Working Well: Tailoring a workforce development model to deliver sustained improvements in community-controlled health care.

Project Report for Gurriny Yealamucka Health Service

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Disclaimer

The purpose of this report is to assist Gurriny to assess their workforce development capacity and performance. We have relied upon information provided to us by Gurriny management and staff, have evaluated the information and believe that it is reliable. The statements and opinions included in this draft report are given in good faith and in the belief that such statements and opinions are not false or misleading.

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CONTENTS

FIGURES

Acronyms and abbreviations used in this report

ACCHO	Aboriginal Community Controlled Health Organisations
CANZUS nations	Canada, Australia, New Zealand and the USA
CHRs	Community Health Representatives
Gurriny	Gurriny Yealamucka Health Service
IHW	Indigenous Health Workers
PHC	Primary Healthcare
QH	Queensland Health
SEIFA	Socio-Economic Indexes for Areas
SEWB	Social and Emotional Wellbeing

Working Well: Tailoring a workforce development model to deliver sustained improvements in community-controlled health care.

> *"Our vision is to provide and maintain the health and wellbeing of all people in the community of Yarrabah and surrounding areas by providing a community-based, community-controlled Aboriginal health service in a culturally sensitive manner".*
>
> *Gurriny Yealamucka Health Service.* http://gyhsac.org.au/

SECTION 1: EXECUTIVE SUMMARY

Staffing levels, retention and turnover were the top challenges listed by Indigenous primary healthcare (PHC) services nationally in Online Services Reports to the Australian Institute of Health and Welfare in 2014-15 (Australian Health Ministers' Advisory Council, 2017). Indigenous PHC services in regional areas, particularly, face 'system wide shortages' of healthcare professionals (Commonwealth Department of Health and Ageing, 2008), as well as disciplinary silos and restrictions imposed by different funding streams and governance models (Australian Health Ministers' Advisory Council, 2017; S. Larkins, Panzera, A., Beaton, N., Murray, R., Mills, J., & Coulter, 2014; Panzera et al., 2016). Indigenous PHC, who most require healthcare, face particularly acute workforce shortages (S. Larkins, Sen Gupta, Evans, Murray, & Preston, 2011). 'Working well' responds to a call for enhancement of the health workforce and workforce systems of one Indigenous PHC: Yarrabah's Gurriny Yealamucka Health Service (Gurriny).

Gurriny assumed community control of PHC services from Queensland Health on 1 July 2014. Since transition, Gurriny has grown employment of local people by more than 75% to improve culturally safe healthcare to Yarrabah's 3,394 clients, and has achieved optimal practitioner to client ratios and workforce stability in some areas (McCalman & Jones, 2015).

However, multiple funding sources with separate agendas and accountabilities have created disjointed workforce planning (S. Larkins, Panzera, A., Beaton, N., Murray, R., Mills, J., & Coulter, 2014). At the start of this project in 2017, Gurriny management considered that further improvements were required in: Indigenous leadership, capacity, competencies, strengths, wellbeing, roles/ professions, coordination, responsibility, control, accountability, liability, performance, retention, progression, underpinning systems and impact. Such issues are common to many Indigenous PHC services.

Defining an optimal workforce model for improved healthcare delivery is challenging (S. Larkins, Panzera, A., Beaton, N., Murray, R., Mills, J., & Coulter, 2014). Health workforce issues are complex and multifaceted, with no one clear best practice approach, or one size fits all option (S. Larkins, Panzera, A., Beaton, N., Murray, R., Mills, J., & Coulter, 2014; Panzera et al., 2016). The National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework 2016–2023 identified six priority areas for building a strong and supported health workforce. These are: 1) recruitment and retention of Indigenous health professionals; 2) skills and capacity of the Indigenous workforce; 3) culturally-safe and responsive workplace environments; 4) recruitment of Indigenous students in health; 5) Indigenous students' completion/graduation and employment rates; and 6) information for health workforce planning and policy development (Australian Health Ministers' Advisory Council, 2017). Previous projects have shown that workforce factors (stability, leadership and teamwork) along with collaborative quality improvement approaches as key reasons for health service quality improvement (S. Larkins, Panzera, A., Beaton, N., Murray, R., Mills, J., & Coulter, 2014).Building capacity requires tailoring to local need; identifying what works, for whom, and why. Following Larkins et al. (2014), this report evaluates the state of Gurriny's workforce development in 2018.

The research comprised three steps:

1. A systematic scoping review of the literature to identify Indigenous PHC workforce models in Canada, Australia, New Zealand and the United States (CANZUS nations) and their enabling conditions, strategies and impacts;

2. Retrospective mapping of change in workforce characteristics against evidence-informed workforce management systems (from transition to community-control in 2014-2017);

3. A grounded theory analysis informed by 1 and 2 plus interviews/yarning circles with staff and key stakeholders about what works well, what does not, and how improvements can be made; developing a workforce model.

Results

Systematic scoping review

The systematic scoping review of the literature found 28 studies that described or evaluated models and systems that support the sustainability, capacity or growth of the Indigenous PHC workforce to provide effective PHC provision. No study reported a "one size fits all" model of workforce development in Indigenous PHC. Studies reported enabling conditions for workforce development as government funding and appropriate regulation, support and advocacy by professional organisations; community engagement; PHC leadership, supervision and support; and practitioner Indigeneity, motivation, power equality and wellbeing. Strategies focused on enhancing recruitment and retention; strengthening roles, capacity and teamwork; and improving supervision, mentoring and support. Only 12/28 studies were evaluations, and these studies were generally of weak quality. These studies reported impacts of improved workforce sustainability, workforce capacity, resourcing/growth and healthcare performance improvements. The review concluded that PHCs can strengthen their workforce models by bringing together healthcare providers to consider how these strategies and enabling conditions can be improved to meet the healthcare and health needs of the local community. Improvement is also needed in the quality of evidence relating to particular strategies to guide practice.

Workforce mapping

The numbers of staff and mix of workforce skills required to maintain service delivery under Gurriny's current model of care has grown considerably since the organisation's transition of PHC services to community control. Overall, staff numbers increased by 71% from 44.5 FTE in 2013-14 to 61.5 FTE in 2014-15, 54 FTE in 2015-16 and 76.0 FTE in 2017-18. Gurriny has actively recruited local Yarrabah health professionals and operational staff. The proportion of local people employed has been maintained at high levels, with 58/76 (76%) positions filled by Indigenous people in 2017-18. The composition of the Gurriny workforce has also changed. The focus of additional positions has been in management, drivers,

administrative/clerical, cleaning, health worker, medical, nursing, drug and alcohol worker, health promotion and health trainee positions.

Interviews with Gurriny Staff

Interviews conducted with 17 Gurriny staff members from various positions in the organisation provided staff members' perspectives on what is working well and what could be working better to build a strong workforce. The conditions, strategies, enablers and barriers of Gurriny's workforce development were identified.

The key *conditions,* or contextual factors that influenced Gurriny's workforce development include macro societal-level factors such as broad political and economic systems, and health and social inequities experienced by Indigenous people in Australia and internationally. As well, conditions operate at community, PHC service, and individual levels. For example, the transition of primary healthcare services in Yarrabah to community control has led to significant organisational growth with a large increase in employment, including of local Yarrabah community members, and the provision of a wide array of comprehensive PHC services and programs. These changes, while enabling, building and strengthening Gurriny and its workforce, have also brought challenges such as changes in the workforce culture and a degree of change fatigue, especially among local staff who have been with Gurriny throughout the transition process and beyond.

The core process for Gurriny's workforce development was identified as *growing a stable, capable and cohesive/collaborative workforce that is responsive to community health needs*. Four key *strategies*, or actions that are, and can be, taken to help strengthen this core process were identified. They were *strengthening workforce stability, having strong leadership, growing capacity* and *working well together*. Each of these core strategies contain further sub-strategies that outlined the specific ways in which Gurriny supports its workforce well, and the ways this could be improved.

Enablers, or factors identified by staff which support Gurriny in their process of implementing the outlined strategies to grow a strong workforce and *barriers*, or factors which make it more difficult for Gurriny to strengthen their workforce are also multi-level; existing at macro, community, PHC and individual levels.

Recommendations

Strengthening workforce stability

- Improve work conditions at Gurriny by ensuring that staff members are paid appropriately and consistently across equivalent roles.
- Fill workforce gaps for Nursing and male Health Worker workforce as priorities.

Having strong leadership

- Provide greater leadership clarity and direction through manager/coordinator positions for Nurses and Health Workers, and more clearly differentiated lines of leadership responsibilities and role boundaries.
- Provide leadership encouragement and positive feedback in formal and informal ways to make staff members feel more valued.
- Promote a learning culture, creating more space for staff members to bring in new ideas.
- Bring Gurriny staff along on the journey of organisational growth and improvement by improving staff understanding of "the Big Picture" PHC and Aboriginal Community Controlled Health Organisations (ACCHO) sector, policy, funding and regulation contexts; communicating to staff how these impact on what Gurriny can do, as well as its strategic direction, in a way that is understood by staff.
- Ensure that staff members feel listened to and heard through consulting them on changes, raising concerns, and sharing ideas to have input into Gurriny decisions and strategic direction, and following through on staff input and feedback.

Growing capability

- *S*trengthen local leadership by providing improved career progression pathways, raising up the next generation of leaders, raising the vision of health worker, and being clear about the role that non-Indigenous professional staff have to play in local staff capacity development.
- Strengthen support for the development of staff capacity through clear, transparent and fair systems for allocating professional development opportunities, and supporting the maintenance of clinical skills and professional requirements.

Working well together

- Strengthen Gurriny's communication systems and structures to facilitate communication about a range of things including managers roles and responsibilities, role expectations and professional development opportunities.
- Support Gurriny staff in getting along together by encouraging and facilitating staff to work outside of role and program boundaries, creating more opportunities for cross-organisational bonding, and facilitating greater understanding about expectations and the impacts of personal circumstances.

SECTION 2: PROJECT BACKGROUND

The Yarrabah community

Yarrabah is the largest Aboriginal community in Australia, located 52 kilometres by road, but only 11 kilometres by sea from Cairns. The traditional custodians of the area are the Gunggandji people. According to census data the community is home to 2700 residents (Australian Bureau of Statistics, 2016); however, local estimates place the population at around 4000. Yarrabah was ranked Australia's most disadvantaged local government area in 2011, based on the Socio-Economic Indexes for Areas (SEIFA). SEIFA is a measure of people's access to material and social resources (Australian Bureau of Statistics, 2014).

Figure 1. Yarrabah

Source: Bentleys (2014)

In 2014, management and accountability for PHC services in Yarrabah were transferred from Queensland Health (QH) to community control through Gurriny. Community control is gaining momentum in Australia, but Indigenous PHC service providers face significant workforce challenges including maintaining adequate staffing levels, and retention and turnover of staff.

Gurriny Yealamucka Health Service

With 3,394 client contacts (2014-15), Gurriny is ranked nationally as a large PHC service, defined as having more than 3,000 clients (Australian Institute of Health and Welfare, 2015a). Only (24%) of PHC services nationally, and nearly half (46%) of the organisations in Queensland, are considered large. Gurriny is located at three sites in Yarrabah—the main primary health clinic building in a tranquil situation in Bukki Road; an administration and SEWB building in Workshop St and another building used for workshops, meetings and other purposes in Noble St. The clinic at Gurriny is open Monday to Friday from 8.30am to 4pm—except for Thursdays, when it closes at 12 noon. Most clients use the Gurriny bus, or seek transport by car, as the Yarrabah community is too spread out for walking to the clinic to be an option. After hours, advice is provided by phone and there is also an intercom at the front entrance for communication with emergency staff.

Project funding and staff

The Working Well project was funded by Lowitja Institute – Australia's National Institute for Aboriginal and Torres Strait Health Research. The need for the project was identified by Ms Ruth Fagan, Business Development Research Manager at Gurriny. Ms Fagan worked with Associate Professor Janya McCalman, from the Centre for Indigenous Health Equity Research (CIHER), Central Queensland University, to develop a successful application for the 2017 competitive research funding round at Lowitja Institute. In January 2018, CIHER employed Dr Sandra Campbell to oversee the conduct of the study at Gurriny.

SECTION 3: PROJECT METHODOLOGY

'Working well' is embedded in a collaborative strengths-based model with engagement and translation at the heart of the methodology (The Lowitja Institute, 2016). The approach emphasises relationship as core and positions 'subjects' as co-researchers (Roxanne Bainbridge, McCalman, Tsey, & Brown, 2011; Bender, Edwards, Kahwa, & Kaseje, 2016). Ethical approval was provided by Central Queensland University, approval number HREC 0000020904.

At the start of the project, Gurriny posed challenging questions including:

- What professions, skill sets, experience and understandings are needed to meet healthcare demand;

- How can the workforce be structured to balance demands for urgent and acute healthcare as well as for ongoing health promotion;
- Is it more effective for staff to be program-focussed or patient focussed;
- What does the concept of Indigenous leadership in healthcare mean, particularly given legal restrictions on health worker practice in Queensland;
- How do Indigenous staff members manage responsibilities e.g. community expectations;
- What makes staff members want to stay, and how can career pathways be built; and
- What systems, frameworks and investment are needed to support staff development and wellbeing?

To answer these and other relevant questions, the 'Working well' research at Gurriny Yealamucka Health Service comprised three steps:

Step 1: A systematic scoping review of the English language scientific literature was conducted using methods recommended by the *Cochrane Collaboration*, to identify Indigenous PHC workforce models in Canada, Australia, New Zealand and the United States (CANZUS nations) and their enabling conditions, strategies and impacts. Search terms and exclusion criteria were defined in collaboration with Gurriny.

Eleven databases of peer-reviewed literature, 10 websites/clearinghouses, and 5 literature reviews were searched for relevant studies from CANZUS nations published in English from 2000-2017. The search strategy is outlined at Appendix 1. A process of thematic analysis was utilised to identify key conditions, strategies and outcomes of Indigenous PHC workforce development as reported in the literature.

Findings were used to inform the development of an interview guide for Gurriny staff in step 3, and a paper was submitted to *BMC Health Services Research*.

Step 2: Changes in Gurriny workforce characteristics were mapped against the evidence of Indigenous PHC workforce management systems. Baseline (pre-transition to community control in 2014) was established using routine data from the national Online Services Reports, other Gurriny data, and a participatory health workforce planning analysis of Larkins et al. (2014). This analysis found that while Gurriny had the workforce numbers required for continuity of service through transition (Bentleys, 2014), there was a shortage of available health workers and allied health workers, and gaps in capacity to manage chronic

disease, and integrate child and youth health and other services (S. Larkins, Panzera, A., Beaton, N., Murray, R., Mills, J., & Coulter, 2014). Annual data (where available) were mapped thereafter to demonstrate changes in workforce characteristics (numbers, professions, Indigeneity etc.).

Step 3: Using participatory action research and grounded theory methods, we theorised the pathways to strengthening the Indigenous PHC workforce by examining the interplay of personal characteristics, workplace environments and systems, and community health needs and expectations that develop, sustain and limit workforce capacity to provide ongoing improvements in healthcare service provision. With the oversight of and coordination by Gurriny staff, we began with a purposive sample of Gurriny management, clinical, SEWB and operational services' staff. Guided by themes/issues identified in step 1 and 2, we conducted interviews and participatory action research yarning circles with staff and community stakeholders to generate data. Theoretical sampling followed based on emergent issues. In total, interviews were conducted with 17 Gurriny staff members to get perspectives on what is working well and what could be working better to build a strong workforce. To get a wide range of perspectives, interviews were conducted with staff from various organisational positions, including senior managers and middle managers, and front-line workers from the clinical, health promotion and social and emotional wellbeing teams. Staff interviews included local Indigenous stall and non-Indigenous staff members. Interviews were conducted by one researcher and audio recorded. Recorded interviews were de-identified and then transcribed by a professional transcriber, and imported into the qualitative data analysis software NVIVO, where a second researcher analysed them for their key themes. While the majority of the data presented in this analysis come directly from staff interviews for this project, some of the contextual factors outlined in the conditions were informed by a concurrent project being undertaken by the research team with Gurriny regarding their experience of transitioning to community control.

Constant comparative grounded theory methods (Roxanne Bainbridge, McCalman, & Whiteside, 2013; Charmaz, 2014) were applied to identify the process pathways underlying processes and systems to strengthen the workforce, and mapped in a causal-consequence model (Roxanne Bainbridge et al., 2013; Glaser, 1978). Using Grounded Theory analysis key themes regarding the conditions, strategies, enablers and barriers of Gurriny's workforce were identified. These are reported in the following sections. The critical output is evidence

to inform PHC models of workforce development. We developed a cohesive theoretical narrative for strengthening a workforce that is adaptable to changing health needs and service delivery environments; optimising access to health care; and continuing to build cultural safety and responsiveness. A grounded theory paper will also be submitted to *BMC Health Services Research*

SECTION 4: PROJECT RESULTS

Literature review to inform the Working Well project

Background

A strong and effective workforce is needed to underpin comprehensive PHC efforts by PHC services. Such a workforce requires stability, leadership, role clarity, support and coordination (Gwynne & Lincoln, 2017; S. Larkins, Panzera, A., Beaton, N., Murray, R., Mills, J., & Coulter, 2014). Yet PHCs face challenges in defining and operationalising an optimal workforce model that responds to the changing need for healthcare delivery (S. Larkins, Panzera, A., Beaton, N., Murray, R., Mills, J., & Coulter, 2014). PHCs and the workforce models that underpin them continue to be framed mainly to address acute conditions (Australian Institute of Health and Welfare, 2016; Nuño, Coleman, Bengoa, & Sauto, 2012). Yet they are also faced with a high and increasing burden of chronic disease in the populations they serve. Addressing chronic disease and wellbeing creates a greater demand for patient-centred care, community-based health services, and personalized long-term care (World Health Organisation, 2017). Health workforce strategies therefore increasingly need to incorporate health promotion, prevention, treatment, rehabilitation and palliative care services, and to work through team-based care (World Health Organisation, 2017).

International studies have suggested that attention to workforce issues such as leadership, motivation and support can make or break efforts to improve healthcare delivery. One study theorised five key workforce development strategies: 1) recruiting staff with skills in service transformation; 2) redesigning and creating new roles; 3) enhancing workforce planning; 4) linking staff development to service needs; and 5) creating opportunities for shared learning and knowledge exchange (Macfarlane et al., 2011). Workforce development clearly requires

multifaceted strategies, but there is no one size fits all option (S. Larkins, Panzera, A., Beaton, N., Murray, R., Mills, J., & Coulter, 2014; Panzera et al., 2016).

For Indigenous PHC, the need to respond better to chronic disease is clear. In Australia, for example, the burden of chronic diseases comprises 70% of the health disparity between Indigenous and other Australians (Vos, Barker, Begg, Stanley, & Lopez, 2009). However, there is added complexity in developing and implementing workforce improvement efforts. Cross-cultural competence in professional and patient relationships, knowledge of Western and Indigenous systems, a need for developing the Indigenous health workforce and valuing of and commitment to Indigenous health should all be considered (Jongen, McCalman, & Bainbridge, 2018; Jongen, McCalman, Bainbridge, & Clifford, 2018). Indigenous frameworks, such as the national Australian Indigenous health workforce development framework, focus particularly on supporting the pipeline of Indigenous graduates into health professions, supporting their recruitment, retention, skills and capacity; and providing culturally safe and responsive workplace environments through workforce planning (Australian Health Ministers' Advisory Council, 2017).

Several reviews of the Indigenous PHC workforce literature describe conditions and strategies that influence strategic human resource management efforts that in turn, aim to achieve improved healthcare performance (Gleadle et al.; Gwynne & Lincoln, 2017; Onnis & Pryce, 2016). Government policies determine the availability of resourcing for workforce development efforts, but disciplinary silos and restrictions imposed by complex funding streams and governance models create challenges in developing consistent, integrated workforce models (Australian Health Ministers' Advisory Council, 2017; S. Larkins, Panzera, A., Beaton, N., Murray, R., Mills, J., & Coulter, 2014; Panzera et al., 2016). ‘System wide shortages’ of healthcare professionals are apparent, particularly in regional and remote locations (e.g. Commonwealth Department of Health and Ageing, 2008). Reviews from Australia and the U.S.A. found that Indigenous health practitioners are often underrepresented and underutilised (Gwynne & Lincoln, 2017; Islam et al., 2015). Training pathways, qualifications and efforts to improve inclusiveness and cultural safety are also needed (Gwynne & Lincoln, 2017; Islam et al., 2015). For non-Indigenous professionals, longevity required clinical experience and access to professional development; supervision and peer support; and cultural competence and perceived connectedness with the community in which they were located (Gwynne & Lincoln, 2017). Strengthening workforce capacity

requires tailoring broad approaches to local need; identifying what works, for whom, and why.

This paper reviews the Indigenous PHC workforce literature to inform the efforts of Gurriny for enhancement of their health workforce environment and systems. Multiple funding sources, with differing agendas and accountability requirements have contributed to disjointed workforce planning approaches (S. Larkins, Panzera, A., Beaton, N., Murray, R., Mills, J., & Coulter, 2014). Gurriny management aims to implement workforce enhancements to further strengthen the workforce and provide a model of healthcare focused on early intervention and health education. The issues entailed are common to many Indigenous PHCs (Australian Health Ministers' Advisory Council, 2017).

This review examines the literature from CANZUS nations on workforce models and systems that support the effectiveness, sustainability and/or growth of the Indigenous PHC. The research question was: What workforce models have been developed and/or implemented in Indigenous PHCs in Canada, Australia, New Zealand and the United States? The objectives were to: 1) Report on the quantity and nature of available literature; and 2) Identify the enabling conditions, strategies, challenges and impacts of implementing workforce models for Indigenous PHC.

Results

The systematic search resulted in twenty-eight publications being included. Most included papers were published in the five years 2013-2017 (15/28 or 54%) (Figure 2).

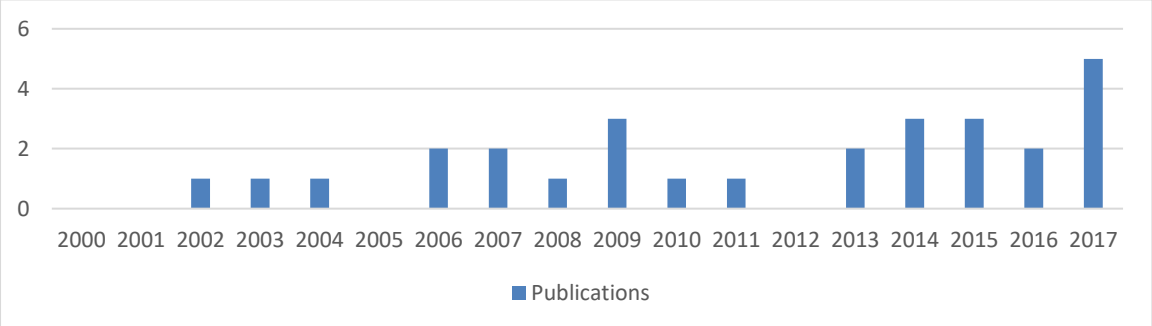


Figure 2. Publications by year

Country of origin

The majority of the studies (n=19; 68%) were published by researchers in Australia; five (n=5; 18%) in the USA; and two each in Canada and New Zealand.

Study design/quality

No best practice intervention studies (level 1 and 2, Figure 2) were found. We found 12 studies of promising practices (level 3, Figure 2) (Browne, Thorpe, Tunny, Adams, & Palermo, 2013; Chernoff & Cueva, 2017; Conway, Tsourtos, & Lawn, 2017; Cramer, 2006; Gampa et al., 2017; King et al., 2017; Lloyd, Wise, & Weeramanthri, 2008; Nagel, 2009; Panzera et al., 2016; Schmidt, Campbell, & McDermott, 2016; Weymouth et al., 2007; Zhao et al., 2017). These included: mixed methods studies; cross sectional evaluations; studies based on grounded theory or thematic analyses of interviews, focus groups and/or project or other documents; action research/continuous quality improvement approaches; and a dynamic regression analysis of workforce payroll and financial data across clinics. We also found 16 studies of emerging practices (level 4, Figure 2). These were program descriptions, commentaries and concept papers, personal reflections, policy briefs and strategic plans.

Workforce participants

More than half of the studies (16/28 or 57%) focused exclusively on Indigenous health practitioners (Figure 3). Ten of these studies focused on the roles of Indigenous Health Workers (IHW); three on specialist Indigenous health workers in child, mental health and alcohol and drug work; one on traditional healers; and two on Indigenous nurses. Indigenous health workers were variously named Māori Community Health Workers, Community Health Representatives, Paraprofessional Health Workers, Aboriginal Health Workers and Community Health Workers. The remaining 12 (43%) studies focused on the general (Indigenous and non-Indigenous) workforce or teams within Indigenous PHC (n=8), doctors (n= 1), nurses (n= 2) and physicians assistants (n=1).

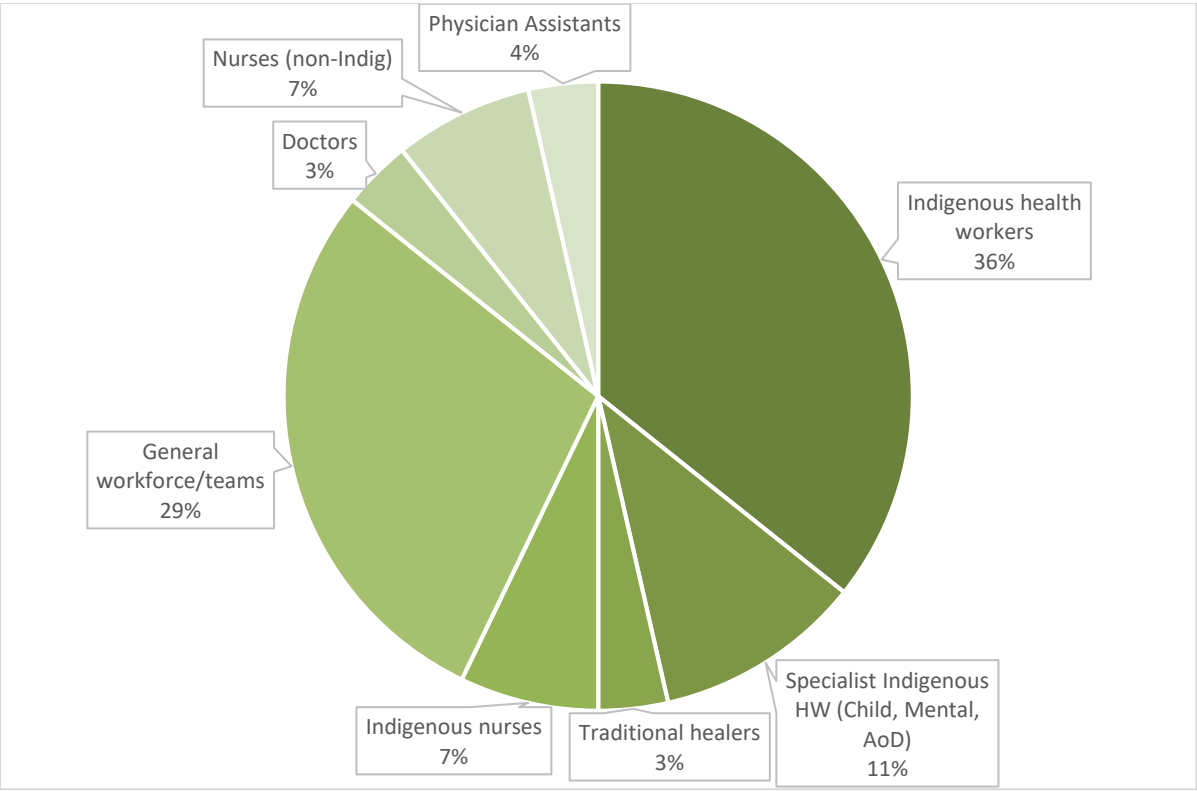


Figure 3: Workforce type

Characteristics of study interventions

The studies encompassed varied geographical locations (remote, rural and urban) and professional groups, but all 28 studies evaluated or described workforce models that were developed and/or implemented in Indigenous PHC. The studies' aims, conditions, strategies and impacts summarised in Table 1 below.

Table 1: Summary of study aims, conditions, strategies and impacts

	Aim	Conditions				Strategies			Impacts			
	Workforce development/support	Govt. & professional org. policies	Communities & cultures	PHC policies & environments	Characteristics of health	Recruitment & retention	Roles, teamwork & capacity	Supervision, mentoring &	Workforce capacity	Workforce sustainability	Resources to enable growth	Healthcare improvements
(Ahuriri-Driscoll et al., 2015)	X	X	X		X			X				
(Boulton et al., 2009)	X		X	X			X	X				
(Browne et al., 2013)	X			X	X			X	X			

(Chernoff & Cueva, 2017)	X						X				X	
(Conway et al., 2017)	X		X	X	X		X	X		X		X
(Cramer, 2006)	X			X	X		X		X			
(Gampa et al., 2017)	X		X		X		X		X			
(Katz, O'Neal, Strickland, & Doutrich, 2010)	X	X		X	X	X	X					
(Keltner, Kelley, & Smith, 2004)	X	X	X	X			X	X				
(King et al., 2017)	X			X				X	X			
(Laufik, 2014)	X	X		X		X	X					X
(Lloyd et al., 2008)	X	X	X			X	X	X	X			X
(The Lowitja Institute, 2014)	X	X		X								
(Mallee District Aboriginal Services, 2014)	X			X		X		X				
(Minore & Boone, 2002)	X			X	X		X	X				
(Minore, Jacklin, Boone, & Cromarty, 2009)	X	X	X	X			X					
(Murray & Wronski, 2006)	X	X		X		X	X	X				
(Nagel, 2009)	X	X		X			X	X	X	X		
(Nelson et al., 2015)	X		X	X	X		X	X				
(Panzera et al., 2016)	X	X		X		X	X	X	X	X	X	X
(Roach, Atkinson, Waters, & Jefferies, 2007)	X			X		X	X					
(Schmidt et al., 2016)	X	X		X	X		X	X	X			X
(Walker, Tennant, & Short, 2011)	X	X		X			X	X				
(Watson, Young, & Barnes, 2013)	X		X	X	X		X	X				
(Weymouth et al., 2007)	X		X	X	X	X	X	X	X			
(Williams, 2003)	X				X		X					
(Wilson, Magarey, Jones, O'Donnell, & Kelly, 2015)	X					X	X	X				
(Zhao et al., 2017)	X	X		X		X		X		X		

Conditions

Studies reported the types of conditions that were necessary and sufficient for enabling workforce development to occur. These conditions occurred at four levels: 1) policies of governments and professional organisations; 2) communities/cultures; 3) health service policies and environments; and 4) characteristics of individual health practitioners (see Table 1).

Governments' and professional organisations' policies

The important role of macro government/professional organisational policies as enablers of workforce development/ implementation was suggested by the frequency of their mention; these conditions were identified in almost half of the studies (13/28 or 46%). Studies identified that it was not only the level and continuity of government funding that facilitated

the ability of PHCs to recruit, develop, support and sustain staff, but also its allocation to meeting particular service needs and skills shortages (Ahuriri-Driscoll, Boulton, Stewart, Potaka-Osborne, & Hudson, 2015; Katz, O'Neal, Strickland, & Doutrich, 2010; Lloyd et al., 2008; Nagel, 2009; Panzera et al., 2016; Roach, Atkinson, Waters, & Jefferies, 2007; Schmidt et al., 2016; Zhao et al., 2017) (See example 1).

Example 1: The role of government resourcing

In their evaluation of the role of the health workforce in the implementation of the Northern Territory Preventable Chronic Disease Strategy (PCDS), Lloyd (2008) identified that new resourcing facilitated implementation of the policy intent to change and expand Indigenous PHC practice from clinical to population health. However effectiveness of the initiative was limited by a lack of funding dedicated to changing structures services or programs and workforce development to enhance skills congruent with the policy goals (Lloyd et al., 2008).

Studies also identified the role of government legislation and/or policy in regulating the recruitment, terms and length of employment, financial accountability requirements, quality of working life, capacity and scope for career development and support for groups of healthcare professionals (Ahuriri-Driscoll et al., 2015; Laufik, 2014; Murray & Wronski, 2006; The Lowitja Institute, 2014; Walker, Tennant, & Short, 2011). Two studies identified the need for improved clarity in government legislation and/or policies concerning the translation of nationally consistent competency standards and qualifications into job specifications and training pathways for IHW (Murray & Wronski, 2006); and practice responsibility for nurses and IHW (Cramer, 2006; Murray & Wronski, 2006). One study (Keltner, Kelley, & Smith, 2004) identified the importance of partnerships between national/state/local government departments and PHC to keep Indigenous health issues on the radar.

Three studies identified the importance of professional organisations in establishing and upholding professional standards and advocating for professional groups such as traditional healers and IHW (Ahuriri-Driscoll et al., 2015; Minore, Jacklin, Boone, & Cromarty, 2009; The Lowitja Institute, 2014). Professional organisations were able to propose clarity of job descriptions; standardised training; accredited educational programs; certification of graduates; and regulation of practitioners. However, authors noted the incongruence of

advocating national standards which may be at odds with the equally important notion of local autonomy (Minore et al., 2009) (see example 2).

Example 2: The role of professional organisations

Ahuriri-Driscoll et al. (2015) evaluated the contracting of traditional healers to provide *rongoā Māori services* by the New Zealand Ministry of Health. The national professional body for traditional healers established standards for practice and professional leadership. Traditional healers tended to practice in an unpaid voluntary capacity but the professional organisation successfully advocated for funding ($1.9 million p.a. across 16 contracts). It was considered likely that formalisation of the *rongoā* through registration and accreditation, would attract additional funding. (Ahuriri-Driscoll et al., 2015).

Communities and cultures

Community historical, social, political and cultural conditions were also critical enablers of workforce development. Leadership and effective practice by Indigenous nurses was enabled by the brokerage of relationships with local tribal governing bodies in communities and Indigenous health service systems (Katz et al., 2010; Keltner et al., 2004). Clanship or kinship ties and obligations in their home community enhanced trust in the IHW-client encounter (Gampa et al., 2017; Nelson et al., 2015), although shared histories (with clients) of stressors and social determinants increased Indigenous workers' levels of stress (Nelson et al., 2015). Changing local circumstances (Minore et al., 2009) and changing community priorities necessitated responsiveness in the types of services provided or ways in which workers' provided them (Boulton, Gifford, & Potaka-Osborne, 2009; Conway et al., 2017; Minore et al., 2009). See example 3. Furthermore, the geographical location of the community, particularly remoteness, was an important condition affecting models of workforce management, including distance management, and workforce supply and retention (Ahuriri-Driscoll et al., 2015; Nelson et al., 2015; Weymouth et al., 2007).

Example 3: How historical and social conditions affect the workforce

In the Navajo nation, Community Health Representatives (CHRs) experienced that historical policies as well as personal clanship or kinship affected levels of trust in the patient encounter. CHRs used their knowledge of community and culture to engender trust in the patient encounter as the essential ingredient in providing necessary and quality

healthcare services (Gampa et al., 2017). Such knowledge of community and culture included: information about kinship ties; proper use of the Navajo language; knowledge and encouragement of traditional therapies, religious ceremonies and traditional practices for funerals; and understanding, respect for, and engagement in cultural values and practices. CHRs were also required to cope with grief related to the death of clients on their own and with limited support (Gampa et al., 2017).

PHC policies and environments

PHC recruitment, support, development and retention policies were identified in 22/28 studies (79%) as conditions that enabled workforce development and implementation. Conditions that enhanced workforce development and/or implementation were: long-term commitment from managers to Indigenous health improvement (Lloyd et al., 2008; Mallee District Aboriginal Services, 2014; Nagel, 2009), strong clinical leadership (Nagel, 2009), and sound relationships between managers with workers (Nagel, 2009). A lack of management support had detrimental effects including: a lack of enthusiasm for work (Weymouth et al., 2007); ineffective team work (Schmidt et al., 2016); poorly designed electronic patient records or failure to share them (Conway et al., 2017; Schmidt et al., 2016); not knowing role expectations (Minore & Boone, 2002; Schmidt et al., 2016); having to prioritise acute care demands over preventive or chronic disease management (Lloyd et al., 2008; Nagel, 2009; Schmidt et al., 2016; Walker et al., 2011); loss of continuity of care and patient trust (Conway et al., 2017); disquiet over the standard of care provided (Cramer, 2006; Minore & Boone, 2002); and staff frustration, stress and turnover (Boulton et al., 2009; Conway et al., 2017; Katz et al., 2010; King et al., 2017; Laufik, 2014; Lloyd et al., 2008; Minore & Boone, 2002; Nelson et al., 2015; Schmidt et al., 2016; Weymouth et al., 2007).

Seven studies highlighted the impact of staff shortages (particularly in remote PHC) on the employment conditions of the remaining workforce. Staff shortages resulted in a heavy reliance on short-term agency-employed nurses and high staff turnover (Conway et al., 2017; Cramer, 2006; Lloyd et al., 2008; Panzera et al., 2016; Roach et al., 2007; Schmidt et al., 2016; Zhao et al., 2017). Partly as a result of workforce shortages, studies described the complexity of roles of remaining workforce groups (Boulton et al., 2009; Katz et al., 2010; Laufik, 2014; Lloyd et al., 2008; Nagel, 2009; Roach et al., 2007; Watson, Young, & Barnes,

2013), time pressures in meeting community members' healthcare needs (Ahuriri-Driscoll et al., 2015; Conway et al., 2017; Schmidt et al., 2016), the need for greater management support (Conway et al., 2017; Lloyd et al., 2008; Nelson et al., 2015; Schmidt et al., 2016), the absence of uniformity in training, roles, or conditions of employment (Laufik, 2014; Roach et al., 2007; Watson et al., 2013), and being given leadership roles for which staff were not prepared for (Katz et al., 2010). See example 4.

Example 4: The conditions for competent nursing

A study of nursing practice in a remote Australian community found that managerial, professional and regulatory neglect of the conditions essential for competent nursing required nurses to practice in an amorphous (changing and inconsistent) way. Nurses experienced being 'dropped' in the remote area where practice rules are disregarded and 'no-one sees your practice'; 'crossing' or 'overstepping boundaries' occurred regularly; and practice 'outside the scope of nursing' was expected. Cramer (2006) urged nurses to reflect on how they could meet their professional obligations given these workforce conditions, since the consequence was to infringe on the rights of Aboriginal people to adequate standards for safe health care (Cramer, 2006).

Individual characteristics of healthcare practitioners

Thirteen/28 studies (46%) identified individual characteristics of healthcare workers as enablers of workforce development. Demographic factors, including the Indigeneity of the healthcare practitioner enhanced their encounters with clients, but also their work/life stress (Conway et al., 2017; Schmidt et al., 2016). One study addressed the effect of non-Indigenous health professionals' attitudes on the quality of healthcare provided (Wilson, Magarey, Jones, O'Donnell, & Kelly, 2015). Their motivation to work effectively in Indigenous health was determined by levels of practical knowledge, fear of practicing in Indigenous health, perceptions of difficulty and willingness to learn (Wilson et al., 2015). For traditional healers, their typically older age was identified as a potential barrier to the sustainability of their workforce (Ahuriri-Driscoll et al., 2015).

Nine studies described high levels of stress and burnout experienced by individual healthcare workers (Ahuriri-Driscoll et al., 2015; Conway et al., 2017; Cramer, 2006; Gampa et al., 2017; Minore & Boone, 2002; Nelson et al., 2015; Schmidt et al., 2016; Weymouth et al.,

2007; Williams, 2003). Stress resulted from other conditions in PHC systems, structures and/or management as well as community/cultural/family responsibilities, but was itself a condition of workforce performance. Its consequences included a reduced staff capacity to invest in strengthening and developing their practice (Ahuriri-Driscoll et al., 2015), and attrition of IHW and nurses (Williams, 2003) (see example 5).

Example 5: Workforce stress

Williams (2003) found that Australian Aboriginal managers had the highest levels of emotional exhaustion, followed by IHW (particularly women). Emotional exhaustion is considered the first stage of burnout and can also be a precursor to physical ill-health. The situation could be exacerbated by pre-existing chronic illness that is highly prevalent in Indigenous communities, including among IHW.

Five studies outlined individual characteristics of healthcare practitioners that facilitated effective practice (Browne et al., 2013; Conway et al., 2017; Lloyd et al., 2008; Walker et al., 2011; Watson et al., 2013). They included readiness to learn and change practice (Browne et al., 2013), perseverance and strength in the face of stressful conditions (Katz et al., 2010), confidence in professional relationships and healthcare knowledge (Browne et al., 2013; Watson et al., 2013), motivation (Conway et al., 2017; Walker et al., 2011) power equality (Browne et al., 2013), and participation and/or leadership (Lloyd et al., 2008). Katz (2010) outlined the explanations of Indigenous nurses for their retention in PHC as commitment to the organisation, ability to resolve problems within the workplace, feeling respected and valued and being able to use independent judgment.

Strategies

In response to the conditions, three key interrelated and overlapping strategies for workforce development and implementation were identified: 1) enhancing recruitment and retention; 2) strengthening roles, teamwork and capacity; and 3) improving supervision, mentoring and support (Table 1).

Enhancing recruitment and retention

Ten studies (32%) incorporated strategies to improve the recruitment of doctors, nurses, IHW and other practitioners to provide healthcare, particularly in remote communities (Katz et al., 2010; Laufik, 2014; Lloyd et al., 2008; Mallee District Aboriginal Services, 2014; Murray & Wronski, 2006; Panzera et al., 2016; Roach et al., 2007; Weymouth et al., 2007; Wilson et al., 2015; Zhao et al., 2017). These included initiatives to improve the pipeline from health practitioner training to practice in Indigenous PHC through mechanisms such as promoting rural health as a career (Roach et al., 2007), advocacy for funding of salaries (Roach et al., 2007), and appropriate selection processes in matching registered nurses to communities (Mallee District Aboriginal Services, 2014; Weymouth et al., 2007). See example 6.

Example 6: Recruitment strategies

A good example of enhancing recruitment strategies was provided by the Mallee District Aboriginal Strategy (2014) that created targets for increasing the proportion of Indigenous employees; Indigenous staff representation on selection panels; Indigenous participation in orientation for all employees; Indigenous staff engagement in delivery of face to face workplace orientation; and supporting Indigenous applications for vacancies. As well, the organisation positioned itself as a specialist consulting advisor to other regional organisations and stakeholders (Mallee District Aboriginal Services, 2014).

Strategies to retain staff were described in six studies (Katz et al., 2010; Murray & Wronski, 2006; Panzera et al., 2016; Roach et al., 2007; Weymouth et al., 2007; Zhao et al., 2017). Retention strategies included extending workforce competencies and skills sets to promote workforce flexibility (Murray & Wronski, 2006), training pathways to equip IHW for expanded clinical roles and robust career pathways (Murray & Wronski, 2006); and supporting advanced training to better equip healthcare practitioners for complex roles in the PHC system (Roach et al., 2007; Zhao et al., 2017). Other incentives for retention included: management support (Katz et al., 2010); attractive leave arrangements, professional feedback, debriefing, professional support and conditions of service (Weymouth et al., 2007); the demonstrated valuing of nurses through use and acknowledgment of their experience in mentoring, policy development, review, decision making and quality improvement efforts; and study assistance and practical incentives (Weymouth et al., 2007).

Strengthening roles, teamwork and capacity

Twenty-two studies (61%) incorporated strategies to enhance roles including leadership, teamwork and capacity (Boulton et al., 2009; Chernoff & Cueva, 2017; Conway et al., 2017; Cramer, 2006; Gampa et al., 2017; Katz et al., 2010; Keltner et al., 2004; Laufik, 2014; Lloyd et al., 2008; Minore & Boone, 2002; Minore et al., 2009; Murray & Wronski, 2006; Nagel, 2009; Nelson et al., 2015; Panzera et al., 2016; Roach et al., 2007; Schmidt et al., 2016; Walker et al., 2011; Watson et al., 2013; Weymouth et al., 2007; Williams, 2003; Wilson et al., 2015). Studies identified issues relating to the definition of professional roles and understanding of practitioners own and others roles (King et al., 2017) within difficult care environments and through team approaches (Minore & Boone, 2002). A Canadian study identified that redefinition of IHW roles was required in response to questions of professional and organisational liability (Minore et al., 2009). Studies commented on the need for enhanced role recognition in relation to a variety of professional groups including: IHW (Minore & Boone, 2002; Minore et al., 2009); traditional healers (Boulton et al., 2009); physical assistants (Laufik, 2014); Indigenous nurses (Katz et al., 2010); alcohol and drug workers (Nagel, 2009); Indigenous and non-Indigenous child healthcare workers (Watson et al., 2013); Indigenous managers and allied health staff (Conway et al., 2017); and Indigenous practitioners as cultural brokers (Watson et al., 2013).

Example 7: Strengthening the roles of IHW

Strategies for ensuring ongoing role development included multi-stage consultation with stakeholders in Canada to determine the scope of IHW practice (Boulton et al., 2009). Seven competencies for IHW practice were identified: 1) Aboriginal and PHC; 2) empowerment, community relations and cultural competence; 3) prevention, promotion and protection; 4) emergency care; 5) communication; 6) ethics, leadership and teamwork; and 7) administration. The consultation also proposed that enhanced recognition and clarity of roles be linked to appropriate remuneration (Boulton et al., 2009).

Four studies focused on strengthening leadership by IHW or improving the integration of IHW within interdisciplinary teams to improve the health of their clients. Examples were provided for maternal and child health (Chernoff & Cueva, 2017), general healthcare/wellbeing (Gampa et al., 2017) and chronic disease prevention and management (King et al., 2017; Schmidt et al., 2016). Strategies for reducing the workload of IHW in rural Alaskan communities included shifting the focus of the PHC upstream to patient education about self-care for minor issues. This shift in PHC focus helped to prevent IHW burnout

resulting from their frequently being called after hours to provide care to community members (Chernoff & Cueva, 2017).

Eight studies stated that teamwork was the only workable means of delivering culturally appropriate health services in remote PHC settings, particularly for chronic disease care (King et al., 2017; Laufik, 2014; Minore & Boone, 2002; Minore et al., 2009; Murray & Wronski, 2006; Schmidt et al., 2016; The Lowitja Institute, 2014; Walker et al., 2011). Overall, an integrated team-based approach required a shared purpose, creative problem solving, mutual respect for the knowledge base of various professional groups, and acceptance and utilisation of overlaps in respective scopes of practice (Lloyd et al., 2008). A focus on developing identity and cohesion across workforce teams was addressed in relation to the alcohol and drug workforce (Nagel, 2009) and more generally in interdisciplinary team work (Watson et al., 2013). Strategies that were explicitly linked to role enhancement within teams were the preparation of graduates to function effectively in teams through professional health sciences' curricula and practice placements (Minore & Boone, 2002), access by all team members to electronic patient systems (King et al., 2017; Schmidt et al., 2016), and strategies for efficient use of existing health workforce by the effective deployment or extension of skills (Panzera et al., 2016). However, as Minore (2009) noted, interdisciplinary healthcare teams often failed to build a common spirit and morale among members (see example 8).

Example 8: Support for role enhancement

In remote Australian communities, Schmidt et al. (2016) found that the confidence and capacity of IHW to provide chronic disease care and service coordination was enhanced by ongoing support by an Indigenous Clinical Support Team, communication of the IHW role to team workers, training to support the IHW role and IHW knowledge of their clients and environment. However, team work would have been improved by a greater emphasis on engaging clinical leaders and local champions about the IHW role in chronic disease care (Nelson et al., 2015; Schmidt et al., 2016).

Professional development to lift the educational and formal health care training levels of existing employees and/or expand opportunities for new workers was identified in seven studies (Ahuriri-Driscoll et al., 2015; Conway et al., 2017; Keltner et al., 2004; Nagel, 2009; The Lowitja Institute, 2014; Walker et al., 2011; Weymouth et al., 2007). Diverse training

pathways were described, with studies finding that no single pathway was likely to meet all practitioners' needs (e.g. Ahuriri-Driscoll et al., 2015). For some, formal institution-based curricula and certification pathways were considered appropriate (e.g. Ahuriri-Driscoll et al., 2015). Indigenous practitioners (such as traditional healers) preferred a dual system incorporating both cultural guidance and support as well as institution-based learning, or an apprentice-style learning system that was consistent with 'traditional' oral knowledge transmission to emphasise an Indigenous worldview and cultural knowledge (Ahuriri-Driscoll et al., 2015).

For non-Indigenous practitioners, the need for cultural education to minimise discrimination and distrust and work towards providing and maintaining culturally safe environments was highlighted as important to preventing cultural mishaps, caused through unintentionally disrespectful practice (e.g. Conway et al., 2017). Management strategies for enhancing workforce capacity included providing training opportunities that were relevant for career advancement, supervision (Boulton et al., 2009; Lloyd et al., 2008; Nagel, 2009; Schmidt et al., 2016; Walker et al., 2011), and implementing dedicated chronic disease positions (Lloyd et al., 2008). Formal skills acquisition (Ahuriri-Driscoll et al., 2015), registration with a professional body and/or accreditation (Ahuriri-Driscoll et al., 2015; Keltner et al., 2004) were also recognised as means of professional advancement and enhanced remuneration.

Improving supervision, mentoring and support

Strategies to improve supervision, mentoring and/or support to health practitioners were identified in twenty (71%) studies (Table 1). Two studies outlined the value of clinical supervision. Nagel (2009) described regular clinical supervision and clinical review provided to Australian alcohol and drug workers. A model of centralised executive support and peer support were both effective for the remote workforce (Nagel, 2009). Similarly, Nelson (2015) identified four different models for effective supervision of Indigenous Australian mental health workers. See example 9.

Example 9: Supervision for Indigenous mental health workers

Four supervision models were variously used by Indigenous Australian mental health workers: 1) cultural supervisors (an Indigenous person with extensive cultural knowledge and capacity); 2) dual supervisors (one with demonstrated proficiencies in professional development and one that balanced professional and community/cultural obligations in

service provision); 3) consultation (where a clinical skills expert provided didactic and skills-based training and sometimes provided additional case consultation/clinical supervision); and 4) communities of practice through modern technologies (particularly for remote-working practitioners). The three essential components for effective supervision were: clinical expertise, personal support recognising the specific issues faced by Indigenous practitioners, and cultural/community understanding (Nelson et al., 2015). The authors concluded that investment in best-practice supervision could reduce the costs of cyclical workforce recruitment and unmanaged mental illness of clients due to workforce gaps.

The only included study of a formal workforce development mentoring strategy established a framework based on reciprocity and equality between Australian IHW and non-Indigenous allied health professionals (Browne et al., 2013). Mentoring partnerships worked most effectively when both parties were comfortable in their roles as both teacher and learner. Power differences between mentoring partners were detrimental to the relationship. Another study identified the potential for tele-mentoring strategies using existing satellite facilities in remote Indigenous communities (Walker et al., 2011). Formal workforce support was described in one study (see example 10).

Example 10: A formal support program for IHW

In the Navajo nation, the integration of CHRs into clinic-based care teams was supported by The Community Outreach and Patient Empowerment (COPE) Program that established improved referral processes, case management meetings, and supported joint home visits and CHR access to electronic health records. Patients were enrolled either by the CHR or via provider referral; CHRs had flexibility in who they chose to enrol, based on their perceptions of who might benefit. In particular, the ability of CHRs to access the Electronic Health Record to document their encounters and obtain clinical information on their clients was an important factor for establishing stronger clinic-community linkages. Nonetheless, the CHR experience of these programmatic efforts suggested that further work was needed, particularly to integrate care teams across the continuum of clinic- and community-based providers (King et al., 2017).

Informal workforce development support was outlined in three studies. Conway (2017) described IHW support structures such as group meetings and debriefing sessions. Implementation champions were identified as "go to" persons and activities were developed to enhance IHW empowerment and knowledge sharing. Weymouth (2007) found that the management support given to remote nurses after a critical incident was poor, but that the Bush Crisis Line provided professional support and was highly regarded. Wilson et al. (2015) presented a model for exploring non-Indigenous health professionals' attitudes to practice in Indigenous PHC. It was proposed as a useful basis for self-reflection on levels of confidence, attitudes, characteristics, experiences, approaches and assumptions about Indigenous health, as an important precursor to future practice. The model was proposed as a framework to facilitate group discussions between all health professionals about working together in Indigenous health (Wilson et al., 2015).

Impacts

Because many of the studies were program descriptions and/or commentaries, only 12/28 studies (43%) identified impact from workforce related interventions. Four types of impacts were identified: 1) workforce sustainability; 2) workforce capacity; 3) resources/growth; and 4) healthcare improvements. No studies identified any impacts relevant to policy initiatives or measures.

Workforce sustainability

Four studies identified impacts related to workforce sustainability. Two studies reported sustained retention of staff and a stable workforce (Nagel, 2009; Panzera et al., 2016). Nagel (2009) found that 20 new positions established to comprise a new Remote Alcohol and Drug Workforce in Australia had been filled after 3 months by Indigenous workers with Certificate level qualifications, and of those recruited, almost all stayed. This was attributed to support provided to workers in both personal and practical ways such as: professional development, peer support, advocacy as a group, career structure, and travel and accommodation support. Panzera (2016) reported improved effectiveness in relation to workforce recruitment and retention. They reported that a stable and sustainable local workforce was developed through strengthening health systems and workforce training solutions e.g. task substitution and redistribution.

The other two studies reported an absence of sustainability in their staff retention (Weymouth et al., 2007; Zhao et al., 2017). Weymouth (2007) found that registered nurses working in remote PHC that were supported through distance management were dissatisfied with infrastructure, support and management, but satisfied with their roles. Dissatisfaction with management support increased staff frustration and stress and prompted staff turnover. Also from Australia, Zhao et al. (2017) found that despite substantial increases in resourcing in remote PHCs, health service models were not sufficiently robust to sustain the supply and retention of resident health staff. In this case, PHCs resorted to a heavy reliance on short-term agency employed nurses and high turnover of government employed staff [32].

Workforce capacity

Four studies (37%) identified an impact that was broadly related to the capacity of the workforce (Browne et al., 2013; Gampa et al., 2017; King et al., 2017; Panzera et al., 2016). Three/4 of these studies found enhanced IHW leadership capacity (Browne et al., 2013; Gampa et al., 2017; King et al., 2017). Browne (2013) found that an Australian mentoring workforce development strategy for IHW and non-Indigenous allied health professionals demonstrated capacity to achieve an increased skill base of IHW; cultural safety among non-Indigenous health professionals; and effective infrastructure, leadership and partnerships. Two-way learning and development occurred; IHW and non-Indigenous allied health professionals reported that they met their identified learning needs (Browne et al., 2013). One Navajo study found that enhancement of the culturally specific factors that build and sustain the CHR-client interaction resulted in improvements in communication, respect for clients and client empowerment (Gampa et al., 2017). Another Navajo study found that a chronic disease healthcare workforce empowerment and support program resulted in CHR perceptions of strengthened validity and reputation, enhanced ability to positively affect health outcomes, and improved ability to deliver health coaching to clients. Eighty percent (80%) felt strongly positive that monthly work-based training sessions in CHR-provider relationships, motivational interviewing, self-care and wellness, and team-building were useful and 45% felt communication and teamwork had improved (King et al., 2017). The other study found enhanced capacity of the general workforce (Panzera et al., 2016). Panzera (2016) found that workplace planning based to address specific workforce skills shortages led to the delivery of locally-relevant workforce training solutions, and extended competencies and skills sets to facilitate task substitution and redistribution.

Resources to enable growth

Impacts in resourcing and growth were identified in two studies (7%) (Chernoff & Cueva, 2017; Panzera et al., 2016). Panzera (2016) found that participatory regional health workforce planning processes in regional Australia accurately modelled current and projected local workforce requirements, and led to an increase in delegated practice models. Chernoff (2017) found that the maternal and child healthcare model delivered to Alaskan Native people living in rural communities was translatable to other tribal and limited-resource contexts. In part, transferability was attributed to its delivery by IHW; but also because the model was tailorable to local context and suited for regions with limited infrastructure and otherwise underserved families and individuals [46].

Healthcare improvements

Finally, six studies reported the effects of workforce strategies on healthcare outcomes (Conway et al., 2017; Cramer, 2006; Gampa et al., 2017; King et al., 2017; Lloyd et al., 2008; Schmidt et al., 2016). Conway (2017) found that IHW implementing the Flinders Closing the Gap chronic disease self-management support program could have been better supported and supplemented, but the IHW reported that the program itself was appropriate, flexible and acceptable (Conway et al., 2017). King (2017) found that an empowerment and support program in the Navajo nation enhanced the ability of CHR teams to improve clinic-community linkages for chronic disease prevention and management (King et al., 2017). This occurred primarily through strengthened collaborations between Public Health Nurses and CHRs, and access to electronic health records. Gampa (2017) found that communication was improved in the IHW-client interaction when IHW utilised culturally-specific knowledge and practices, and clients became more empowered.

The other three studies found that in the absence of a supportive service model, nurses and IHW were unable to facilitate improved healthcare. From remote Australian communities, Cramer (2006) claimed that managerial, professional and regulatory neglect of the conditions essential for competent nursing meant that Aboriginal people did not receive the basic standards for safe health care. Schmidt et al. (2016) reported that IHW were most able to strengthen systems and practice where they had skills and knowledge i.e. client self-management support and linking with community and other services and resources. They found that a skilled, dedicated and satisfied IHW workforce was accompanied by client

satisfaction. But despite their competence, capacity, and client satisfaction, they were unable to address all of the systems' issues that were barriers to best practice chronic care. Also working in remote Australian communities, Lloyd (2008) found that the IHW workforce tended to implement aspects of chronic disease policy that drew on their existing skills and avoided or delayed implementation that required new skills. Because workforce issues were not addressed, policy recommendations were only partly implemented.

Limitations

Although a rigorous and thorough search strategy was used, there is the possibility that the review did not locate all relevant studies. Many existing publications may not be available in key international databases (Alonso, 2011). The authors of the review are based in Australia with extensive knowledge and experience in Indigenous health research in the Australian context. Because of this direct knowledge and experience, several known databases specific to Australian Indigenous health research were searched. Similar Indigenous specific databases from other included countries are unknown to the reviewers. This may have resulted in a bias towards Australian studies. It is also possible that relevant intervention descriptions or evaluations may have been misclassified; however, the high level of agreement between blinded coders, and consensus on all included studies suggests not. Evaluations with positive findings are more likely to be published. Therefore it is possible that the published evaluations reviewed overestimate the true effectiveness of PHC workforce development interventions for Indigenous peoples (Easterbrook PJ, 1991).

Discussion

This review found that an optimal sustained, capable and growing workforce model requires strategies for enhanced recruitment and retention; strengthened roles, capacity and teamwork; and improved supervision, mentoring and support. In turn, these strategies are enabled by government funding and appropriate regulation, support and advocacy by professional organisations; community engagement; PHC leadership, supervision and support; and practitioner Indigeneity, motivation, power equality and wellbeing. These findings have been used to develop a framework for Indigenous PHC workforce development and support (see Figure 4).

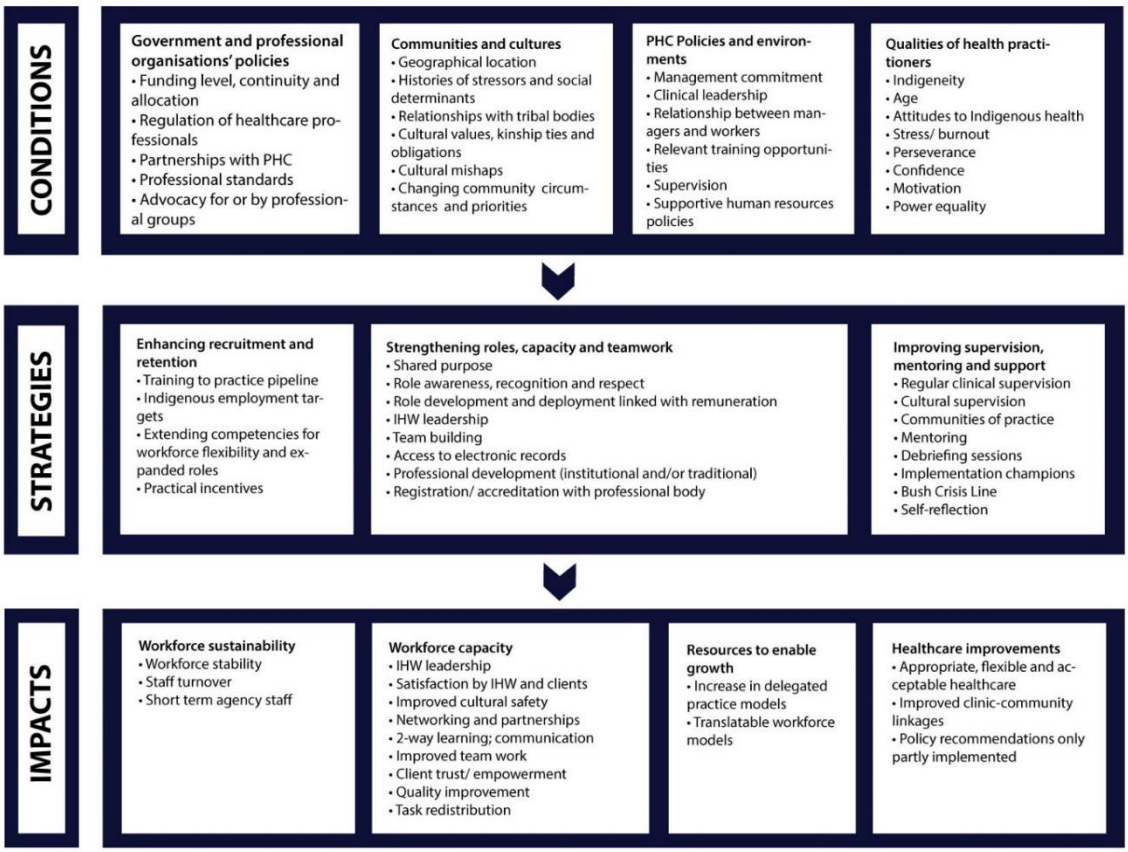


Figure 4: Framework for Indigenous PHC workforce development and support

Because there were only 12/28 (43%) studies that provided any evaluation of the workforce strategies and most of these studies used weak study designs, there is little definitive evidence of the effects of particular strategies to guide practice. We found no best practice intervention studies, 12 studies of promising practices, and 16 of emerging practices. Our overall impression of the literature was that commentaries and policy documents that described the domains of best practice workforce development and implementation were plentiful. However, there was a dearth of studies that examined *how* best practice should be achieved, or what worked to improve workforce sustainability, capacity, resources to enable growth or healthcare improvements. There was significant heterogeneity in the strategies and outcomes, making comparisons of intervention effects difficult. We cannot therefore make categorical recommendations about particular strategies for PHC workforce development and implementation. However, the reviewed studies can be used to inform workforce development decisions.

The 2/12 studies that reported positive effects of sustained staff retention and a stable workforce noted that workforce stability was related to healthcare service systems

development (Nagel, 2009; Panzera et al., 2016). Processes such as participatory continuous quality improvement were useful for navigating such changes (e.g. Panzera et al., 2016). Such interactions between personal, professional, organisational and contextual factors in efforts to improve service delivery have been noted in other reviews of Indigenous PHC workforce development (Gleadle et al., 2010; Gwynne & Lincoln, 2017; Onnis & Pryce, 2016), and in workforce change efforts internationally (Macfarlane et al., 2011).

Three of the four studies that found improved workforce capacity (Browne et al., 2013; Gampa et al., 2017; King et al., 2017; Panzera et al., 2016) focused primarily on the capacity for team leadership by IHW. The importance of enhancing the capacity of Indigenous staff, including IHW, is suggested by international studies that found that people prefer to visit health professionals from the same ethnic background (Jongen, McCalman, & Bainbridge, 2018; Meyer & Zane, 2013). The critical clinical functions of IHW in CANZUS nations include: first point of contact; liaison and cultural brokers; promoting health; community and/or clinical care; administration; policy development and program planning. Indigenous health professionals can align their unique technical and sociocultural skills to improve patient care, improve access to services and ensure culturally appropriate care (Anderson, Green, & Payne, 2009; Bainbridge R, 2015). Yet studies documented a lack of understanding or recognition of their potential leadership roles within teams, high levels of stress, and typically low payment. Like other literature reviews (Gwynne & Lincoln, 2017; Islam et al., 2015), studies described strategies for strengthening IHW team leadership roles in preventive health education; ensuring their access to electronic client records and inclusion in case management collaborations within chronic care teams; mentoring and supervision; and pathways to training and qualifications, including for task substitution and redistribution. Two-way mentoring between IHW and allied health practitioners was a notable strategy. Mentoring was fund to enhance two-way empowerment and potentially of healthcare performance. These findings are consistent with that of a recent review of mentoring initiatives to enhance Indigenous health, education, employment and justice system capacity (R. Bainbridge, Tsey, McCalman, & Towle, 2014). They are also consistent with international evidence that staff development needs to be closely linked to service needs (Macfarlane et al., 2011).

The two studies that identified enhanced resourcing and growth (Chernoff & Cueva, 2017; Panzera et al., 2016) suggested that it was not only the resourcing of PHC systems

enhancements that were important to developing improved chronic disease care, but also the allocation of funding to remedying particular skills and capacity shortages. As for the Indigenous child protection sector, empowering participatory planning processes were effective in PHC for accurately modelling current and projected local workforce requirements and skillset requirements (McEwan, Tsey, McCalman, & Travers, 2010; Mary Whiteside, Tsey, McCalman, Cadet-James, & Wilson, 2006). For PHC, participatory planning led to an increase in delegated practice models (Panzera et al., 2016).

Finally, three studies found that workforce strategies were effective in enhancing chronic disease and other healthcare performance (Conway et al., 2017; Gampa et al., 2017; King et al., 2017). Findings of included studies suggested, for example, that chronic disease management will not be optimised unless workforce issues are addressed (Lloyd et al., 2008), but that it is also necessary to simultaneously address systems issues (Schmidt et al., 2016). As found in other Indigenous community studies (e.g. Haswell-Elkins et al., 2009; Kinchin et al., 2017), workforce support facilitated the successful strengthening of systems and practice where IHW had skills and knowledge, but team support was unable to address all barriers to systems improvement. Such efforts in improving the Indigenous welfare workforce have also found that a long-term commitment and ongoing support are required to enhance the empowerment of workers and clients (Haswell-Elkins et al., 2009; M. Whiteside, Tsey, Cadet-James, & McCalman, 2014). For example, MacFarlane et al. (2011) predicted that the success of strategic human resource management in the UK public healthcare sector would, in part, be due to the extent to which national policymakers were willing to implement a responsive systems-based model of health service change, with attention to the inter-relationships between the different parts.

Conclusion

The important and complex work of improving Indigenous healthcare and health outcomes relies on the day to day efforts of the PHC workforce. This review suggests that it is not easy to facilitate an optimal sustained, capable and growing workforce model that can confidently improve Indigenous PHC performance. Such a model requires enhanced recruitment and retention strategies, strengthened roles, capacity and teamwork, and improved supervision, mentoring and support. In turn, the conditions required to enable these strategies include government funding and appropriate regulation, support and advocacy from professional organisations; engagement with and service delivery appropriate to the local community;

PHC leadership, supervision and support; and practitioner Indigeneity, readiness to learn, and wellbeing. However, within these broad categories, there was little definitive evidence of the effects of particular strategies to guide practice. Improvement is needed in the quality of evidence relating to workforce retention/sustainability and growth, and the contribution of the workforce to enhancing healthcare and health outcomes.

Workforce mapping

At the time of transition to community control of PHC services in Yarrabah, Bentleys (2014) reported that Gurriny had the workforce required for continuity of service to the community during and after transition. Since transition, the numbers of staff and mix of workforce skills required to maintain service delivery under Gurriny's current model of care has grown considerably (**Error! Reference source not found.**). Overall, staff numbers increased by 71% from 44.5 FTE in 2013-14 to 61.5 FTE in 2014-15, 54 FTE in 2015-16 and 76.0 FTE in 2017-18[1]. Gurriny has actively recruited local Yarrabah health professionals and operational staff. The proportion of local people employed has been maintained at high levels, with 58/76 (76%) positions filled by Indigenous people in 2017-18. Employment of Indigenous people has increased by more than 26% since transition (46 positions in 2013-14 to 58 positions in 2017-18).

The composition of the Gurriny workforce has also changed. The focus of additional positions has been in management, drivers, administrative/clerical, cleaning, health worker, medical, nursing, drug and alcohol worker, health promotion and health trainee positions (**Error! Reference source not found.**). Gurriny is also working to improve access to allied health services such as dieticians, diabetes educators, physiotherapists, exercise physiologists, podiatrists, psychologists and social workers (Gurriny Yealamucka Health Service, 2015). Gurriny provides cultural orientation for non-Indigenous staff.

[1] The Gurriny Online Service Report for 2016-17 was not available.

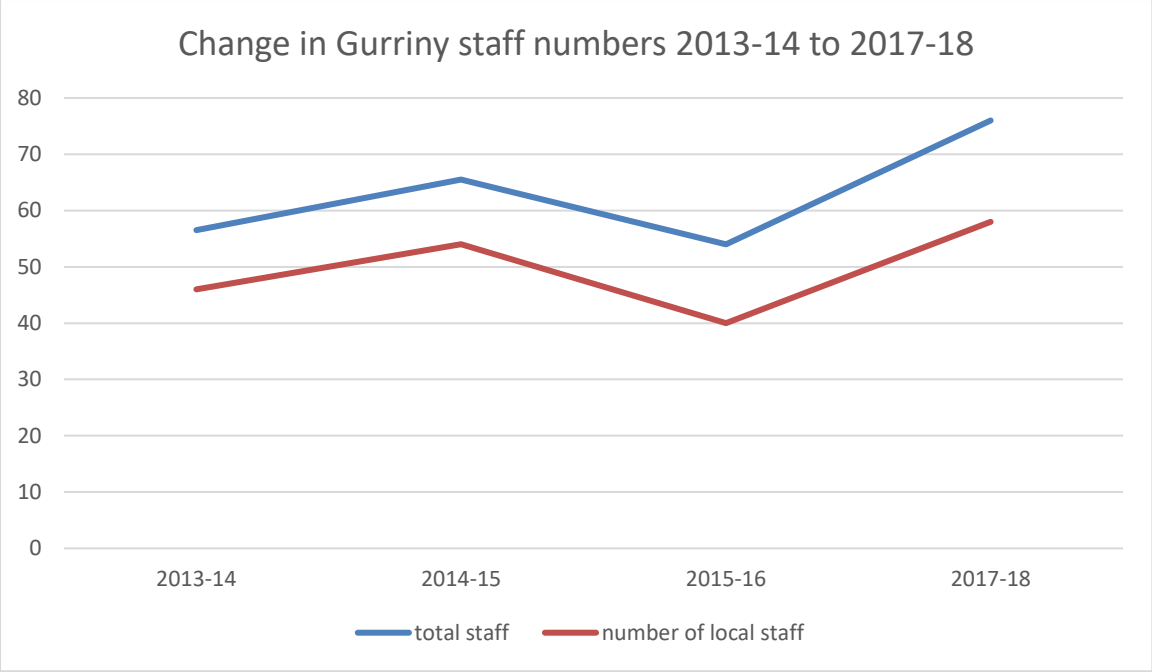


Figure 5: Change in Gurriny staff numbers 2013-14 to 2017-18

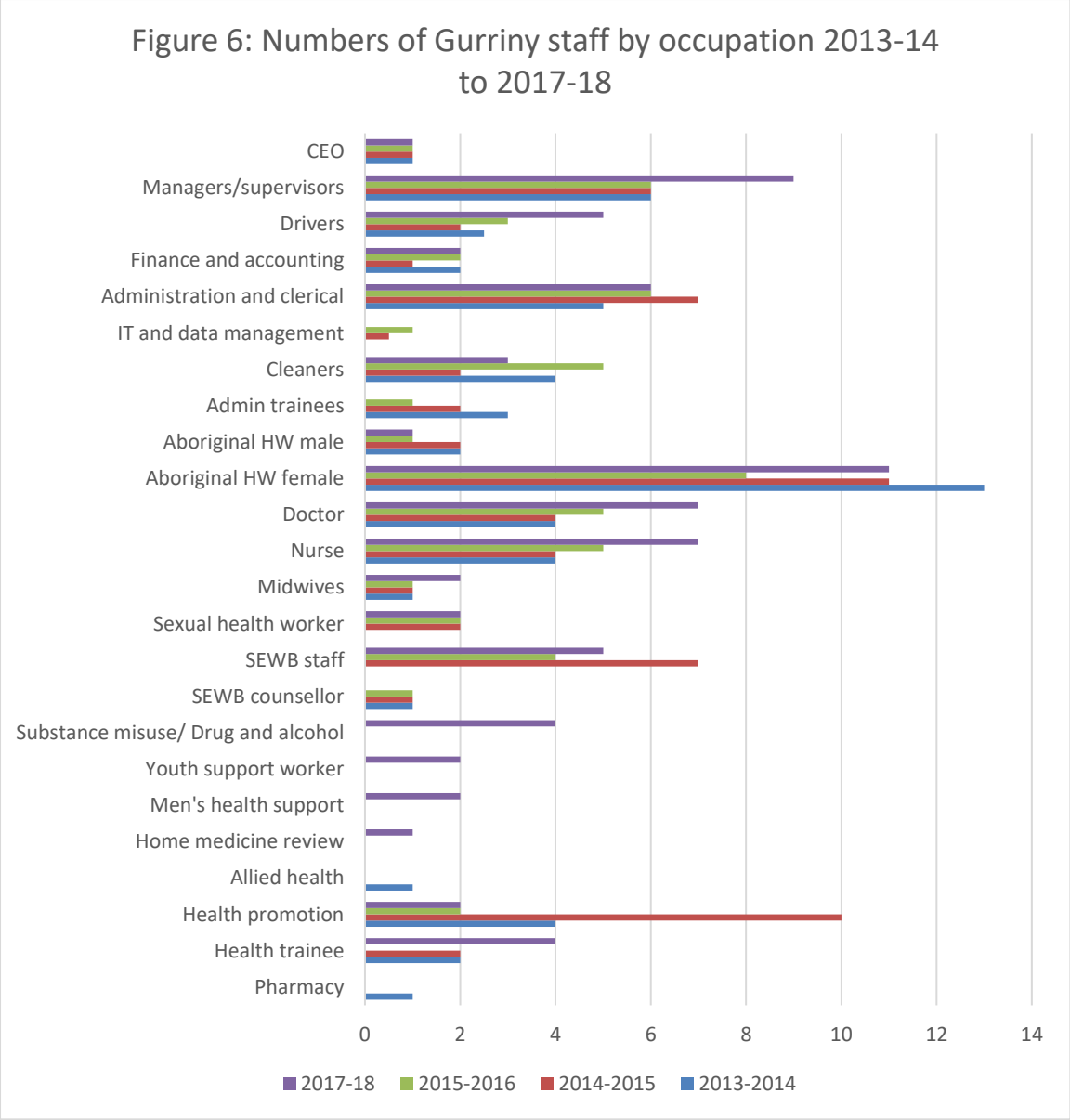


Figure 6: Numbers of Gurriny staff by occupation 2013-14 to 2017-18

Interviews with Gurriny Staff

Grounded Theory analysis of interviews was used to identify the key themes recognised by participating staff in regard to Gurriny's workforce and the ways in which it is working well and could be working better. The following analysis looks at the conditions, strategies, enablers and barriers of Gurriny's workforce (see figure 7).

The *conditions* represent the context within which Gurriny's workforce operates. They operate at macro, community, PHC service, and individual levels. These contextual factors can be enabling and/or constraining. Enabling conditions are the aspects of the context that

support Gurriny to have a strong workforce, and constraining conditions are those which negatively affect the strength of Gurriny's workforce. Some conditions can be both enabling and constraining.

Strategies are the actions that are, and can be, taken to help strengthen Gurriny's workforce. These include formal and informal systems and processes which can work towards supporting a strong workforce, or work against it. Figure 7 shows the overarching strategy areas that identified through analysis of staff interviews. Each of these core strategies contain further sub-strategies each with more detailed points on the specific ways in which Gurriny supports its workforce well, and the ways these could be improved. Taken together these strategies outline many different suggestions for what Gurriny can do to improve its workforce, informed directly by Gurriny staff themselves

Enablers are factors identified by staff which have the potential to support Gurriny in their process of implementing the outlined strategies to grow a strong workforce. Whereas *barriers* are factors which do or have the potential to make it more difficult for Gurriny to strengthen their workforce. These enablers and barriers, like the conditions, are multi-level; existing on macro, community, PHC and individual levels.

The rest of this section of the report provides the results of the grounded theory analysis of participating staff interviews, providing further details on the conditions, strategies, enablers and barriers to Gurriny's efforts to improve their workforce, and concludes with a discussion of the implications of these results for Gurriny and other ACCHO into the future.

Figure 7: Diagram of the conditions, strategies, enablers and barriers of Gurriny's workforce.

The Core Process

The core process identified through the grounded theory analysis is *growing a stable, capable and collaborative workforce that is responsive to community health needs.* This is the essence of what Gurriny is doing and aims to continue in their process of improving the organisations workforce.

Conditions

Gurriny's current workforce exists within a broader context which includes historical and contemporary factors in social, political, economic, cultural, organisational, community and individual levels. These contextual factors impact on Gurriny's workforce by shaping the environment in which it operates. For example, Gurriny operates within broader social systems where western cultural norms, political and economic systems, and organisational management and clinical practices and processes dominate. It also exists within a larger context of health and social inequities experienced by Indigenous people in Australia and internationally. This is a reality which impacts the Yarrabah community and the local workforce of Gurriny on a daily basis. These are factors which sit outside the control of Gurriny, yet which heavily impact on the organisation and its workforce.

As well, the recent history of transition of PHC services in Yarrabah to community control is a major overarching condition which has shaped the context of Gurriny's current workforce in multiple ways. The transition to community control was itself enabled by factors such as government support for the transition and the wider national and international Indigenous self-determination movement on the macro level. It was also enabled by Yarrabah community desire and motivation to have local ownership and control of Yarrabah's PHC service, Gurriny's organisational history as a social and emotional wellbeing service, and the individual commitment and leadership of community members who drove the transition.

The transition to community control has led to significant organisational growth, with a large increase in employment, including of local Yarrabah community members, and the provision of a wide array of comprehensive PHC services and programs. The transition however, while enabling, building and strengthening Gurriny and its workforce, has not come without its challenges. These include an increase in reporting requirements expected by government funders, changes in the workforce culture in response to organisational growth and service modifications, and a degree of change fatigue, especially among local staff who have been

with Gurriny throughout the transition process and beyond. Understanding these factors is important to be able to appreciate what exists around Gurriny to either support or hinder the organisation in its journey of growing a stable, capable and cohesive workforce.

CONDITIONS		
Conditions are the factors identified by participating staff which exist within and around Gurriny prior to and independent of the Working Well project. They are the context in which Gurriny as an organisation, and Gurriny's workforce exists and operates. These conditions are multi-level existing on macro, community, PHC and individual levels, and can be enabling and/or constraining in terms of how they support Gurriny to have a strong workforce.		
	Enabling Conditions	**Constraining Conditions**
MACRO	Broader national and international movements and discourses of Indigenous self-determination and community control of community services Nurse and other health care profession's professional requirements and regulatory environments Government commitment to support transition to community control in Yarrabah	Dominance of western culture, cultural norms, political systems and organisational processes and expectations Dominance of western organisational management and clinical systems Reporting requirements for government funding, which have increased since transition Nurse and other health care profession's professional requirements and regulatory environments Limited funding Workforce shortages and instability in rural and remote health services
COMMUNITY	Community desire and drive to have local ownership and control of Yarrabah's PHC service Successful transition to community control of Yarrabah's PHC Community/family relationships and politics Community level social and cultural dynamics, norms and systems which are different to but effect the organisational system	Social and health inequities experienced by the Yarrabah community Community/family relationships and politics Ongoing social issues in the community, such as overcrowded housing, domestic violence, and suicide, which impact on local staff Different needs and priorities of the Board, organisation, community and other stakeholders, such as government

PHC SERVICE	Gurriny's history as a community-controlled Social & Emotional Wellbeing (SEWB) organisation Rapid and significant organisational growth over recent years since transition to community control Gurriny's governance structure with the Board, community membership and Senior and Operational management tiers Major changes in the focus and composition of the organisation following transition, new programs and services, providing further employment and better enabling Gurriny to meet Yarrabah health needs Holistic understanding of the determinants of health as demonstrated through the model of comprehensive PHC Trauma informed and family-centred model of care that extends to the workforce and understanding issues that staff face Having the freedom and flexibility to do things differently within the community controlled PHC model Increased need for more management and more differentiated organisational hierarchy to deal with the quantity of staff and complexity of the organisation. This has led to the need for more senior management and middle management positions	Major changes in the focus and composition of the organisation following transition and taking on responsibility for all Yarrabah's PHC including clinical care leading to a perceived disconnect between clinical and SEWB services which has affected service cohesiveness Rapid and significant organisational growth over recent years following transition to community control has led to a change in workforce culture which is not always perceived or experienced as positive by staff e.g. poorer communication or greater mix of personalities. Growing fast as an organisation has meant that some staff felt left behind Challenges in regard to physical space and having staff spread across multiple locations, which has resulted in some disconnect among staff Increased expectations with service growth and improvements as a challenge for staff
INDIVIDUAL	Strong local leadership which drove the transition to community-control Large percentage of local, Indigenous staff Responsibility felt by local staff to improve the health and wellbeing of the Yarrabah community serves to motivate staff Increases in staff post-transition has taken a load off staff who had been carrying too much responsibility in the smaller organisation	Local staff live the social and health issues being faced in the broader community Lack of local staff with medical or allied health qualifications Experience of change fatigue among staff Burden of responsibility felt by local staff can be a stress for staff impacting on work due to the reality that staff never really leave work and are more emotionally invested in community health outcomes

KEY STRATEGIES

Strategies are the actions and processes that are, and can be, taken to help strengthen Gurriny's workforce. Strategies include areas that are working well to support Gurriny's workforce, and also highlight areas that could be working better. These are factors which are identified as being within Gurriny's organisational control to help grow a stable, capable and cohesive workforce.

Several core strategy areas were identified. These core strategies identify the actions or processes Gurriny can take to continue to grow a stable, capable and cohesive workforce. In the following sections on '*What is Working Well'*, we have outlined effective strategies that Gurriny could continue and build on into the future to help maintain and strengthen its workforce. Staff participants also identified several areas which could be improved. These are outlined in the sections on *'What Could be Working Better'* and can be taken as suggestions or recommendations.

Using a Grounded Theory analysis approach, four core overarching strategies to strengthen Gurriny's workforce were identified. These include *Strengthening Workforce Stability, Having Strong Leadership, Growing Capacity,* and *Working Well Together.* These core strategies encompass other sub-strategies, which in turn incorporate and explain several more specific actions and processes identified by participants. When taken together, these core strategy areas provide a comprehensive set of suggestions and recommendations informed directly from Gurriny staff interview data. They are about what Gurriny can do to improve its workforce culture and create the kind of stable, capable and cohesive workforce that is needed to be able to effectively meet Yarrabah community health needs.

STRENGTHENING WORKFORCE STABILITY

The first core strategy area identified as crucial to strengthening Gurriny's workforce is *Building a Stable Workforce.* Having stability in the workforce is foundational for Gurriny's organisational improvement efforts. Through analysing participant interviews, two sub-strategies of *Building a Stable Workforce* were identified. These include *'Creating Good Work Conditions',* and *'Filling Workforce Gaps'.*

There was strong evidence indicating several ways in which Gurriny already does well in creating good work conditions for its staff members. In particular through providing a lot of flexibility and benefits to support staff in their roles, professional development, and personal circumstances. However, staff also frequently mentioned how work conditions at Gurriny could be improved. The issue of staff being paid appropriately and consistently was an area of particular importance discussed by a majority of interview participants, from a variety of different organisational positions. Other issues regarding providing appropriate support for staff were also identified by some participants. In the other sub-strategy of *Filling Workforce Gaps*, participants identified that Gurriny has successfully achieved stability in their workforce in several key areas, particularly in the General Practitioner (GP) and Health Worker workforce. However, further work is needed to fill workforce gaps. The key gaps are for Nursing staff, which is the area with the highest turnover and retention issues, and increasing the male Health Worker workforce, which is an area of significant shortage. Addressing Nursing staff shortages and turnover is connected to other strategies such as *creating good work conditions* and strategies covered in the following sections.

Quotes from Gurriny staff members

"you're just not doing the patient assessment or just sitting behind a desk and doing a lot of observation or that. They sort of utilise you to go out within the community"

"I undertook my diploma… So I done it here based in Yarrabah… luckily Gurriny has… Thursday afternoons and luckily my training fell on Thursdays so it just worked out well over that year."

"even though you get so sick, you use up all your sick leave, you use up all your holidays, they still support you"

"We get a lot more Study Leave. Like most of our staff, if there's training, we pay for it and they do it"

"They get their day off for their birthday… fully paid day. They get the time off at Christmas to spend with their family and get paid for that… They get a lot more compassionate leave than what you would get normally in mainstream"

"All the nurses realise that we could be being paid a lot better anywhere else."

" a lot of them are still sitting on the same wages as before"

"I feel, if they're a Cert IV Health Worker, they should all be paid the same ...pending their grade and things like that."

"last year I had the same issue, and I documented it on a calendar… For a month I might've had a Health Worker three days out of that month"

"R-D-O's, we have it once a month and I think that has kind of impacted on some of our staff. Myself, I am starting to get really tired… at least when we had the once a fortnight, you know you had time… they need to review the R-D-O. I think that's something that really needs to be sat down and looked at."

Creating Good Work Conditions

What is Working Well	*What Could Be Working Better*
• **Having Flexibility and Benefits**, including: - Having flexibility and diversity in roles and responsibilities to keep work interesting; - Having flexible study support and training opportunities, such as Thursday afternoon for professional development; - Having flexible leave conditions e.g. Allowing extended leave/time off when needed to be able to deal with personal issues; - Taking personal circumstances into account; - Allowing people to reduce their hours if necessary; - Extra paid leave over the Christmas break; - More paid study leave than industry standards; - Paid funeral leave separate to normal leave; - Paid day off on birthdays.	• **Being Paid Appropriately**, including: - Assuring that pay rates are consistent with roles, responsibilities and award rates; - Providing annual salary increases; - Reconsidering the award wages for Health Workers and Nurses. • **Assuring Appropriate Staff Support**, including: - Ensuring that all staff have support in their daily responsibilities from a team or other staff member; - Increasing the Rostered Days Off (RDO's) to once a fortnight to support staff wellbeing and help improve staff motivation and energy levels; - Sharing responsibilities among staff to reduce work pressure.

Filling Workforce Gaps

What is Working Well	What Could Be Working Better
• **Having stability in the medical workforce**, including: - Having a stable GP workforce; - Having a stable Health Worker workforce; - Having stable senior management.	• **Losing Nurses, Needing More Nurses,** including: - Addressing the significant turnover in Gurriny's Nurse workforce; - Improving Continuing Professional Development (CDP) planning and opportunities for Nurses; - Assuring appropriate leadership for Nurses. • **Building the Health Worker Workforce**, including: - Increasing the male Health Worker workforce. • **Attracting Staff with the Right Skills and Values**, including: - Ensuring that staff understand and agree with the philosophies of community control and PHC; - Attracting and retaining staff with the right skills and experience.

"So most of the doctors that are here now have been here for more than two years, which is unusual."

"So one of the difficulties over that time is being able to establish enough of an RN support workforce… The RN's, we've had- that's probably the area where there's been more attrition. We've had a couple of RN's leave"

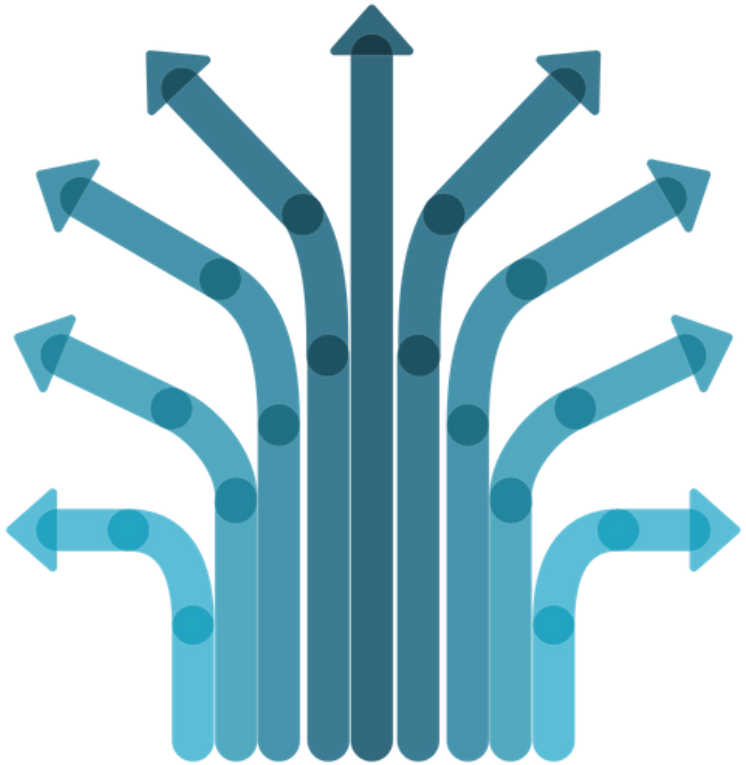
"I would say with nursing staff at this point in time, there has been in the last couple of months, a bit of a turnover"

"… sometimes I have to really go back and say, 'come on guys, I need you. I need you here with me… we need male Health Workers."

"I think there's a real need for more male health workers within our organisation. Because we only currently have one Indigenous male health worker"

"I think that we've gotta be really careful for what we shop for… because I think we've for too long put bums on seats and that's cost us greatly… I think that that person needs to be infused with our way – the way that we do things and really get the philosophy of community control… because we can have a brilliant clinician, but if they're not primary health care, we can be in for a rough ride because of the difference and the conflicting mindset and concepts"

"wish that management could see that they have a high risk, high acuity in this community and if they want- they deserve the best skill that they can get and they're not going to attract that skill by being half-baked in the way they advertise their positions… You know, '…they're happy just to take a new grad.' 'No, this is why you can't take a new grad. It's not okay! …it wouldn't be serving your community"



HAVING STRONG LEADERSHIP

The second and largest core strategy identified in the analysis of interviews is *Having Strong Leadership.* For Gurriny to build a stable, capable and cohesive workforce, it needs strong, stable leadership. The sub-strategies for *Having Strong Leadership* found were *providing clarity and direction, listening and being heard, understanding the big picture* and *being supportive, encouraging innovation.*

Some participating staff indicated ways that Gurriny leaders already provide the *clarity and direction* needed of strong leadership. This includes having clinical leadership which understands needs and challenges of the medical workforce and can provide the support and guidance needed. Also having leaders to steer Gurriny forward with their strong strategic vision and understanding of the broader context impacting Gurriny. However, there was strong indication from several staff members that Gurriny leadership can provide greater clarity and direction. Staff identified that leaders who understand their specific professional roles are needed for both Nurses and Health Workers. Several staff also suggested that there is a need for more distinguished lines of leadership and clarity around leadership responsibilities and role boundaries.

Another major concept which came out of staff interviews was that of *listening and being heard*. While staff mentioned some ways that Gurriny does well in listening to and being responsive to staff, including having a formal system for responding to staff conflicts, this is certainly an area

where there is relative consensus among staff regarding the need for improvement. One particular way staff identified that Gurriny could do better at listening and making sure staff are heard, is through supporting a bottom-up approach. This is about there being formal processes and opportunities for staff to be consulted on changes, raise concerns, and share ideas to have input into Gurriny decisions and strategic direction. This is also about Gurriny managers' being responsive by following through on staff input and feedback to show that they are being heard.

One other important aspect of *Having Strong Leadership* identified by staff was *Understanding the Big Picture*. This is about Gurriny leaders bringing their staff along on the journey of organisational growth and improvement by communicating about and including staff in the strategic direction and decision making of the organisation. This requires communicating to staff the broader context that Gurriny operates in, as well as its strategic direction, in a way that is understood by staff. There are examples of how Gurriny does well in this regard, such as with the Gurriny operational management forum, which is designed to include operational managers in the broader strategic direction so they can better understand and also share that understanding with their teams. However, the difference in perspective and understanding between many front-line workers and even middle managers suggests that Gurriny could be doing more to try to help staff understand the big picture. This big picture includes things such as better understanding the broader PHC and ACCHO sector contexts, as well as policy, funding and regulation contexts and how these impact on and limit what Gurriny can do. It also involves better communication on the nature of ACCHS's and some of the tensions that exist between the drive for local leadership and the need for professionals with the knowledge, skills and experience to understand that broader context.

The final sub-strategy, *being supportive, encouraging innovation*, staff identified many ways in which Gurriny leaders are supportive and encouraging, and also encourage innovation and flexibility among Gurriny staff. While Gurriny leadership has processes in place to provide encouragement and positive feedback, some staff indicated that this could be done more, in both formal and informal ways. Also, while several staff praised Gurriny's creativity, innovativeness and openness to try new approaches, some staff also indicated that Gurriny leaders could promote a learning culture and create more space to bring in new ideas.

"in terms of the Board's strategic direction looking at the whole of the community and mental health, and social community and mental health areas… now we've got funding to create a Mental Health Service, we're looking at bringing on board our first psychologist and social workers in relation to providing that service to community."

"the Senior Medical Officer role is not just to be in clinical governance, but is absolutely supporting that medical workforce and putting all the enablers around that so that they can practice efficiently… to mentor and supervise the group of doctors"

"I think one of the next evolutions for the service would be that there would be like a Team Leader for the nursing component, just like we had a Senior Medical Officer for the doctors? I think the nurses need like a Nursing Manager or a Team Leader"

"They need a Senior Health Worker… They don't want to go to… someone who's got no idea what a Health Worker is, yeah. They want to go to one of their own… And then that person can go and represent them in a forum somewhere"

"It would be good to have a team leader. At least then they could you know, put strategies in place for the teams."

"some roles go outside of where they should be sitting as well. The S-M-T team should be more defined in their responsibilities."

Providing Clarity and Direction

What is Working Well	*What Could Be Working Better*
• **Steering Gurriny Forward** - Having strong strategic vision and direction for improving and growing Gurriny; - Understanding the broader PHC, ACCHO, funding and policy contexts. • **Being Led by Leaders Who Understand** - Having a Senior Medical Officer which provides strong leadership for the medical workforce.	• **Being Led by Leaders Who Understand** - Having profession specific leadership, ie. Nurses having a Nurse leader, and the same for Health Workers; - Ensuring appropriate knowledge, skills and experience among leaders. • **Having Clear Lines of Leadership** - Having clarity around where responsibility for leadership lies in teams; - Creating team leader positions to create clearer chains of command and address the issue of managers having too large teams or managing multiple teams; - Clearly defining the boundaries of senior management roles and responsibilities.

Listening, Being Heard

What is Working Well	*What Could Be Working Better*
• **Listening and Being Responsive** - Managers having an open-door policy; - Strong responsivity from middle management. • **Having Systems for Responding to Staff Conflict** - Having formal organisational and informal community processes for responding to staff conflicts and community conflicts which impact on local staff.	• **Supporting a Bottom-Up Approach** - Ensuring that staff can speak out without facing negative consequences; - Providing opportunities for staff to influence the strategic direction of the organisation; - Having formal processes for voicing concerns and sharing ideas; - Consulting staff about decisions which impact them; - Responding to staff feedback and concerns; - Creating a workforce culture that encourages staff input and is responsive to staff concerns. • **Being Responsive** - Following up with staff regarding concerns expressed or need identified; - Acting on staff ideas and concerns to demonstrate they have been heard. • **Responding to Staff Grievances** - Having processes in place to follow up with staff following conflict or grievances to try to ensure resolution.

"when you become a Senior Manager you're at that strategic level, but what's happening up there has to filter down to the rest of us you know? And vice versa… You hear about that bottom-up approach… that doesn't really happen"

"there's lots of great things going on, but there's no consultation. Like with the whole organisation, to be a great leader you've gotta include your staff in decision making and feedback"

"sometimes the Senior Management Team will make a decision… And it'll have direct effects on us and we'll say, '…see. I told you it's not gonna work.'… I just think that the operational input into a strategic decision needs to be considered because it does cause a lot of frustration and stresses"

"I think management… they don't realise they've got staff who really have their finger on the pulse… they've got all this valuable information... I think we're sitting with solutions and we're sitting with um…creative ideas but we've actually got no outlet for them."

"Even the staff surveys like the satisfaction survey that were done, the results weren't really generated to us and I guess… people got offended because some managers just said they weren't happy with what was said in there… Instead of taking it as constructive criticism you know? So nothing really came about that."

"they had this whole big healing workshop thing and all these recommendations came out of this healing workshop and we all sat back and we all said, '…yeah, yeah, yeah. We're gonna see if that actually comes to fruition.' And hardly any of it did."

"I did go to… Senior Management… and basically get patted on the head, patted on the head, yeah we'll see what we can do."

"When I first became employed… every second Friday… we'd work extended hours and then we'd have an R.D.O… and without any consultation or anything, they just took it away… so that was really disappointing coz there wasn't any consultation. There wasn't an opportunity to express like how it would impact."

"the middle managers… they're able to be a part of understanding the strategic direction of the board, filtered down to them from the senior management team… middle management… then at least could share back with their team members, where we're heading and why some of the decisions were being made, what directions were happening."

"communication's key and I think there are times where as a manager some of that perhaps fell down in terms of keeping the staff abreast of where we were heading and all the changes. But I think we're getting much better at that. That's just a growth process"

"Even us at Social and Emotional Wellbeing… sometimes we don't feel as a group, that we're a part of the Gurriny structure anymore… I think it will help a lot of people too if they learn on Social and Emotional Wellbeing"

"my understanding was okay, well it's community controlled, community driven a hundred per cent local staff. But no, so we had like a senior manager says, '…no, that's not the definition or term of community control.' So community control means like being governed by a community local board… See so when community heard about Gurriny's going into community control, they didn't make it clear what is community control?... like especially in senior management… like they're non-indigenous"

"sometimes it's hard to really mentor and get people to see the wider vision, like for example, in order to do my job, you really need to understand the whole of the funding, political, strategic, primary health care sort of stuff."

"I don't think the workforce actually… appreciate how lucky they are. The benefits (and)… conditions that they have, that they're offered here are out of this world compared to mainstream. They don't know how lucky they are"

"I feel that they've done all this work and just left everybody behind – didn't take them with them and then there's expectation for everybody to jump on board"

Understanding the Big Picture

What is Working Well	*What Could Be Working Better*
• **Communicating the Big Picture** - Communicating the strategic direction and broader context of the organisation with staff.	• **Understanding the Big Picture** - Navigating tensions between different perspectives regarding what community-controlled PHC means and looks like; - Communicating and sharing information about the broader PHC and ACCHO sector contexts, as well as funding, policy and regulation contexts; - Better communicating about comprehensive, holistic primary health care and the role of Social and Emotional Wellbeing services in this model of care; - Developing understanding and appreciation for the work conditions provided at Gurriny. • **Bringing Staff Along the Journey** - Including staff in the strategic direction and decision making of the organisation; - Better informing staff about changes in the organisation and its direction.

Being Supportive, Encouraging Innovation	
What is Working Well	*What Could Be Working Better*
• **Supporting and Encouraging** - Being available and approachable; - Providing encouragement and positive feedback; - Having rewards and incentives. • **Jumping Out of the Box** - Encouraging change positivity; - Encouraging creativity and innovation in program design and delivery; - Trying new ideas and approaches; - Not being confined by old rules and approaches.	• **Supporting and Encouraging** - Providing encouragement and positive feedback; - Making staff feel valued. • **Jumping Out of the Box** - Having more flexibility in the way Gurriny is run and the approaches taken; - Bringing new thinkers into the mix; - Creating the space for staff to share and implement ideas and solutions.

"another thing is to drive that is…constructive feedback, staff motivation, words of encouragement"

"Little things like oh, '…good on you… you ran a really successful clinic today… I really appreciate the work you do here at Gurriny.' But don't say it out of- just for the sake of saying it. Say it because you mean it and you want to make your team – the staff in your team feel valued."

"whoever worked well… that team will get a certificate for working well... so that inspires us to keep up the good work… That sort of really boost us up and help us"

"if you are not open to change, nothing will change... if something's not working, you need to embrace change and try something else."

"the beauty of working here was the creativity. They said basically, this is it. You can go for it... we could be free to reinvent what Queensland Health had just said, 'this is how your care's going to look.'"

"I think they've been there quite a long time and I think they're used to doing things in a certain way and I think they're open to change and I think they're flexible but I do think that even if we throw some new thought into the mix, I think that we can then sit down and say, 'well how about let's jump out of the box. Let's just take this to a whole new level.'"

"That's what I'd like to see anyway. Just a bit of change in management – ease up and new strategies in how they do things out there."

"And I think we're sitting with solutions and we're sitting with um…creative ideas but we've actually got no outlet for them."

"I think if they can continue to support creativity and thinking laterally and encourage staff to think outside the box and support Health Worker led initiatives, and maybe create a platform for that – to bring ideas. Coz when you start sitting and talking to some of the Health Workers, the strategies and the solutions that they've come up with are just amazing!"

GROWING CAPABILITY

The third core strategy area is *Growing Capability.* This is essentially about professional development and capacity building of Gurriny staff, particularly local staff members. The two sub-strategies developed from participant interviews were *Growing up Our Own* and *Developing Staff Capacity*.

Growing up Our Own is a set of more specific strategies focused on the development of local staff. It was evident from staff interviews that Gurriny does a lot to support local Indigenous self-development. Many different participating staff members talked about a range of opportunities provided by Gurriny to build the knowledge, skills and experience and capacity of local staff. However, this was also an area with some of the compelling evidence for what could be working better at Gurriny to grow a stable and capable workforce. Staff talked a lot about the need and desire for strategies towards strengthened local leadership, in other words, *Being Led by Our Mob*. The primary ways to achieve this identified by staff include: *providing improved career progression pathways; raising up the next generation of leaders* by recognising and rewarding potential and ambition and providing leadership experience opportunities; *raising the vision of health worker*, which is about building health worker knowledge, understanding, skills, experience and confidence; and finally, *being clear about the role that non-Indigenous professional staff* have to play in local staff capacity development.

The other sub-category identified is *Developing Staff Capacity* which is about more general professional development for both local Indigenous and non-Indigenous staff. This is an area in which Gurriny does already excel. Many staff members talked about a range of ways that Gurriny supports staff professional development and capacity building, such as through having accessible study options, training and education support, career progression pathways and processes for developing senior and operational manager skills and capacity. Different ways to better support the development of staff capacity were also identified by several different participants. In particular having clear, transparent and fair systems for allocating professional development opportunities, and supporting the maintenance of clinical skills and professional requirements.

Growing Up Our Own

What is Working Well	What Could Be Working Better
• **Supporting Local Indigenous Staff Development**, including: - Supporting Health Workers to gain the Cert IV; - Having access to scholarships to support professional development; - Having opportunities to start as a trainee in admin or reception and then move into other positions; - Opportunities to travel nationally and internationally to present at and attend conferences; - Supporting access to external mentorship; - Employing staff educators; - Providing paid study leave; - Supporting staff to complete training and certificates; - Having opportunities to role fill for higher positions; - Mentoring youth in the community to promote the young person's health check; - Supporting leadership opportunities such as taking a lead role in a project and being part of a leaders' forum; - Formal and informal mentoring.	***Being Led by Our Mob*** • **Providing Pathways for Career Progression,** including: - Creating more middle management and team leader positions; - Giving staff a chance to move into leadership positions; - Increasing wages. • **Raising Up the Next Generation of Leaders,** including: - Recognising potential; - Recognising and rewarding staff effort, determination and ambition; - Giving local staff a chance to take on leadership positions; - Planning for succession; - Clearly mapping out career progression pathways and having systematic processes for staff to follow; - Being clear about the role of non-Indigenous staff members in supporting local staff career progression and leadership capacity development; - Providing opportunities for leadership experiences.

"I was privileged last year to go (overseas) to be a part of the… (name of) conference"

"one of my role… is I'll often backfill for (the team manager) when she's not around. So I'll do some of the management stuff"

"I think Gurriny is very big on professional development… Thursday's we have professional development day, so there's always something happening for us around professional development."

"initially most of the health workers were only Cert Three, so they're now on Cert Four, so they're being supported over the last couple of years of going off for training and improving those."

"I've just been in the same position. There was no opportunity really to move here or there."

"I am bored. I want to do something different. Like I do want to stay in health, but I don't want to be at the operational level anymore. I want to go up"

"our junior staff, they're a lower pay and a lot of them have been on the same pay rates for a very long time... So we're all under the... community control… it's not a very good award. If you go to places like Queensland Health, they pay you know, good money compared to here. A lot of them are above the award"

"But you just can't win. You can't get through. They knock you back. And it's like there will be opportunities, but I don't know, you just still can't get it and I know some staff you know, they have the potential, we see the way they work. Staff see the way they work but managers don't"

"I think some mindsets need to change. I think that there needs to be some more growing of our own and I think that we need to start raising leaders"

"A lot of our Health Workers- they're exceptional people... I just sometimes think Gurriny just doesn't understand what gems they have… And I know they say they do. But they need to like show it by providing pathways and rather than building outwards at the moment"

Growing Up Our Own – Continued…	
What is Working Well	What Could Be Working Better
	• **Raising the Vision of Health Workers**, including: - Increasing health worker confidence through improved training and more experience; - Building Health Worker clinical skills through the right kind of training which puts skills needed in their broader context; - Supporting Health Workers to become Health Practitioners; - Providing opportunities and creating systems to ensure that Health Workers are applying the knowledge and skills learnt in training. • **Being Clear About the Role of Non-Indigenous Staff in Local Staff Capacity Development**, including: - Establishing mentoring/role shadowing systems and having that built into peoples' contracts and KPI's.

"We've been asking, 'where's the succession plan for this organisation?'… you've got young ones there that are energetic. That want to be in that leadership position, and that can do it as well. You know, these are local people… they should've identified… what skill-sets do they have? Are they able to work at that level now or how can we build their capacity say in the next five years."

"that's why I sort of always advocate and say you know when we're doing health checks and assessments, let the Health Workers do it to build their clinical skills up too. Because if they don't, they're gonna lose it you know?"

"because of the way (Health Workers are) trained… they work very separately… basically at the end of it, there's very little confidence and very little ability to try and slate an isolated sort of action to the bigger picture."

"It would be good if they could I suppose upskill us in some of the areas that some non-indigenous can you know, we could step in... we probably could get you know, injection, vaccines... Training in immunisation"

"too much training's given and… They're not bringing it back and applying it. There's no follow-up… they're not managed and mentored back into giving that back into the organisation and applying it."

"I think that people that come on, that have the expertise… it should be part of their K.P.I.'s. I think part of leadership is to identify, 'who can I grow into (that) position?'… say, '…look, I'll be very clear with you. I am not shopping for permanent. I am only shopping for a two to three year contract. In that time I'm gonna be good to you, but you must-' you know, 'I am going to measure you and one of your K.P.I.'s within the first six months is to get him over the line with one of the skills-' or twelve months or whatever is reasonable and appropriate for that person's learning capabilities"

"Anything that I've asked for… that's one thing I just cannot fault them... They'll do whatever they can to support me."

"Just recently, and the Senior Managers, we had a three day workshop which was all about us getting to understand how to better manage."

"the Operational Management Forum… that's a forum where all the operational managers and the senior managers meet… it's a way of keeping operational managers informed? It's a way of them participating in decision making in the organisation. It's a form of mentoring in terms of including them and giving them a broader perspective across all the issues that you need to include in decision making when you're in a management role in the organisation."

"I undertook my diploma …, with the help of scholarships… I done it here based in Yarrabah…. So these training were offered in Yarrabah which was made accessible and easily to attend you know?"

"Well I feel I've lost a lot of my skill set now because I've been behind a computer and I feel that my skill set has definitely deteriorated since I've been here."

"So we've had a lot of turnover in terms of… nursing staff because… there's no C.P.D. planning"

"So they supported me through that but with this one I'm currently doing now, we were all told that we weren't gonna have any training? But I went and got a scholarship to do my diploma and I got ten day's study leave so I'm basically gonna do that off my own back"

"But we were told we were unable to do further training. If you want to do training, training would have to come out of our own funds"

"I thought primary health cert three or four would help with what I do and also help Gurriny with only (one)… male Health Worker… but I've been knocked back numerous times from Gurriny because it wasn't in my scope of work"

Developing Staff Capacity

What is Working Well	What Could Be Working Better
• **Supporting non-Indigenous staff development** - Access to training, conferences and other professional development opportunities. • **Developing Senior and Operational Management skills and capacity** - Training for senior managers - The creation of an Operational Management Forum • **Making Study Accessible** - Having training and education opportunities in Yarrabah and Cairns - Providing time off work to study or having paid or unpaid study leave • **Having Career Progression Pathways** - Creation of middle management positions • **Providing Training and Education Support** - In house training and access to external training and education	• **Having clear, transparent and fair systems for allocating professional development opportunities:** - Developing a system to ensure that processes for approving training and professional development requests are fair and equal; - Having transparent systems in regards to the amount and type of training available to staff and communicating this clearly to all staff. • **Supporting the maintenance of clinical skills and professional requirements:** - Ensuring that Nursing staff have adequate Continuing Professional Development (CDP) planning and activities to maintain registration; - Ensuring adequate opportunities to maintain clinical skills.

WORKING WELL TOGETHER

The fourth and final core strategy area identified in the grounded theory analysis of participating staff interviews, was *Working Well Together*. This covers strategies that are all the relevant to strong and positive work culture where staff get along, feel good in the workforce and work well together in providing healthcare to meet Yarrabah community health needs. The sub-strategies included here are *Communicating and Sharing Information* and *Getting Along Together.*

One concept which emerged in relation to working well together was around *Communicating and Sharing Information.* Once again, while some staff did talk about the good communication system that Gurriny already has in place, including regular team meetings and the operational management forum, there was strong sentiment that this is an area needing improvement. Several staff members talked about the need for improved information sharing in regard to a range of things including managers roles and responsibilities, and professional development opportunities. Along a similar thread, several staff talked about the importance of creating and communicating clear expectations. All of this would be facilitated by improvements in Gurriny's communication systems and structures.

The other sub-strategy identified is *Getting Along Together* which is about the cohesiveness of the workforce culture on an interpersonal level. This is one area where Gurriny does really well. There were accounts from many staff about the different ways that Gurriny staff get along together. This happens through staff just being there for one another, getting past personal differences and maintaining respect and

professionalism. Staff talked positively about the strength of Gurriny's multidisciplinary teams, and the ways that Gurriny staff, from all different positions and programs, Indigenous and non-Indigenous, learn from each other. Gurriny supports this process through creating opportunities for cross-organisational bonding, which managers have indicated they are committed to continuing. Despite this area being a strength, staff did indicate that work can still be done to support Gurriny staff in getting along together. This includes facilitating understanding between staff about things like different expectations, or better understanding the impacts of personal circumstances on staff. There could also be improvements in encouraging and facilitating staff to work outside of role and program boundaries, and creating more opportunities for cross-organisational bonding.

Communicating and Sharing Information

What is Working Well	*What Could Be Working Better*
• **Having Good Communication Systems** - Having regular team and all of staff meetings; - Effective use of email communication; - Utilising the Operational Management Forum to communicate and share information across the organisation; - Having team plans with matching KPI's.	• **Sharing Information** - Greater information sharing between staff, teams and management about services, others roles and responsibilities, and professional development and training opportunities; - Providing clear guidelines and instructions. • **Creating Clear Expectations** - Providing longer, more in-depth induction training to teach Gurriny's philosophy and model of care; - Creating clear expectations around roles and responsibilities; - Creating clear expectations about benefits and entitlements, such as training, leave and R.D.O's. • **Having Good Communication Systems and Structures** - Having transparency, i.e. Sharing senior management and operational management meeting minutes; - Having regular all of staff meetings with an open agenda for people to be able to raise issues.

"What we (the operational managers) do is… we include all the other managers in to let them know what's happening… we will c.c. everybody in and say, '…hey can you jump in on this and add to this conversation.'"

"each Monday, we come to work, eight o'clock we have our meeting with everyone, all Health Workers, all doctors, all nurses… and then when we come away, then the doctors and the nurses stay behind for their meeting? And our team- the Care Coordination team, we have our meeting down at the back… then at least we will know what each one is doing"

"the Operational Management Forum… it's a way of keeping operational managers informed"

"there's been issues around privacy, confidentiality, where the clinic- or those in those positions didn't feel that I needed to know any of that kind of stuff which I guess hindered me in some way in my work"

"clear instructions. This is what I want you to do. This is what I want you to achieve and by this time… And notice, yeah"

"you… go out to the community they're like, 'oh do you know when the next team is coming? Like when the next visiting service is?' I'm like, 'I wish I knew that but no, I don't work in that area.'"

"our induction processes… I think it's over a day. And I think it just needs to be over a week and I think that that person needs to be infused with our way – the way that we do things and really get the philosophy of community control"

"What I've got is from what (Health Worker has) told me… is just this huge waste of potential because she's just so lacking in confidence to move anywhere because she's not given any clear guidelines."

Getting Along Together

What is Working Well	*What Could Be Working Better*
• **Being There for One Another** - Helping each other out; - Having a supportive team culture; - Understanding personal context. • **Working Well in Multidisciplinary Teams** - Collaborating between doctors, nurses, health workers, drivers etc; - Effective integration of clinical services with Social and Emotional Wellbeing services, Health promotion and visiting Allied Health specialists. • **Creating Opportunities for Cross-Organisational Bonding** - Formal and informal whole of organisation and team/program specific team building events. • **Getting Past Interpersonal Differences** - Maintaining professionalism; - Being respectful; - Being kind to one another. • **Learning From One Another** - Learning from other professions; - Indigenous and non-Indigenous staff sharing knowledge.	• **Building Understanding Between Staff** - Navigating different expectations; - Getting past personal differences; - Understanding personal context; - Understanding others roles and responsibilities. • **Working Outside of Program Boundaries** - Being willing to work in other programs or roles when needed; - Better integrating clinical and SEWB programs and services. • **Helping and Supporting Each Other** • **Being Able to Rely on One Another** • **Creating More Opportunities for Cross-Organisational Bonding**

"you've gotta kind of have a sense of… how other people operate in your space. When you assume that a person maybe is not doing their job properly or is undermining you, it's not at all, it's just that they're coming from it from a completely different angle."

"I still learn a lot (from) our Registered Nurse here, if I'm not… hundred per cent sure… (I) just get clarification first"

"there might be Health Workers away… today and we've got a clinic, we just all help one another"

"I wouldn't be able to do anything that I do here without the support and interaction I have with every single staff member out the back there. So all the nurses… all the Health Workers, the Social Emotional Wellbeing team"

"I can be in the Care Coordination team… But then like I'll get pulled into the clinic… but people don't like to do that. They like to say, no this is my job, this is my role. That they don't see the bigger picture"

"We had like a team bonding day last month… all the staff… they just had so much fun and they really enjoyed it. It just made me feel like even though… things happen when staff are taking offence or getting frustrated – there's a real willingness to actually try and make it work"

"A lot of different community families are here, so there's stuff happening out in the community so I think it's great that no one really brings that into Gurriny so there's professionalism right there"

"I really think that everyone has respect for one another. I think everyone, they do well to come to work and put their differences aside. Everyone always works towards positive outcomes, regardless of whatever issue"

"(Health Worker) is the expert on our community and she's in turn training me all the time. Especially around how do you be, you know, amongst her community"

KEY ENABLERS

Enablers are the factors which support Gurriny in the core process of '*growing a stable, capable and cohesive/collaborative workforce that is responsive to community health needs'* as identified by participating staff. These enablers are multi-level existing on macro, community, PHC service and individual levels.

MACRO	• Support from, and involvement in, the broader ACCHO sector; • Government funding for organisational expansion.
COMMUNITY	• Keeping community and family conflicts or issues outside of the workplace; • Collaborating with other services; • Future leaders rising in the community, including young people who are gaining medical qualifications; • Community commitment to improving the health and wellbeing of Yarrabah community; • Having strong local leaders; • Community support and involvement.
PHC SERVICE	• Having strong local leadership including the board of directors, senior managers, middle managers and experienced workers; • Having non-Indigenous staff for community members who don't want to see other community members for their health care; • Understanding and accommodating for the challenges that local staff face; • Having flexibility in service provision to allow for services to address the social determinants of health and a formal framework and acknowledgement of that; • Expanding Social and Emotional Wellbeing services; • Service expansion and development; • More senior management, middle management and team leader positions to create more opportunities for local leadership development and career progression; • Expanding and providing increasingly comprehensive services with more opportunities to meet community health needs; • New programs and services, providing further employment and better enabling Gurriny to meet Yarrabah health needs; • Having the freedom and flexibility to do things differently within the community controlled PHC model; • Reflecting on practices and approaches, and learning from mistakes.
INDIVIDUAL	• Maintaining strong professional boundaries between work and community/personal connections; • Embracing change/encouraging change positivity; • Staff being motivated and taking opportunities; • Staff commitment to meeting the health needs of the Yarrabah community, and to Gurriny as an organisation; • Local staff ambition and motivation to develop professionally and build their skills and experience; • Local staff completing studies and gaining qualifications; • Staff taking responsibility and supporting one another; • Non-Indigenous staff commitment to working in the ACCHO sector and improving Yarrabah community health and wellbeing; • Staff creativity, innovation and initiative to improve the workforce culture and build team cohesiveness; • Responsibility felt by local staff to improve the health and wellbeing of the Yarrabah community serves to motivate staff; • Being reflective.

KEY BARRIERS

Barriers are the factors which constrain Gurriny in the core process of '*growing a stable, capable and cohesive/collaborative workforce that is responsive to community health needs'* as identified by participating staff. These barriers are multi-level existing on macro, community, PHC service and individual levels.

MACRO	• Increased risk, responsibility and government accountability that comes with being a large PHC organisation; • Funding insecurity; • Insufficient funding; • Being limited by external practice regulations.
COMMUNITY	• Few local people have senior management skills, experience and capabilities to operate such a large and complex organisation; • Few local people have clinical qualifications, skills and experience; • Community or family conflicts can impact staff relationships; • Challenges that can come when working with other services.
PHC SERVICE	• Challenges in communicating across a large organisation with 75+ staff and multiple different teams; • Larger staff numbers make for more complicated interpersonal dynamics and potential conflicts; • Few locals in senior management positions creates feelings of marginalization amongst local staff, and discontent; • Disconnect/lack of understanding between the strategic direction/big picture health system context and operational/everyday practice context; • Organisational and community/family factions, particularly having families with a strong influence as staff and board members in the organisation; • More expected and planned growth and changes in the organisation runs the risk of creating further change fatigue and burnout among staff; • Lack of stability in senior management; • Staff turnover; • Difficulties meeting workforce requirements; • Limited physical space to house the expanding workforce ; • Loss of cohesiveness that comes with a workforce which is spread out across multiple locations.
INDIVIDUAL	• Lack of motivation among local staff due to the overwhelming social and health issues experienced in the community; • Personal and family issues and challenges impacting on staff; • Change fatigue among staff; • Lack of confidence of health workers; • Different expectations among staff ; • Interpersonal conflicts and differences; • Lack of understanding among staff of each other's contexts and challenges; • Staff members whose values and approaches do not fit with those of the organisation; • Burden of responsibility felt by local staff can be a stress for staff impacting on work due to the reality that staff never really leave work and are more emotionally invested in community health outcomes; • Local staff having limited experience working in healthcare outside of Gurriny.

Ways forward

This analysis identified that there are some key tensions which need to be addressed as part of Gurriny's workforce strategy. These tensions are commonly experienced by many Indigenous PHC services. One of these tensions is in regard to Gurriny's leadership and in particular the degree of local Indigenous leaders in management positions. There was strong agreement from many participating staff regarding the desire to have more local people in leadership positions in the organisation. Many local staff also demonstrated significant motivation and ambition to become leaders, with staff having undertaken various studies and training and professional development. There was a sentiment expressed that Gurriny could do more to prepare and support local people for leadership positions.

One reason provided for why there is not more local leadership, particularly in senior management positions, is due to the paucity of local staff with the appropriate skills, qualifications and experience in the relevant fields. In particular, the value in working outside of Yarrabah to attain understandings of the broader context and conditions of primary healthcare for Indigenous peoples, was expressed. There is no straightforward way to resolve this tension, which is made more complex by the fact that there is little literature addressing this issues in the ACCHO sector. The perspectives raised in interviews with staff does show that it is an issue that warrants further attention, exploration and communication so that Gurriny's workforce can collectively try to reconcile this tension and find creative solutions.

Another key tension included the potential discrepancy between staff requests for certain work conditions or benefits and organisational capacity or funding availability to provide these. An example is with the issues of parity of staff wages with the award wages of government health employees, discussed in the strategies. Any systems for enacting such desired strategies would need to be carefully planned in the context of Gurriny's budget as a whole, to ensure financial sustainability. To address this tension, Gurriny needs to communicate and share information so that staff can better understand such limitations while also listening to and being responsive to staff concerns.

Finally, the interviews indicated that there is a tension that exists between different staff perspectives regarding the extent to which the personal circumstances and challenges faced by local Gurriny staff should be accommodated in the workforce. Navigating such different perspectives is something that Gurriny will no doubt continue to have to do. However, this

may be helped by strategies mentioned by staff, such as recruiting people with the right values and who understand the particular challenges and stressors faced by local staff. Having clear organisational principles and policies to support such an approach, and completing a thorough induction processes with new staff to help build this understanding were other suggested strategies.

APPENDIX 1: Literature review search strategy

Search strategy

Electronic database search: In consultation with a librarian (MK), we ran an initial exploratory search in Scopus/Elsevier and PubMed Clinical Queries to look for relevant studies and to see how they had been indexed; then downloaded selected references. The librarian then completed a comprehensive search of electronic databases: Medline, Embase, PsycINFO, EBM Reviews - Cochrane Database of Systematic Reviews, The Campbell Library, CINAHL, Global Health, ATSIHealth /Informit, APAIS-ATSIS/Informit, AIATSIS: Indigenous Studies Bibliography/Informit and PAIS/ Proquest. Searches were completed from 2-9 January 2018.

Search strategy: Terms searched were:

1. Indigenous OR Aborigin* OR "Torres Strait Island"* OR Inuit OR Maori OR Iwi OR "Tangata Whenua" OR "First Nation"* OR Metis OR "Native American"* OR "American Indian"* OR "Native Hawaiian" OR tribal;
2. Healthcare OR "health care" OR "primary health care" OR health;
3. Service OR provider OR program OR clinic OR center OR centre OR "health services, Indigenous" OR "health care delivery" OR "community program" OR "health care research";
4. Workforce OR retention OR recruitment OR coordination OR develop* OR "personnel selection" OR "health manpower" OR "health care manpower" OR "health personnel" OR "professional development" OR "professional role" OR "personnel management" OR "healthcare workers";
5. Model* OR process* OR strateg* OR plan* OR "practice guidelines" OR "cultural competency" OR "capacity building" OR "professional competence" OR "health planning" OR "health model organizational";
6. 4 OR 5;
7. Canada OR Australia OR New Zealand OR USA;
8. 1 AND 2 AND 3 AND 6 AND 7.

Supplementary search: A supplementary search on workforce motivation, productivity and incentives was conducted in Medline (including Epub Ahead of Print, In-Process & Other Non-Indexed Citations)/Ovid on 31 March, 2018 but produced no useful references.

Websites manually searched: A research support worker (CS) searched generic (Google Scholar and Google) and country-specific websites and clearinghouses:

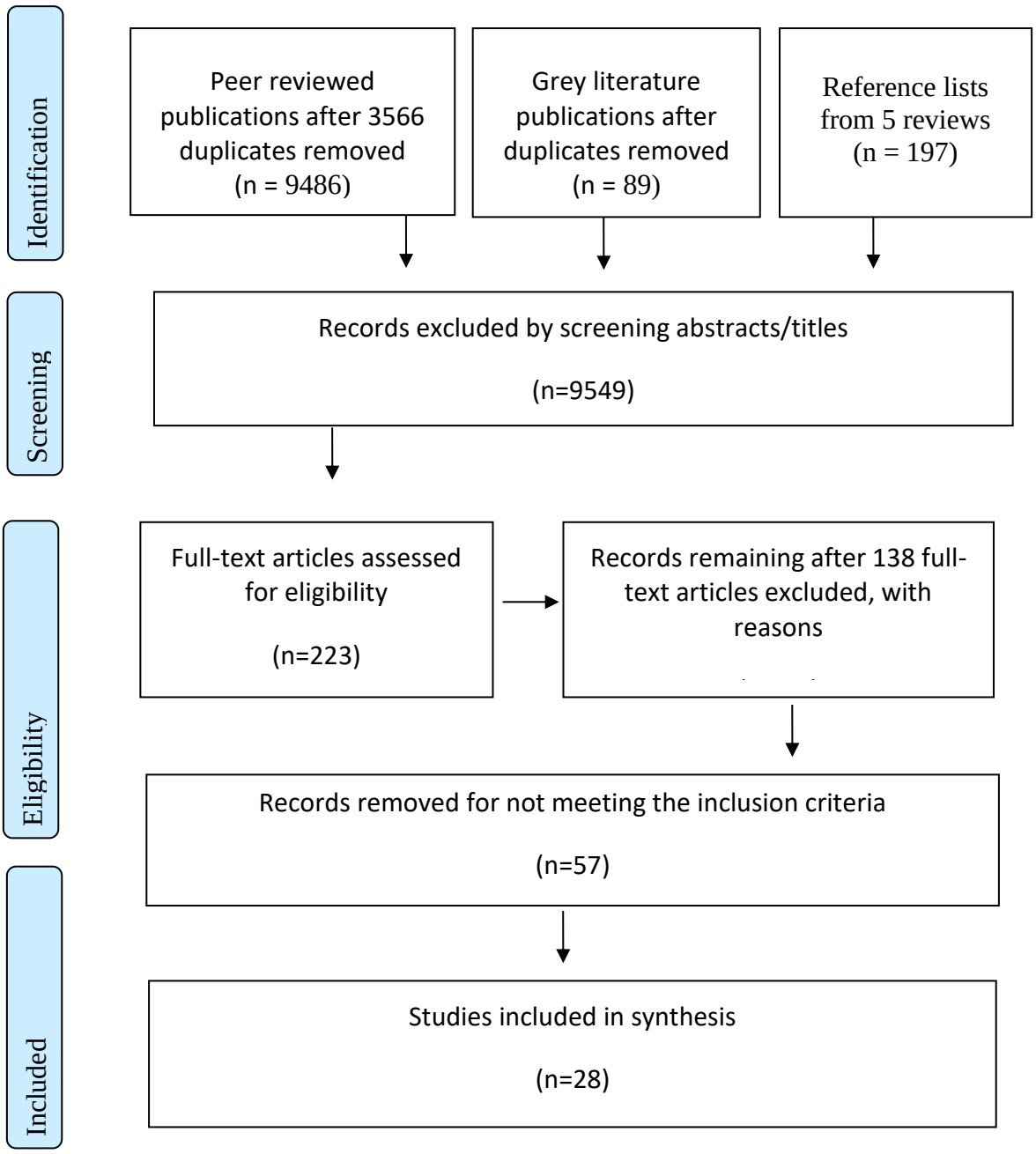
- Canada: Canadian National Collaborating Centre for Aboriginal Health; Health Council of Canada: Aboriginal Health
- Australia: Australian Indigenous HealthInfoNet, Australian Closing the Gap Clearinghouse
- New Zealand: New Zealand Maori Health, Whakauae: Research for Maori Health and Development, MAI: A New Zealand Journal for Maori Health and Development,
- USA: US American Indian Health, US National Indian Health Board, and US Centres for American and Alaska Native Health.

Search terms were tailored to specific sites, but included:

1. Indigenous OR First Nation* OR Inuit OR Metis OR Aborigin* OR Torres Strait Island* OR Maori OR Iwi OR Tangata Whenua OR Native American* OR Native Alaskan* OR Native Hawaiian* OR Indian OR tribal
2. healthcare OR health care OR primary health care OR health;
3. workforce
4. 1 AND 2 AND 3.

Reviews: The reference lists of systematic literature reviews concerning Indigenous PHC workforce planning and development were also screened for interventions that met the inclusion criteria.

APPENDIX 2: Literature review - flow chart of included and excluded studies



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