so they are better prepared to work in the country on graduation.

Personal factors and boundaries

AHPs who come to rural and remote areas can work across a broad range of clinical areas, with a range of other health professionals. They reap the benefits of living in a country town with the opportunity to get involved in the community.

It was acknowledged that living in the country has challenges too. There is less to do in rural areas, especially if the individuals don't play sport. They need to be aware of privacy and confidentiality issues in country areas as they may work with clients who they see socially as well. They need strategies to separate their personal and professional lives.

If AHPs are experiencing professional isolation they need to know where to get support from more experienced or specialist clinicians so good networks are important. They also need to establish a good work life balance and find outlets outside of work, there are lots of sporting opportunities.

Monitoring of quality and complaints

The consumer representatives thought health professional's practice should be monitored to ensure a high quality service as they felt the skills and abilities of health professionals in rural areas was sometimes variable. The consumers representatives were aware of complaints that consumers give around wait times and lack of follow up from health professionals after the initial appointment. Sometimes there is a mismatch between what is promised and what is delivered and often consumers didn't know where to go for help. They noted this was sometimes due to turnover of staff but felt that better systems and documentation could prevent issues from arising. Often the health professionals were blamed for system issues or the performance of one professional caused the community to generalise their perceptions to the whole service or profession.

Travel for services

The consumer representatives didn't think their communities were travelling much for allied health services except for highly specialised services including; psychology, paediatric specialists and hand therapy. They did note that consumers were traveling for medical appointments but that they were able to access reimbursement of travel costs where a suitable local medical service was not available.

Aim 5: To identify where the AHRGP works, which professions, locations and individual characteristics are particularly suited to the AHRGP.

This aim will be explored in future phases of research.

Aim 6: To explore costs and benefits of the AHRGP

Direct costs

Direct costs associated with the implementation of the AHRGP have included trainee enrolment fees for the AHRGP training program delivered by JCU, a project manager role, and funding allocation for Flinders University to undertake a formal evaluation strategy. These funds have been provided through the Rural Health Workforce Strategy.

The Rural Support Service (RSS), on behalf of South Australian regional LHNs, entered a formal agreement with JCU for delivery of the AHRGP training program.

An AHRGP project manager role, funded for the 2019 calendar year, was filled from mid-March to December 2019 at 0.5FTE. This role initially developed the project plan and associated processes, managed recruitment and selection of trainees and liaised with JCU. From July this role coordinated communication about the AHRGP to key stakeholders, and provided extensive support to trainees, supervisors and line managers, all of whom reported this to be a vital and valued aspect of the project. In May and June a short term project manager was also appointed for 6 weeks to ensure appropriate supervision arrangements were in place for all trainees prior to their commencement in the program. Extensive in-kind project support has also been provided by the RSS allied health directorate staff.

Flinders University was funded to evaluate the AHRGP outcomes from July 2019 - June 2020 which will be done in two phases, the first in 2019 and the second by June 30, 2020.

Indirect costs

To meet the requirements of the Allied Health Rural Generalist training program, trainees were allocated 0.1 – 0.2 full time equivalent (FTE) time within their workload to undertake study activities which each regional LHN provided in kind support for. It is anticipated that these in-kind costs will be recuperated over time through service efficiencies and improved quality as an indirect outcome of the AHRGP. Costs associated with this time are variable depending on the salary of the individual and the time allocated.

Supervisors, line managers and ACLs also provide extensive support for the AHRGP both directly to the trainees and indirectly through meetings and administrative tasks. These roles and responsibilities will be described and explored further future phases of the research.

Summary

Phase 1 of the AHRGP has explored the perspectives and experiences of a range of stakeholders during the initial implementation of training positions across rural SA. A significant investment in funding has allowed the AHRGP to assist 13 early career AHPs to develop rural generalist skills, knowledge and resources.

Challenges and opportunities of rural and remote work were found to be wide ranging and relating to personal and work-related factors. Many similarities were identified between the perspectives of the trainees and those who were supporting them. Rural background, proximity of loved ones, the amount time spent travelling and the degree to which individuals embed themselves in a community were described as significant. Having the right mix of staff in a location, onsite support, and a core group of young clinicians were also raised as retention factors. Short term contracts with limited notice of extension and associated accommodation implications may also be factors that impact on an individuals' intention to stay in a rural or remote area. These and other emerging factors will be further explored in the next phases of this research.

Trainees are generally very motivated to work across different clinical areas in rural generalist roles. Many were motivated to take the job because of the rural lifestyle, the varied caseload, the job opportunities and the ability to work in a public health service. Line managers, supervisors and ACLs enjoy working with early career AHPs and appreciate the enthusiasm, energy and skills they bring to a community. The perceived confidence and competence of trainees was rated by stakeholders and these will be monitored over time for trends and changes. At this early stage, line managers are the most confident about the trainees' competence and confidence compared to the trainees themselves and the supervisors.

This preliminary evaluation has found that the trainees are excited and hopeful that the AHRGP will give them the confidence and ability to work as a rural generalist to meet the needs of their local communities. They are also hoping it will support their career development and assist them to be more advanced clinicians. Supervisors, line managers and ACLs working with trainees are also positive about the AHRGP and looking forward to seeing the outcomes that can be achieve for the trainees themselves, for the broader teams, for the regional LHNs and for consumers. A range of potential impacts were raised, and future phases of this research will compare and contrast the anticipated and actual outcomes as they emerge.

All participants recognised enablers and barriers that will potentially facilitate or hinder the success of the AHRGP, with time being the most significant issue. Heavy workloads, staff shortages, complex cases and processes all impact on trainees' ability to protect their study time and truly commit to the program. It is clear that all stakeholders are aware of these pressures and will advocate for the trainees' time where possible. The recent establishment of six regional LHNs may also impact on the success of the AHRGP for individuals and services as networks choose to invest their time and resources into various local priorities. It was discussed that benefits for each network must be evident for the ongoing sustainability of the AHRGP.

Consistent support from the RSS, ACLs, line managers and supervisors has been a significant enabler for trainees which has had a positive influence on this early implementation phase. Trainees are generally feeling supported and appreciated as they begin their training AHRGP. Some minor variances in levels of support available were noted and will be further explored in the next phase of implementation.

Recommendations

At the conclusion of phase 1 of the South Australian AHRGP evaluation the following preliminary recommendations are made:

- Continue to invest in the AHRGP due to the overwhelmingly positive experience of all stakeholders to date
- Continue regular clinical supervision for trainees from a profession specific senior clinician who is invested in the trainee and their ongoing development
- Prioritise trainees to receive regular access and support from a line manager or team leader to provide local workload support, sharing of resources and ideas for projects and assignments
- Continue to protect trainees' time at work to dedicate to coursework and projects, acknowledging that this may fluctuate at times
- Continue to have the RSS support trainees, supervisors and line managers as this is seen to be pivotal in the sustainability of the program
- Match projects and coursework activities with the needs of the regional LHNs and rural and remote communities so that the outcomes are relevant, beneficial and appropriate locally
- Regional LHNs to continue to work with their local AHPs to identify factors that would impact on their intention to stay in their community and advocate for relevant retention strategies to be available where possible.

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