Introduction

In 2012 the Victorian Department of Health (the department) developed a statewide implementation program to actively support the growth and utilisation of the allied health assistant (AHA) workforce across Victoria. This program builds on a broad body of work implemented by the department since 2005 and is modelled on a consultation-based data collection and analysis methodology developed and piloted by Alfred Health during 2009-11.

The Allied Health Assistant Implementation Program (the program) is being rolled out across Victoria via a staged approach. The program is underpinned by a partnership between the department, Alfred Health and Monash Health and adopts a train-the-trainer approach to assist and support health and community services from across Victoria to quantify the opportunity to build their AHA workforce, and allied health workforce capacity, for the future in a sustainable way.

Stage one of the program was introduced in 2012 and involved health and community services from rural / regional Victoria. Stage two was introduced in 2013 and was conducted in 11 major metropolitan health services. Stage three is being implemented in 2014-15 and delivered in metropolitan community health and ambulatory services. A contextualised program is also being implemented in 2014-15 which targets Victorian medical imaging departments to support the further development and utilisation of a support workforce within the Victorian medical radiations and imaging sector.

This paper summarises the project scope, key outcomes and future activities arising from stage two of the program and should be read in conjunction with the stage one program report.

Program aim

The program is being implemented across Victoria to assist health and community services to strategically position themselves to sustainably build their future AHA and allied health workforce capacity using the Victorian Assistant Workforce Model (allied health) (the Model). A summary of the program background and a detailed description of the Model is provided as an appendix to this report.

The program aims to increase the AHA workforce and utilise AHAs to their full scope of practice to increase allied health workforce capacity, make most effective use of highly skilled clinicians, improve access to allied health services and grow a sustainable allied health workforce.

The program is underpinned by the *Supervision and delegation framework for allied health assistants* (the framework) and is being rolled out across Victoria through a staged approach.

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**AHA Implementation Program**

Stage one of the program was implemented over a seven month period, from August 2012 to February 2013. It included 16 sub-regional clusters; involving over 1000 allied health and community service staff from 86 organisations across rural-regional Victoria. A sub-regional cluster approach was adopted to ensure a critical mass of AHPs participating in the methodology (for data collection purposes) and to increase strategic cooperation and collaboration between allied health service providers. This approach strengthened partnerships between participating organisations (including with other sector stakeholders i.e. training providers), facilitated a more collaborative approach to workforce planning at a sub-regional level and encouraged the pooling and sharing of knowledge and resources to support local allied health service delivery. Three program mentors were also engaged from Bendigo Health, Gippsland Lakes Community Health and Northeast Health Wangaratta to provide cluster coordinators with mentoring support from an innovative rural-regional perspective. Further information about the scope and outcomes of stage one is available in the stage one program report.

Stage two was implemented over a nine month period from April – December 2013 and incorporated acute and subacute settings of 11 major metropolitan health services, including a maternity collaborative at three tertiary hospitals. This stage consisted of 34 sites and almost 2000 allied health staff. Given the size and diversity of these services, a cluster approach was not applied to this stage of the program.

Stage three is currently being implemented in metropolitan community health and ambulatory services. There are 29 organisations (56 sites) participating in this stage of the project. These have been clustered into eight metropolitan sub-regional hubs. Similar to stage one, stage three has adopted a cluster approach to ensure a critical mass of participants and to ensure cooperation and collaboration between local allied health service providers in the development of their allied health workforce strategic plans. A number of stage two metropolitan health services with significant community service arms or linkages are also participating in this stage of the program. Stage three is due to be completed in April 2015.

As part of the implementation of the *Medical radiations and imaging technology workforce strategy*, the department is also supporting four Victorian medical imaging departments to introduce the program, contextualised to the medical imaging environment. This project is due to be completed in May 2015.

**Stage two**

Stage two of the program was conducted in 2013 in the acute and subacute settings of 11 major metropolitan health services that were selected and established through an expression of interest process (figure 3). This included a maternity collaborative comprising three tertiary maternity hospitals and their sites, specifically focussing on AHA roles within maternity services. Monash Health led this collaboration in partnership with Mercy Women’s Hospital and The Royal Women’s Hospital.

Each participating organisation appointed a project manager to work with the program team to determine the project scope and implement the model within their service. A steering committee of senior representatives was established in each organisation to provide governance and strategic oversight of the program at a local level. The three project leads from the maternity collaborative also met between training days to share resources and discuss issues and successes pertaining specifically to maternity services.

The train-the-trainer component of the program differed marginally from stage one to accommodate the metropolitan context. This included the project methodology taught to project leads through four (instead of six) face-to-face training days, allowances for increased flexibility in the project planning and project resources contextualised to meet the needs of the participating services. In addition, stage two did not include ‘separate’

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project mentors. This mentoring role instead fell to the program team, reflecting their experience implementing the methodology in similar sized metropolitan health services.

The following allied health disciplines were represented in stage two: art therapy, audiology, dietetics, exercise physiology, music therapy, occupational therapy, orthoptics, pastoral care, physiotherapy, podiatry, prosthetics and orthotics, psychology, social work and speech pathology.

Figure 3: Stage two organisations

Program implementation team

Alfred Health and Monash Health worked in close partnership with the department to implement the program through a train-the-trainer approach, coaching project leads to implement the elements of the Model within their organisations from April to December 2013. Monash Health program staff led the implementation of the Model in the tertiary maternity collaboration.

The program implementation team were also available to stage two organisations post-project to provide mentoring, advice and guidance during the implementation of their strategic plans for integrating the AHA workforce.

Results

Baseline data

Project leads collected baseline staffing profiles at program commencement. The data indicated that AHAs made up 8.26% of allied health staff across stage two organisations at that point in time (table 1).

Table 1: Stage two baseline staffing profiles (2013)

<table>
<thead>
<tr>
<th>Staffing type</th>
<th>AHP</th>
<th>AHA</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physical number of staff</td>
<td>1783</td>
<td>173</td>
<td>1956</td>
</tr>
<tr>
<td>EFT</td>
<td>1325.68</td>
<td>119.37</td>
<td>1445.05</td>
</tr>
</tbody>
</table>

% AHA staff in allied health = 8.26

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6 These figures include the maternity collaboration.
Organisations varied significantly in size and number of allied health staff as well as disciplines and program areas participating as part of the program scope.

The tertiary maternity collaboration consisted of a total AHP EFT of 74.43 across the three organisations and 1.7 EFT of AHA staff. Across the collaboration AHAs made up 2.28% of allied health staff. It should be noted that one organisation did not employ any AHA staff at program commencement.

**Staff workforce survey**

A staff workforce survey (previously referred to as a staff satisfaction survey) was conducted by project leads at program commencement (table 2). Separate AHP and AHA online surveys were used with an overall 88% survey response rate.

These surveys were a particularly valuable tool for participating organisations, providing them with an insight into the current status of their allied health workforce.

**Table 2: Stage two staff workforce survey (2013)**

<table>
<thead>
<tr>
<th>Survey Measure</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of AHAs recording job satisfaction as satisfying or highly satisfying</td>
<td>86%</td>
</tr>
<tr>
<td>Percentage of AHPs recording job satisfaction as satisfying or highly satisfying</td>
<td>91.3%</td>
</tr>
<tr>
<td>Percentage of AHAs recording work roles as stimulating or highly stimulating</td>
<td>79.5%</td>
</tr>
<tr>
<td>Percentage of AHPs recording work roles as dissatisfying or highly dissatisfying</td>
<td>7.9%</td>
</tr>
<tr>
<td>Percentage of AHAs reporting learning needs are being met</td>
<td>95%</td>
</tr>
<tr>
<td>Percentage of AHPs reporting that AHAs were employed by their organisation</td>
<td>89%</td>
</tr>
<tr>
<td>Percentage of AHPs reporting access to AHAs to support their work</td>
<td>57%</td>
</tr>
<tr>
<td>Percentage of AHPs reporting additional tasks exist for AHAs within their current workload</td>
<td>56%</td>
</tr>
<tr>
<td>Percentage of AHPs reporting utilisation of AHAs in daily workload as not applicable</td>
<td>9.4%</td>
</tr>
</tbody>
</table>

As identified in table 2, 89% of AHPs reported that AHAs were employed by their organisation, with 57% reporting access to AHAs to support their work. 56% of AHPs reported that they currently completed clinical tasks that could be delegated to an AHA, indicating further opportunity for AHA workforce growth.

AHPs reported a high level of confidence in the clinical skills and utilisation of the current AHA workforce as well as confidence in delegating clinical tasks to AHAs (graph 1). The tertiary maternity collaboration recorded similar results (graph 2)

**Graph 1: AHP confidence in AHA workforce (stage two)**
Graph 2: AHP confidence in AHA workforce (tertiary maternity collaboration)

![Graph showing confidence levels for referring clinical tasks, AHAs' skills to meet clinical demands, and satisfaction with AHA use.]

**Quantification survey**

As with stage one, stage two project leads actively engaged AHPs and AHAs through a series of focus groups to identify current and potential future AHA roles and tasks. These focus groups explored topics such as the benefits of increasing the AHA workforce as well as potential barriers and solutions. The focus groups were a key component underpinning the program’s change management methodology; upskilling staff to better understand the AHA role and ensuring they felt like an integral part of the process to develop and implement a sustainable workforce solution for the delivery of allied health services into the future.

The project leads analysed the tasks identified through the focus groups and categorised them into 10 agreed practice categories. These were used to develop the data collection forms for the quantification survey. Allied health managers were then consulted and required to ratify the identified tasks prior to data collection.

While a range of staff participated in the focus groups and consultation process, the quantification survey was completed only by AHPs (as this element of the Model requires full understanding of the nature of allied health clinical interactions to provide valid results). At present the Model has not been validated in any workforce in addition to AHAs.

AHPs completed the quantification survey for a five day period (the timing of which was determined at a local level). The quantification survey response rate was 76%.

As per the methodology the quantification survey aims to identify and quantify the total work AHPs completed that potentially could have been delegated to an AHA. The survey is paper-based and requires AHPs to record the amount of time, in minutes, for daily tasks they complete that could potentially be delegated to an AHA. The data is recorded under each of the 10 practice categories. Data is collected by discipline or by service and entered into a custom-built Microsoft Access Database to facilitate analysis. Examples of the discipline specific surveys developed as part of the original Alfred Health pilot are included as appendices to the Guidelines.

The Access Database and results provided in this report included a conversion factor applied to the quantification survey data. This factor, the Allied Health Staffing Factor, is a model developed and utilised by Alfred Health allied health to translate clinical activity into EFT requirements of clinical roles. This factor captures indirect activities of AHPs necessary to support clinical practice, including clinical support responsibilities and annual, study and personal leave. Based on feedback from stage one, the factor was amended from 1.818 (factor used in Alfred Health acute and subacute bed based services) to 1.449 to reflect the clinical care activity across organisations participating in the program. Some organisations chose to analyse

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their actual raw data to inform their strategic planning process.

Similar to stage one, stage two of the program identified a clear need for a suitably trained and supervised AHA workforce to assist AHPs to deliver health care in metropolitan health services.

The quantification survey results for stage two indicated that participating AHPs spent just over 8500 hours on AHA attributable tasks (table 3). This equates to 17% of the AHP workforce or 224 EFT. These results indicate substantial scope to reconfigure the allied health workforce to make more effective use of AHP skills, and that a workforce proportion of greater than the current level of 8.3% AHA: AHP in metropolitan health services is indicated.

Table 3: Stage two quantification summary

<table>
<thead>
<tr>
<th>Total hours identified</th>
<th>8533</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHA attributable work identified as a % of EFT</td>
<td>17%</td>
</tr>
<tr>
<td>Total EFT identified</td>
<td>225 EFT</td>
</tr>
</tbody>
</table>

The results also indicated that 669.43 hours of AHP time from across the tertiary maternity collaboration could have been delegated to an AHA which equated to 17.62 EFT. As with stage one, it is not expected that all of the ‘potential AHA attributable time’ identified through stage two should be reallocated and implemented into new AHA roles, as a range of these tasks must be retained by AHPs in order to support students and junior staff teaching and to balance caseloads. Instead, this data was used to guide further investigation and the development of new and amended roles, and the realignment of skill mix and staff profile to optimise the effectiveness, productivity and capacity of the whole allied health workforce. This includes identifying opportunities to shift some administrative tasks currently undertaken by AHAs to administrative staff to free up AHAs to take on more clinical duties and in turn increase AHPs’ capacity to work to the higher end of the scope of practice and, where possible, undertake advanced practice roles.

One stage two organisation undertook a secondary quantification survey to determine the amount of AHA time spent on administration or other tasks that could have been undertaken by another workforce. The purpose of this survey was to free up AHA time to support AHP’s and better align AHA roles to support clinical tasks.

The stage 2 quantification survey results indicated that 75.65% of identified AHA attributable work was clinical. Similar to the findings of the original Alfred Health pilot and stage one of the program, this appears to suggest that there is a strong need for support for AHPs in the clinical tasks they complete, rather than from a purely administrative point of view, and that AHPs are starting to recognise the increased contribution AHAs can make in the provision of clinical services. A breakdown by practice category is provided in table 4.

Table 4: Quantification of AHA attributable tasks by practice category (% of total EFT)

<table>
<thead>
<tr>
<th>Categories of AHA tasks relating to clinical areas of AHP practice</th>
<th>Assessment (with feedback from AHP)</th>
<th>Treatment</th>
<th>Complex cases</th>
<th>Clinical reporting</th>
<th>Discharge planning</th>
<th>Equipment and environment</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>11.40%</td>
<td>32.73%</td>
<td>3.47%</td>
<td>8.28%</td>
<td>10.42%</td>
<td>9.35%</td>
</tr>
<tr>
<td>Clinical = 75.65%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Categories of AHA tasks relating to non-clinical areas of AHP practice</td>
<td>Research and Quality</td>
<td>5.43%</td>
<td>Supervision</td>
<td>2%</td>
<td>Administration</td>
<td>15.27%</td>
</tr>
<tr>
<td>Non-clinical = 24.35%</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

At a discipline level, orthoptics recorded the highest percentage of AHA attributable time that could have been

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8 These figures include the maternity collaboration.
delegated to an appropriately qualified and supervised AHA workforce at 55.89%. This was followed by podiatry, prosthetics and orthotics, speech therapy, music therapy and dietetics. This may be attributed to the relatively lower levels of access these disciplines currently had to AHAs to support their work and indicated a greater need for AHAs to support these workforce groups (graph 4). Disciplines with significantly lower levels of AHA attributable time may be explained by limited previous exposure and understanding of the potential use of an assistant workforce. This may be an area of future development.

Graph 4: Quantification of AHA time identified by discipline (% of total EFT)

The results from the tertiary maternity collaboration indicated that social work (89%), closely followed by physiotherapy (63%), recorded the highest percentage of AHA attributable time (graph 5). These results may reflect the very low levels of access all AHPs have to AHAs to support their clinical work in this service and the limited focus maternity services have had in general on their allied health workforces to date.

Graph 5: Tertiary maternity collaboration quantification of AHA time identified by discipline (% of total EFT)
Strategic plans for integrating the allied health assistant workforce

Project leads utilised the quantitative and qualitative project data, combined with the outcomes of extensive stakeholder consultations to inform the development of strategic plans for growing and integrating the AHA workforce.

These strategic plans provide an evidence-base and agreed approach for the introduction of AHA roles within the participating organisations over the next four to five years. The plans are staged through short, medium and long term goals. The strategic plans will assist organisations to develop and grow their allied health services and workforce in an informed and strategic way, as funding becomes available through local reallocations or potential future funding rounds (both state and national).

A number of themes and innovations, involving the introduction of amended or new AHA roles, were common across several stage 2 strategic plans. These include:

- Interdisciplinary AHA roles in oncology, social work/pastoral care and social work/psychology, orthopaedics and AHAs in pre-admission clinics
- AHA roles in audiology, play therapy, lymphedema, palliative care, speech pathology, physiotherapy, dietetics and podiatry
- Realignment of existing AHA roles to utilise the full scope of practice
- Expanding allied health services to include multidisciplinary AHAs employed on weekends
- AHA leadership & operational roles to manage the AHA workforce, including AHP managers with AHA portfolio and/or operational responsibility
- Implementation of AHA workforce governance frameworks including credentialing and a scope of practice guide
- Development of AHA position descriptions and competencies
- Formalisation of supervision and delegation models
- Developing and embedding AHA career pathways, structures and professional development opportunities
- Increasing capacity to undertake AHA student placements
- Delivery of clinical supervision skills training for AHPs supervising AHAs
- Development of an e-learning package for AHPs working with AHAs
- Completion of an AHA skills audit

In addition the tertiary maternity collaboration also identified a number of innovations and key themes to:

- introduce or increase AHA EFT in all maternity services
- up-skill existing maternity Grade 3 AHAs to complete Diastasis Recti Abdominal Muscle checks, provide transcutaneous electrical nerve stimulation education and third degree tear information and to run post natal classes.
- increase the capacity of the allied professional workforce to enhance their scope of clinical practice and research, aligned with the organisations’ strategic plan and broader community health care needs
- develop an AHA governance framework for maternity settings
- develop an interdisciplinary women’s health AHA role
- continue to collaborate, share and develop resources across the tertiary maternity organisations.

Similar to the outcomes of stage one, the vast majority of strategic plans from stage two also included provisions to support the development and implementation of formalised supervision and delegation governance structures within organisations. This may suggest that while the original staff workforce survey results indicated a high level of AHP confidence in delegating tasks to AHAs, it is likely that AHPs did not fully realise the contribution and value-add AHAs could bring to the delivery of services. While this reinforces the findings from stage one, it also highlights a key long-term benefit of the program. Increased awareness of AHA’s contributions will also ensure the wider uptake and integration of the assistant workforce into allied health in the future.

A number of organisations identified a need for tailored clinical supervision training for AHPs supervising AHAs. To directly address this identified training gap, and to ensure a consistent approach to supervision training is accessible and applied across Victoria, the department, in partnership with Wodonga Institute of TAFE, delivered a training program to support the supervision of Victorian AHAs in May and June 2014. These workshops used the framework to build on AHPs’ knowledge of the AHA role and provide them with practical
clinical supervision and delegation skills. Tailored workshops also offered Grade 3 AHAs the opportunity to develop practical skills in supervision and leadership.

The workshop series was well attended; with 77 AHAs and 219 AHPs from across Victoria participating in the training. Feedback indicated that the workshops equipped participants with practical skills in determining appropriate tasks for delegation, confidently delegating a specific task and effectively supervising the delegated task. It also formed an excellent platform for the facilitation of valuable conversations between practitioners from different health services, leading to the sharing of information and the cross-fertilisation of ideas. In the longer-term there would be benefit in considering how these skills might be included in undergraduate qualifications for future AHPs.

As previously noted, there were considerable similarities in key themes from the strategic plans from stages one and two, particularly in relation to the development of robust structures and governance frameworks to support the introduction of new and amended AHA roles. Key themes across stages also included the development of interdisciplinary AHA roles, professional development opportunities and AHA career pathways. The department will continue to maintain relationships with project participants through existing networks and will seek to make resources and case studies of successful roles and approaches available where possible.

**Broader program outcomes**

An independent evaluation of the three stages of the AHA Implementation program is planned for 2015-16. This will measure the medium-term outcomes of the program, including those relating to the introduction of new or amended AHA roles. Similar to stage one, a number of stage two sites have already reported some broader program outcomes that have emerged, demonstrating the more immediate positive impacts of the program and approach.

**Focus on allied health**

Despite allied health playing a pivotal and growing role in the delivery of acute and subacute services, planning for the expansion of these services, and the creation of new services, can often overlook the valuable contribution AHAs can make to the allied health team. This program has provided participating organisations with an opportunity to focus their attention on their allied health workforce and strategically plan for the future of this workforce in a collaborative, inclusive, evidence-based and structured way. Feedback from some stage two sites has indicated that AHAs, and the tasks they can undertake, is now being explicitly considered when looking at the development and delivery of new allied health services within their organisations.

The program has encouraged and facilitated new ways of thinking in relation to the AHA workforce, the disciplines they operate in and the contribution they can make. It has challenged an assumption held by a number of AHPs that AHAs only work with more traditional disciplines such as physiotherapists and occupational therapists, has raised the potential of AHA roles being created in other allied health disciplines and services and has helped to identify opportunities for roles to operate across disciplines.

One stage two organisation has advised that they have successfully utilised their program data to support a business case for the creation of a new AHA role within their hydrotherapy program. This AHA role has been implemented as additional allied health EFT and has supported the increased provision of allied health services to the community. The scope of the role is focused on tasks identified by allied health staff, including AHPs, through the program.

Robust program data has also been used to support the introduction of three Grade 3 AHA positions in occupational therapy, physiotherapy and speech therapy in an organisation that did not previously employ any Grade 3 AHAs at program commencement. The program has enabled an informed review of existing services and roles and has led to a re-grading existing Grade 2 AHA positions to better meet service demand. One of the reported benefits of the introduction of these roles is the ability to develop a structure, and provide capacity, to take on AHA student placements, commencing 2015.

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Feedback received from one organisation has also identified that participation in the program, especially through the consultation and strategic plan development process, helped to inform the introduction of a new AHA role in an area outside of their stage two program scope. This reflects a broader recognition of the potential value AHAs can bring to service delivery across many areas of an organisation.

There is keen interest in the implementation of new AHA roles in maternity services from a number of organisations within the tertiary maternity collaboration. Opportunities to introduce new roles as part of the strategic plan implementation process are currently being explored. This is in addition to current allied health EFT.

Similar to stage one, AHPs from stage two who have not previously worked with AHAs, greatly benefited from participating in the program focus groups as they enabled them to hear about, and discuss, the kinds of tasks that AHAs were undertaking in other disciplines. AHPs who participated in the program also reported that they felt more confident identifying tasks that could be delegated to AHAs and had developed a greater understanding of the scope of the AHA role. This has been further enhanced through their participation in the department's training to support the supervision of Victorian AHAs.

AHAs in participating organisations have reported that the implementation of the framework and the program has raised the profile of AHAs as valued members of the healthcare team. This has included AHA staff being supported to undertake professional development opportunities such as attendance at the Victorian AHA Conference 2013 and the department's training sessions to support the supervision of Victorian AHAs. Feedback has also indicated that participation in the program has led to some organisations reviewing their orientation processes for AHAs (which in some cases were non-existent) and aligning them with the processes established to orientate new AHPs.

**Communication and collaboration**

The program has facilitated high levels of collegiality and communication regarding the AHA workforce across stage two organisations.

In recognition of the similarities between strategic plan priority areas, and the broader benefits of continuing the relationships built over the course of the program, all 11 participating health services, Alfred Health, Monash Health and the department has established a cross organisational metropolitan Allied Health Assistant Working Group. This includes the tertiary maternity collaboration. The purpose of this group is to collaboratively develop and integrate the AHA workforce and provide a forum for communication, consultation and a platform for resource sharing and innovation.

This is a significant outcome of the project and provides a valuable ongoing platform to support collaborative work between health services. This echoes the ongoing cluster relationships from Stage one and may provide an approach that can be built upon by the department in other initiatives.

**Informing future activities**

In recognition of the value and positive outcomes of the program, six stage two organisations (with community and/or ambulatory services) have partnered with other metropolitan community services to form metropolitan sub-region hubs as part of stage three of the program.

Early feedback has also indicated that the effect of the program, and its focus on AHAs, has been felt beyond the participating organisations including in the private sector, where the broader benefits, flexibility and potential of AHA roles in allied health service delivery have been recognised.

There is also potential, in the future, to expand the use of the overarching principles and elements of the Model to other workforces. However, further work to scope and evaluate this potential is required.

The program resources from all three stages will be packaged and made freely available for health and

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community services interested in implementing the Model at the completion of stage three of the program. This will ensure that organisations that did not participate in the program, or organisations that wish to repeat the methodology in another department, or at a future point in time, will have free access to all the guidance materials, templates, surveys, tools and databases to support this process.

**Conclusion**

The AHA Implementation Program is underpinned by a collaboration-based approach within and between health and community services. It has directly influenced the professional culture of participating organisations by involving all key stakeholders, including allied health staff, ensuring they are an integral part of the process to develop a sustainable workforce solution and shared vision for the future. The model has enabled these organisations to identify an evidence-based practical approach to develop integrated teams of AHPs and AHAs working to their full scope of practice. This approach will be implemented in the short, medium and long-term, so while participating organisations have already reported some positive impacts, the full impact of the program will not be felt for some time.

Stage three of the program is due to conclude in April 2015 and will represent the end of the formal implementation phase of the program. An evaluation in 2015-16 will capture the outcomes relating to the Model and introduction of new AHA roles and services and will seek to understand the broader productivity impacts enabled by the program.

**Further information**


Appendix

Program background

The allied health workforce is an essential component of the health workforce, and the demand for allied health services will continue to increase with the ageing of the population, the growing burden of chronic disease and an increasing emphasis on the delivery of multidisciplinary care. In responding to this challenge, we must consider new service models that use our allied health workforce to the best effect, and acknowledge the important role these service models will play in meeting evolving and increasing service demands.

While the AHA workforce has operated in Victoria for many years, the sector is now recognising the enormous benefits these roles can bring to the delivery of allied health services across a broad range of disciplines, settings and program areas. Improved utilisation of the AHA workforce will help to alleviate some of the increasing demand on allied health services, provide improved access and continuity of service to clients and, in turn, support more advanced practice opportunities for AHPs, all of which will have a positive impact on the retention of AHPs.

Since 2005 the department has implemented a range of initiatives to support the increased uptake and utilisation of the AHA workforce. These have included:

- grants to support the development and uptake of AHA related training,
- the development and implementation of pilots to trial and evaluate new innovative AHA roles and service delivery models; and
- the development of guidelines, frameworks, resources and workshops to increase the sector’s understanding of the AHA role and the value-add it can bring to allied health service delivery.

The AHA Implementation Program draws on, and builds upon, this important work.

Victorian Assistant Workforce Model (allied health)

The ‘Victorian Assistant Workforce Model (allied health)’ (the Model) was developed and piloted by Alfred Health during 2009-2011. The original Alfred Health methodology was published in the Guidelines to scope and introduce new allied health assistant roles (the Guidelines). The first four steps of the Guidelines have been expanded, adapted and contextualised to support the implementation of the program. These steps form the foundation of the Model.

The Model (figure 1) is designed to increase participating AHPs’ understanding of the AHA role and the benefits that AHAs can bring to the delivery of allied health services.

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Central to the Model are three overarching principles; change management, organisational priorities and consultation. These principles resonate through all phases of the Model.

**Overarching Principles**

<table>
<thead>
<tr>
<th>Change Management –</th>
<th>Consultation –</th>
<th>Organisational Priorities –</th>
</tr>
</thead>
<tbody>
<tr>
<td>Understanding the drivers for change and the importance of strong leadership, key stakeholder engagement, and allied health staff consultation is essential to the program’s success and an integral part of the process to develop a sustainable workforce solution and shared vision for the future.</td>
<td>Identifying organisational governance structures and consulting and communicating with key stakeholders, including allied health staff, through formal and informal opportunities throughout the program is vital to the project management process and crucial to the success of the program and change management process.</td>
<td>Developing a clear understanding of organisational priorities is required to ensure that the program is contextualised and relevant to your local organisation. This is an important link throughout the program consultation and quantification process and will inform planning to successfully integrate the AHA workforce to support and meet service demands.</td>
</tr>
</tbody>
</table>

**Model elements**

The Model consists of six key elements (figure 2): project initiation, staff engagement, data collection, data analysis, strategic planning and finalising the project and next steps. Each element has been incorporated into three integrated phases that form the foundation of the model; inform and engage, investigate and analyse and strategic and future planning.
Figure 2: Victorian Assistant Workforce Model Elements

1. Project initiation
   Establish organisational governance framework including project scope, project plan, risk management plan and communication strategy.

2. Staff engagement
   Actively engage and inform allied health staff of the project drivers, background and aims and links to organisational strategic priorities. Activities include staff engagement forums, focus groups and informal meetings. The element, and ongoing communication through the project, is critical to the Model's change management methodology.

3. Data collection
   Collect quantitative and qualitative data, which will be used to complete a needs assessment and analysis of potential AHA workforce growth across allied health services within project scope.

4. Data analysis
   Use data to determine the scale of need for amended and new AHA roles and service delivery models utilising the full AHA scope of practice. Based on this evidence, identify priority areas in preparation for strategic planning.

5. Strategic planning
   Condense project findings into an evidence-based strategic plan for sustainably incorporating and integrating AHA into an appropriate workforce skill mix, consistent with organisational priorities and governance.

6. Project Finalisation and next steps
   Communicate project findings and promote strategic plan priorities to executives, allied health managers, staff and other key stakeholders. Embed ongoing mechanisms for sustainably implementing the strategic plan post-project.