# Attract Connect Stay.

## Final Project Evaluation

Dr. Anna Moran | unplex

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I acknowledge the original and ongoing custodians of the lands on which we live, work and play and pay my respects to their elders past, present and emerging. We commit to working alongside First Nations people for healing, reconciliation and justice.

I wish to acknowledge the incredible efforts of the project implementation team in bringing the Attract Connect Stay project to fruition. The team comprised Dr. Cath Cosgrave (Cath Cosgrave Consulting / The University of New England), Dr. Christina Malatzky (Queensland University of Technology), Dr. Susan Waller (Monash University) and Dr. Rosalie Boyce (Barwon Health and South West Healthcare / Rosalie Boyce Consulting).

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# EVALUATOR

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Dr Moran has 18 years' international research, evaluation and consultancy experience. She has a passion for working with health and social care organisations to simplify complexity around planning and executing workforce change so they have greater capacity to meet the needs of the individuals and communities they serve. Anna also manages a small, vibrant healthcare business with her husband in Wodonga on Dhudhuroa and Wiradjuri country, where they live with their four children.

# Introduction

Attract Connect Stay (ACS) is an evidence-based, place-informed rural health workforce solution. It is underpinned by 10 years of rural health workforce research and brought to life through translation of this evidence modelled on an existing, proven program operating in Marathon, Ontario Canada. The Marathon model mobilises the gifts, knowledge, and practical skills of residents, community groups and local organisations to better attract and retain health workforce professionals through the establishment of a locally funded, locally recruited and locally managed Health Workforce Recruiter Connector (HWRC) position.

The ACS program was funded by the Foundation for Rural Regional Renewal (FRRR) as a two-year, community-based participatory action research project. The purpose of the program was to develop and pilot a Blueprint that codified the necessary steps required to plan for and implement the ACS solution, embodied by a HWRC, into rural communities in New South Wales and Victoria, Australia. The implementation and oversight of the project was led by Dr. Cath Cosgrave (Cath Cosgrave Consulting / The University of New England) alongside Dr. Christina Malatzky (Queensland University of Technology), Dr. Susan Waller (Monash University) & Dr. Rosalie Boyce (Barwon Health and South West Healthcare / Rosalie Boyce Consulting) and was administered by Services for Australian Rural and Remote Allied Health (SARRAH).

This report describes the success and impacts of the ACS project and solution and the key mechanisms that contributed to these.

# EXECUTIVE SUMMARY

This evaluation has determined that Attract Connect Stay is a viable and impactful solution to addressing complex rural health workforce problems in small- to medium-sized rural communities.

**Viability and impact are, however, contingent upon the rural community:**

- Intimately and collectively understanding and wanting to overcome the health workforce problems they face.
- Critically assessing whether or not they have the necessary pre-conditions to successfully undertake the Attract Connect Stay solution to address their health workforce problems.
- Rallying together and leveraging their assets and strengths to undertake all steps in the program in appropriate order.
- Generating and/or securing appropriate funding that supports place-based implementation of the program.
- Seeking mentoring to adapt each step in the program to the local context.

## Attract Connect Stay (ACS) is an evidence-based, place-informed rural health workforce solution underpinned by 10 years of rural health workforce research and brought to life through translation of this evidence modelled on an existing, proven program operating in Marathon, Ontario Canada.

As a program ACS was funded by the Foundation for Rural and Regional Renewal (FRRR) as a two-year, community-based participatory action research project. The purpose of the program was to develop and pilot a Blueprint codifying the steps required to plan for and implement the ACS solution into rural communities in New South Wales and Victoria, Australia.

The implementation of the project was led by Dr. Cath Cosgrave (Cath Cosgrave Consulting / The University of New England), working alongside Dr. Christina Malatzky (Queensland University of Technology), Dr. Susan Waller (Monash University) & Dr. Rosalie Boyce (Barwon Health and South West Healthcare / Rosalie Boyce Consulting).

## This evaluation sought to:

i) iteratively inform the development of each feature of the Attract Connect Stay – Health Workforce Recruiter Connector Blueprint [referred to as 'the Blueprint'];

ii) measure its impact on rural communities; and

iii) understand what has worked, for who, to what extent and why for the multiple phases and parts of the

iv) Attract Connect Stay (ACS) project.

To achieve these goals, the evaluation was undertaken throughout the life of the ACS project. Realistic evaluation techniques [1, 2] were used to plan, gather and analyse data to answer the following evaluation questions:

1. To what extent did the ACS project achieve its goals? What were the activities and mechanisms that enabled this to happen?
2. What was the impact of the ACS solution and Health Workforce Recruiter Connectors (HWRC) on small (population 7,000-20,000) rural (Modified Monash Model 4-5) communities? What were the activities and mechanisms that enabled the impact?
3. To what extent does the Blueprint enable rural communities to design and implement place-appropriate health workforce attraction, recruitment and retention strategies? What are the mechanisms that need to be in place or considered to enable this to happen?

A multi-level data gathering approach was used to respond to the evaluation questions. Sources included key documents, project outputs, interviews with stakeholders, locally gathered HWRC data and surveys of pilot sites and Blueprint users.

## Based on a synthesis of all information gathered, it was concluded that the ACS project fully achieved three of five of its goals and partially achieved the remaining two. ACS enabled real-time development and piloting of an evidence-informed Blueprint in co-design with a single rural community in Australia.

The *Blueprint* successfully captured, codified and prioritised each evidence-based step that rural communities need to take to successfully implement the ACS solution and realise the outcomes of a HWRC position for their community.

The project identified a need for significant time investment in the 'READY' and 'SET' phases of the ACS solution. As a result, Phase Four (piloting and uptake of the Blueprint across further communities) was not undertaken.

**The impact of the ACS project is demonstrated by the outcomes achieved by the single pilot community** (population size 8,873, Modified Monash Model 4) that progressed through all phases of the Blueprint to implement a HWRC in their community. These outcomes include:

- Over $50,000 funding raised to support the HWRC position and the ACS-Glen Innes Incorporated Association.
- 7 healthcare professionals and 5 family members supported to move to and/or settle/connect into the community in the initial 6 months of the HWRC position being active.

  This included 2 General Practitioners, 1 Pharmacist, 1 Exercise Physiologist, 1 Diabetes Educator, 1 Nurse Practitioner, 1 Speech Pathologist.
- The arrival of the first General Practitioner in August 2022 led to 70 patients being moved off waiting lists, equating to 224 hours of additional clinical care provided to the community over a 3.5-month period.
- With a second General Practitioner commencing in mid-November, Glen Innes will see at least 70 more patients being moved off the waiting list and significantly more hours of clinical care provided.

## The success of the ACS project is attributable to several mechanisms that were progressively identified, refined, implemented, and built into each phase of the project and subsequently codified in the Blueprint (see Figure 1).

**1 Activities and mechanisms that were required to successfully develop the Blueprint included:**

- Ten years of evidence-building with each piece of research strategically informing the next.
- Identification of the transferability of the Marathon Model to the Australian context.
- Learning from early adoption of ACS into other regional and rural communities in Australia.
- FRRR funding for the Blueprint to be co-designed and implemented with rural communities.
- Infusion of Asset Based Community Development (ABCD) principles and evidence into the ACS project strategy.
- Identification and recruitment of 'READY' communities who committed to and trusted the process and did the hard work.
- The ACS implementation team and pilot communities engaging with 'the right' strategic stakeholders who understood the problem from both a community and business perspective and could see the potential for ACS to work in their rural communities.

**2 With these (1) activities and mechanisms in place, the following allowed the pilot sites to successfully implement the HWRC and the ACS solution into their rural community and realise impact:**

- The community exhibited exemplary 'READY'-ness to adopt and implement the ACS solution. This was particularly enabled when the community had experienced significant, pervasive and long-standing difficulties in recruiting and retaining healthcare workers and therefore a deep and personal connection to the impact of health workforce struggles, especially in relation to doctor shortages.
- The business structure, composition, and activities undertaken by the ACS management committees were evidence-informed but adapted to be place-appropriate.
- The community (and management committee) in each site undertook significant work to ensure that high levels of understanding, awareness of and support for the goals of ACS were present across the community.
- The community in each site formed strong, trusting relationships with the Implementation Lead, made a commitment to the ACS process and trusted in it.
- There was a deliberate, gradual, and mentored transfer of ownership of ACS from the Implementation Lead to the community.

3 **With these (2) mechanisms in place, the following were then required for the Blueprint to be engaged with by further rural communities:**

- Marketing and promotion of the ACS project to ensure high levels of awareness of the ACS solution, as well as exposure to and engagement with the Blueprint.
- An engaging ACS website with clear and practical information.
- A willingness on the part of interested rural communities to take the necessary time to read through the Blueprint information and undertake the learning modules provided.

4 **Finally, moving forward, the following activities and mechanisms are recommended in order for the Blueprint to be more widely adopted and used by other rural communities to implement HWRCs:**

- Interested rural communities use the Blueprint to critically appraise their readiness to undertake the solution
- Interested rural communities have access to support and mentoring to help them plan and implement the solution in their own community
- Specific strategies are explored for communities to implement the ACS solution when a particular need for Allied Health professionals is identified
- Rural communities that are committed to implementing the ACS solution have access to matched funding schemes

The findings of this evaluation are limited by data only being available from one pilot community that completed all steps in the ACS program, with the Blueprint not being piloted in further communities in Victoria. The available evidence indicates, however, that the Blueprint allows small- to medium-sized rural communities to fully understand the entirety of activities that need to be undertaken, the conditions that need to be in place for the ACS health workforce solution to be successful, and whether or not they are the kind of community that are in a position to undertake the solution.

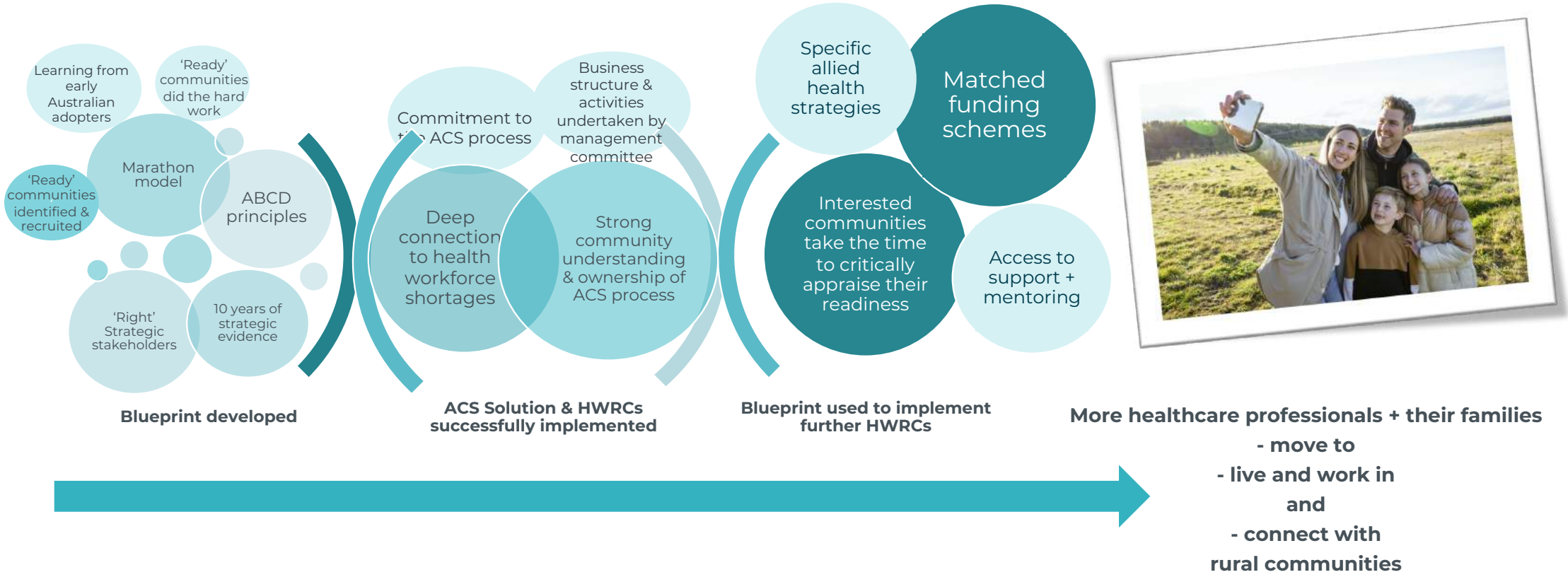
Further work needs to be undertaken to understand the effectiveness of the Blueprint, in combination with support from the Implementation Lead, in enabling rural communities to work through and apply the critical steps in the ACS solution to their own rural community.

While the ACS project has enabled the single pilot community to attract and support a range of healthcare professionals, this was predominantly achieved through leveraging the community's need and drive for medical doctors. There is further work to be done to understand how the ACS solution and the Blueprint can be improved to support communities who have a dominant need for healthcare workers outside of the medical workforce.

Strategies for communities to implement ACS when they identify a particular need for Allied Health professionals is currently lacking. This is partly due to low health workforce literacy among the general and specifically the rural population [3].

Improved options for communities to secure appropriate and sustainable funding to undertake the ACS solution also require further exploration. The Implementation Lead has identified that the government should ideally provide a level of matched funding to communities who are 'committed to doing the hard work' to implement the ACS solution.

## Figure 1 Summary of key mechanisms contributing to outcomes of the ACS



## Glossary and Abbreviations

| | |
|---|---|
| **Activity** | The actual activities, actions or interventions undertaken to realise the goals of ACS. |
| **ACS** | Attract Connect Stay |
| **ACS Solution** | Describes the entirety of the ACS program and the necessary context required to support the implementation of a Health Workforce Recruiter Connector position. |
| **the Blueprint** | The codified steps, as detailed on the Attract Connect Stay website, that are required to implement the Attract Connect Stay solution, including steps to plan and introduce a Health Workforce Recruiter Connector position into a rural community |
| **Codesign** | Co-design brings stakeholders together to design new products, services, and policies |
| **Context** | The physical, material, organisation and/or social environments in which the activity is taking place [4] |
| **Community (Macro)** | The community context as a whole and the macro level activities that the Management Committee, Council, local industry and community representatives in the local Government Area, state or federal government undertake that may influence the outcomes for the community (see Figure 2) |
| **EOI** | Expression of Interest |
| **FRRR** | Foundation for Rural and Regional Renewal |
| **GP** | General Practitioner |
| **HWRC** | Health Workforce Recruiter Connector |
| **Individual (Micro)** | New-to-area healthcare professionals and their family members (see Figure 2). |
| **LGA** | Local Government Area |
| **Mechanism** | Mechanisms attempt to explain why change occurs or why a particular outcome is observed. Mechanisms capture the essence of 'what it is about a program that makes it work' [4] (p66). In this report barriers and facilitators to change were identified. Often (but not always) the barriers and facilitators are the opposite of each other, and when written as a positive statement, they become the mechanisms to support change. |
| **NSW** | New South Wales |
| **Organisational (Meso)** | Businesses and organisations, workplaces and employers, community organisations, community groups, critical infrastructure/suppliers (see Figure 2). |
| **Outputs** | The material or measurable products of undertaking the process or project under investigation [4]. Outputs are tangible, countable, and relatively uncontentious products of the project and they are often the clearly codifiable components of the process. |
| **Outcomes** | Outcomes are the changes resulting from the intervention or program and should be closely related to the goals. Outcomes often require a formal process of evaluation/research to capture in a meaningful way. |
| **PHN** | Primary Health Network |
| **Professionals** | Highly skilled health and social care, infrastructure (engineering), education and finance professionals. For example medical doctors, nurses, Allied Health, mental health workers, engineers, engineer/project managers, teachers and executive roles in these sectors. |
| **SARRAH** | Services for Australian Rural and Remote Allied Health |
| **Success** | Success was defined in this evaluation in terms of: the extent to which planned project phases were undertaken and implemented and the extent to which goals were achieved. |
| **VIC** | Victoria |

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# Background

## The problem

Chronic healthcare workforce shortages and high turnover of health professionals are common challenges facing many rural communities. Successfully recruiting and retaining out-of-area health professionals is essential to maintaining an adequately sized and skilled health workforce to meet local healthcare needs in rural areas.

The World Health Organisation [5] has identified rural health workforce shortages as a leading cause of the inequitable access to healthcare that exists between rural and urban residents. The rural health workforce problem is primarily one of maldistribution [5]. There is an oversupply of health professionals in metropolitan areas and an undersupply in rural areas. These health workforce shortages intensify the more remote the community is, particularly for the Allied Health and medical workforces.

In Australia, the impact of this maldistributed health workforce is that rural Australians experience poorer health outcomes than their city counterparts—living shorter lives, acquiring greater levels of chronic disease, sustaining more injuries, and experiencing poorer mental health.

Governments in high income countries have tended to consider their maldistributed health workforce problem primarily within the conceptual framework of economic (demand/supply) theory [6]. Thus, their policies have focused on increasing supply to address unmet demand and ensuring the 'optimal' organisation of the health workforce for different rural settings.

**To improve the supply in relation to the rural health workforce, governments have implemented a rural pipeline strategy which is concerned with [7, 8]:**

- Prioritising the selection of students already sensitised to rural living.
- Exposing medical and health students during training to rural curriculum and rural practice (through clinical placements).
- Building regional post graduate training and professional development opportunities.

Despite substantial investment by national governments in this 'rural pipeline' for more than 30 years and some signs of improvement [8], overall the maldistribution of the rural health workforce persists [9].

Dr Cosgrave's research reveals that health professionals' decisions to accept a rural health position, and their subsequent decision to stay or leave, are complex and are influenced by myriad highly interactive dimensions [5, 10-18]. **These can be broadly categorised into three domains:**

- Organisational (or workplace).
- Role (including profession and career development opportunities).

- Personal (including individual characteristics, spousal and family support, social aspects, and lifestyle interests.

Until recently, research and human resource strategies have mostly focused on strengthening understanding and improving organisational and role conditions. Much less focus has been given to the inter- and intra-personal determinants, despite the fact that psychosocial and personal factors are increasingly being found to significantly influence both recruitment and retention [19].

In addition, the need for active community participation in settling new recruits into community [20] has been identified as an 'essential' strategic element for the recruitment and retention of the 'right' professionals needed to achieve a 'sustainable', 'fit-for-purpose' rural health workforce.

In summary, there are significant influences on recruitment and retention that are currently not being addressed either by government or rural health services. **Specifically, these factors are:**

- The personal needs of individual health professionals [11, 16-18].
- The unique contextual circumstances of rural communities [21].

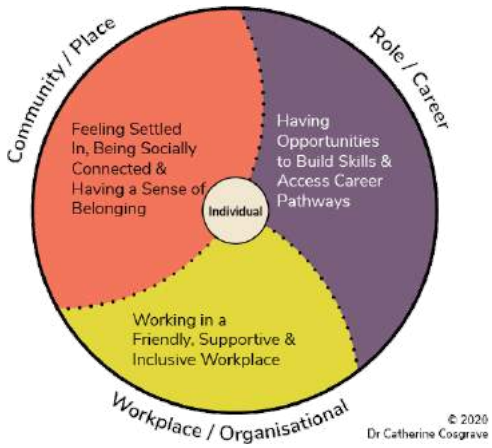
Dr Cosgrave argues that there is an urgent need to move towards a more person-centred and holistic approach to rural health workforce problems. The development of the Whole-of-Person Retention Improvement Framework [11] is the response to this suggestion.

## Conceptual Framework

Dr Cosgrave's Whole-of-Person Retention Improvement Framework (WoP-RIF) [11] (Figure 2) is based on ten years of research and hundreds of interviews with rural health professionals, health service managers and CEOs and meetings held with other business and organisational leaders and community members in Australian rural towns and regional cities .

Dr Cosgrave's Whole-of-Person Retention Improvement Framework (WoP-RIF) addresses the identified need for a person-centred, holistic, approach to successfully attract and retain health professionals to rural places.

**Figure 2. Whole-of-Person Retention Improvement Framework**



The WoP-RIF conceptual framework recognises and embraces the need for a whole-of-community response to address challenges experienced at the individual, organisational and community levels.

**WoP-RIF identifies three domains impacting retention:**

- Workplace / Organisation
- Role / Career
- Community / Place

Each domain identifies the necessary pre-conditions for improving rural health workforce retention through strengthening health professionals' job and personal satisfaction (see Table 1).

## Table 1: Pre-conditions for improving rural retention by WoP-RiF domain

| Types of Satisfaction | WoP-RIF domains | Major influences on job/personal satisfaction |
|---|---|---|
| **Job satisfaction** | Workplace | High quality workplace relationships with line manager and team |
| | Organisational | Organisation managed efficiently and strategically |
| | Role | Opportunities to engage with other discipline-specific health professionals and governing bodies |
| | Career | Opportunities for career development/advancement |
| **Personal satisfaction** | Place | Experience a sense of connection leading to belonging |
| | Community | Community involved in the planning and implementation of recruitment and retention strategies |

A distinguishing aspect of WoP-RIF, compared to other rural professional workforce retention frameworks/models, is the way in which the 'Community and Place' domain is given a weighting equal to that of the Workplace/Organisational and Role/Career influences.

While the 'Community and Place' domain has relevance for all health professionals, it is of particular importance in relation to health professionals (and their partners and other family members) who have relocated and need support to settle in and make social connections. Dr. **Cosgrave's research identifies that if 'newcomers' do not settle well or develop strong social bonds within the first 12 months of relocating, then turnover is likely.** The Attract Connect Stay project therefore has a dominant focus on the community and place domain of WoP-RIF.

## The Marathon model, Health Workforce Recruiter Connectors and Attract Connect Stay

While the successful settlement and social connection of skilled professionals (and partners and other family members) is known to be important for retention, there is very little evidenced-informed research available to guide rural communities on effective attraction and retention strategies.

To address this knowledge gap, in 2018 Dr. Cosgrave was awarded a Churchill Fellowship [13] travel to Canada to investigate community-led strategies to support new-to-area health professionals' resettlement and their social connection and belonging. While in Canada, Dr. Cosgrave came across the highly successful Health Workforce Recruiter Connector model operating in the town of Marathon in the Province of Ontario.

The Attract Connect Stay (ACS) project, funded by the Foundation for Regional Renewal (FRRR), is based on the Marathon Health Workforce Recruiter Connector (HWRC) position, which has now been in place for thirteen years. Activities undertaken in Marathon have proven highly successful in attracting and retaining a broad range of health professionals for the medium-to-long-term, and notably there have been no vacant health professional positions since the inception of the position - despite severe health professional shortages in the region.

The Attract Connect Stay project combines Dr. Cosgrave's evidence-based, whole-of-person strategies and research literature on rural health workforce strengthening [10, 11, 16, 17] with evidence-based whole of community strategies [20, 22-25], adaptation of the Marathon HWRC model to the Australian context [13], and Dr. Cosgrave's experience of working directly with other Australian regional and rural communities implementing the HWRC model [26].

**The ACS project therefore aimed to:**

1. Use evidence informed strategies to adapt the Marathon HWRC model to the rural Australian context and codify this process such that a resource would be publicly available to any rural Australian community who wished to implement a community-engaged response to achieve a sustainable health workforce

2. Build the evidence base for the effectiveness of the ACS community-engaged program in strengthening the rural health workforce.

## Applicability of ACS to other jurisdictions and contexts

Given recent arguments that rural communities and health service environments internationally have more in common with each other than with their metropolitan counterparts, and considering Australia's leadership in the field of rural health development [17], the insights generated through this Australia-based project have relevance for health policy and practice further afield. The findings are likely to be particularly relevant to other high-income, Eurocentric and metrocentric countries with public health systems, such as the UK and Canada.

# 1. Purpose, Objectives and Scope

## 1.1. ACS purpose and objectives

The Attract Connect Stay (ACS) project has worked towards developing, promoting and implementing an evidence-based and place-informed, online Health Workforce Recruiter Connector (HWRC) Blueprint [here on referred to as the Blueprint], consisting of tools and resources that are publicly available to rural communities through a dedicated website.

The project goals were to create tools and resources that would help rural communities successfully establish, manage and financially sustain their own Health Workforce Recruiter Connector position, and to pilot these with rural communities in New South Wales (NSW) and Victoria (Vic).

The overarching aspiration for the Blueprint was to provide rural communities with resources that would enable them to independently and successfully develop and implement contextually viable and suitable HWRC positions. This aspiration was driven by the need for rural communities to have proven strategies that would enable them to address complex health workforce problems in order to thrive.

Funding was received from the Foundation for Regional and Remote Renewal (FRRR) for a project implementation team, led by Dr. Cath Cosgrave, to develop and implement the Blueprint across pilot sites in New South Wales (NSW) and Victoria (VIC) over 2-year time frame (December 2020-December 2022).

The key required output was a Blueprint website that provided rural communities with tools and resources to enable understanding and addressing of rural health workforce problems through the establishment and implementation of a HWRC.

The key required outcomes were that, using the Blueprint, communities would be enabled to innovate or respond to local opportunities / issues; to develop stronger local economies, and to developed an enhanced community identity, improved community wellbeing and a sense of place.

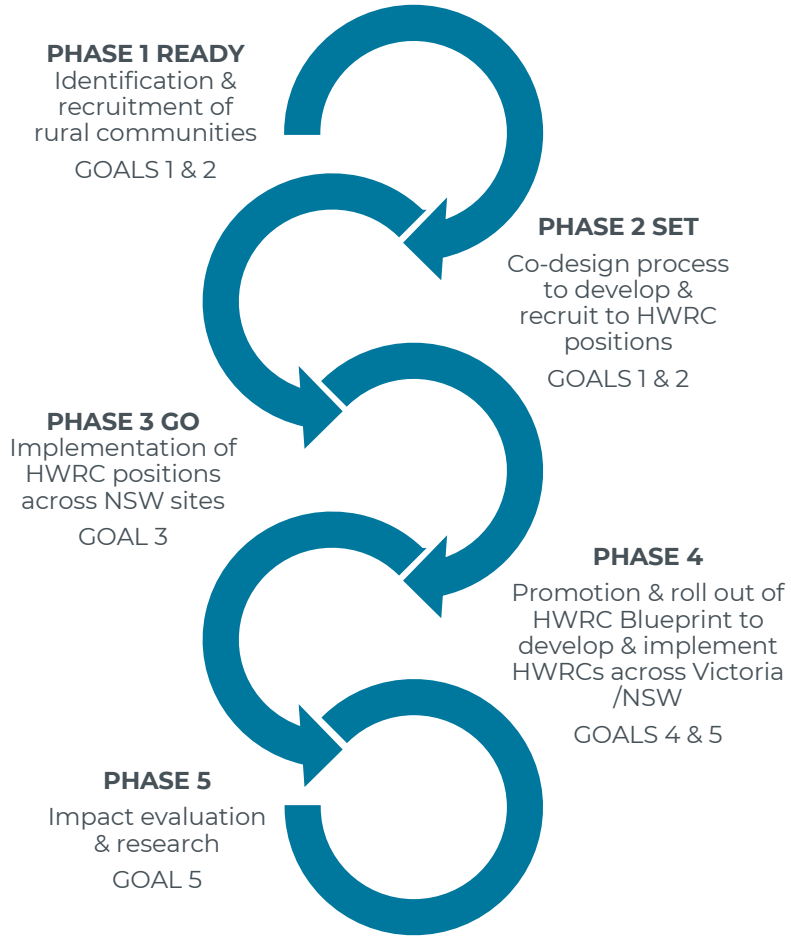
## 1.2. ACS project scope

Peer-reviewed evidence, consultation with key stakeholders, collaboration and co-design with pilot sites, strategic marketing and ongoing, iterative, quality-assurance evaluation cycles were used to develop and promote the Blueprint. These strategies were employed over five project phases detailed below ( and ).

## Table 2 ACS project phases and goals

| Project phase | Goal |
|---|---|
| Phases 1-3 [READY, SET, GO] | 1.0 Recruitment of and learning from pilot sites to inform the Blueprint |
| Phases 1-3,5 [READY, SET, GO, Blueprint Impact Evaluation] | 2.0 Production of a Blueprint |
| Phases 3, 5 [GO, Blueprint Impact Evaluation] | 3.0 HWRC positions implemented in NSW and impact observed for these rural communities |
| Phase 4 [Promotion & Piloting] | 4.0 Awareness, uptake and piloting of the Blueprint observed in Victorian rural communities |
| Phase 5 [Blueprint Impact Evaluation] | Understanding of the impact of the Blueprint and HWRC positions in rural NSW and Victorian communities and identification of key contexts, activities and mechanisms that enabled success |

## Figure 3 Project phases and goals



## Phase 1 READY

**December 2020 – November 2021**

*Project initiation => Identification and selection of pilot sites => establishing evaluation cycles => understanding steps required to assess readiness to participate => recruiting pilot sites => constructing the 'READY' learning modules and information for the Blueprint.*

### Phase 1 desired outcomes (success indicators):

| | |
|---|---|
| GOAL 1.0 Recruitment of and learning from pilot sites to inform the Blueprint | 1.1 Three pilot communities recruited to ACS project<br>1.2 Three pilot communities complete 'READY' phase and successfully progress to 'SET' phase |
| GOAL 2.0 Production of a Blueprint | 2.1 'Ready' Blueprint developed & launched |

### Key activities undertaken to achieve desired outcomes:

- Critical review of evidence.
- Formation of and consultation with Project Advisory Group (PAG).
- Development of side-by-side evaluation strategy.
- Nomination of a range of rural LGAs by the Attract Connect Stay project advisory group.
- Recruitment of NSW pilot sites.
- Translation of 'READY' evidence into strategies for use in recruiting pilot sites to the project and assessing their readiness to participate.
- Facilitation of workshops with engaged rural LGAs to describe the project and to enable discussion of the key elements that would need to be in place to ensure success for each LGA.
- Engagement and relationship-building with key stakeholders at pilot sites.
- Capture and review of the key processes and mechanisms needed by pilot communities to effectively assess their readiness for establishing, self-funding and managing their own HWRC position.
- Survey of pilot sites.
- Early development of the ACS website (Blueprint).
- Development of ACS branding.
- Extracting and translating learning and evidence from pilot sites into production of the 'READY' learning module and website information.

## Phase 2 SET

**November 2021 – June 2022**

*Understanding the steps required to plan and develop the business (and governance) structure for operating ACS in rural communities => understanding the steps required to set a budget and secure funding for ACS in rural communities => understanding the steps required to plan for recruiting a HWRC position in rural communities => constructing the 'SET' learning modules and information for the Blueprint.*

### Desired outcomes (success indicators):

| | |
|---|---|
| GOAL 1.0 Recruitment of and learning from pilot sites to inform the Blueprint | 1.3 Three pilot communities complete 'SET' phase and successfully progress to 'GO' phase |
| GOAL 2.0 Production of a Blueprint | 2.2 'Set' Blueprint developed & launched |

### Key activities undertaken to achieve desired outcomes:

- Translation of 'SET' evidence into strategies for use with pilot sites to enable them to develop (and implement) their business, governance and HWRC plans and structures.
- Ongoing relationship development and mentoring of pilot sites.
- Provision of merchandise and branding for pilot sites.
- Identification and review of the key processes and mechanisms needed by pilot communities to effectively develop their business and governance structures, raise money and plan for a HWRC position.
- Ongoing refinement of the ACS website (Blueprint).
- Extracting and translating learning from pilot sites plus evidence into production of the 'SET' learning module and website information.
- Interviews with pilot sites.
- Promotion of READY and SET phases of the Blueprint.

## Phase 3 GO

**June – November 2022**

*Understanding the steps required to implement and support a HWRC into the community => understanding the steps required to realise financial sustainability => understanding the steps required to develop evaluation or success measures => development of case studies of HWRCs and ACS management structures => constructing the 'GO' learning modules and information for the Blueprint => promoting the Blueprint to Victorian communities.*

### Desired outcomes (success indicators):

| | |
|---|---|
| GOAL 1.0 Recruitment of and learning from pilot sites to inform the Blueprint | 1.3 Three pilot communities complete 'SET' phase and successfully progress to 'GO' phase<br>1.4 Three pilot communities complete 'GO' phase |
| GOAL 2.0 Production of a Blueprint | 2.3 'Go' Blueprint developed & launched |
| GOAL 3.0 HWRC positions implemented in NSW and impact observed for these rural communities | 3.1 Three pilot communities implement HWRC positions in NSW |

### Key activities undertaken to achieve desired outcomes:

- Translation of 'GO' evidence into strategies to enable pilot sites to implement and support HWRC positions, identify and measure impact of HWRC positions, and ensure financial sustainability past the first year.
- Mentoring of pilot sites.
- Early development of an ACS community of practice for pilot sites.
- Workplan and success measure strategy session with pilot sites.
- Capture and review of the key processes and mechanisms that pilot communities need to effectively implement and measure impact of a HWRC position.
- Ongoing refinement of the ACS website (Blueprint).
- Extracting and translating learning and evidence from pilot sites into production of the 'GO' learning module and website information.
- Interviews with pilot sites that completed all stages of the Blueprint.

## Phase 4 Promotion and piloting of the Blueprint

**July – November 2022**

*Promoting the Blueprint to Victorian communities => piloting the Blueprint across Victorian communities => refining the Blueprint.*

### Desired outcomes (success indicators):

| | |
|---|---|
| GOAL 4.0 Awareness, uptake and piloting of the Blueprint observed in Victorian rural communities | 4.1 There is awareness of / high levels of exposure to ACS / HWRC Blueprint website across Victorian communities<br>4.2 There is engagement with the ACS website and learning modules (HWRC Blueprint)<br>4.3 Those who engage with the ACS website and learning modules find the information useful and helpful<br>4.4 There is uptake of the ACS solution across Victorian communities<br>4.5 HWRC positions are developed and/or implemented in Victorian communities<br>4.6 Learning from Victorian sites contributes to refinement of the Blueprint |

### Key activities undertaken to achieve desired outcomes:

- Development of a marketing and promotional strategy for Victorian communities.
- Establishment of data capture mechanisms for the website, social media and learning module.
- Promotion of the Blueprint / implementation of the marketing strategy for Victorian communities.
- Analysis of website, social media and learning module feedback and engagement data.
- Interviews with Victorian pilot sites that completed all stages of the Blueprint.

## Phase 5 Impact evaluation and research

**August 2021 – November 2022**

Development of an evaluation strategy => identification of research gaps => data gathering => data analysis and reporting on impact.

### Desired outcomes (success indicators):

| | |
|---|---|
| GOAL 5.0 Understanding of the impact of the Blueprint and HWRC positions in rural NSW and Victorian communities and identification of key contexts, activities and mechanisms that enabled success | 5.1 Iterative data gathering and input across the life of the project assists with refinement of the Blueprint<br><br>5.2 Understanding of the impact of HWRC positions in rural NSW and identification of key contexts and activities that enabled success<br><br>5.3 Understanding of the impact of the Blueprint on Victorian sites and identification of key contexts and activities that enabled success<br><br>5.4 Understanding evidence gaps for future consideration. |

### Key activities undertaken to achieve desired outcomes:

- Implementation of the evaluation strategy.
- Data gathering across all project phases.
- Iterative data analysis and provision of feedback to the project implementation team across all project phases.
- Synthesis of all data to inform understanding of impact and mechanisms contributing to impact.

# 2. ACS evaluation strategy

The Attract Connect Stay (ACS) project evaluation sought to inform the development of each feature of the prototype HWRC Blueprint, measure its impact on rural communities, and understand what has worked, for who, to what extent and why for the multiple phases and parts of the ACS project [1, 2] (Figure 3).

In accordance with the ACS solution community-based action research principles [27], the evaluation was undertaken throughout the life of the ACS project. Realistic evaluation techniques [1, 2] were used to plan, gather, and analyse data during each phase of the project (action research cycles) in order to answer the following evaluation questions:

1. To what extent did the ACS project achieve its goals? What were the contexts, activities and mechanisms that enabled this to happen?

2. What was the impact of the ACS HWRCs on rural communities? What were the contexts, activities and mechanisms that enabled this to happen?

3. To what extent does the HWRC Blueprint enable rural communities to independently design and implement place-appropriate health workforce attraction, recruitment, and retention strategies? What are the contexts and mechanisms that need to be in place (or considered) to enable this to happen?

## Approach

Realistic Evaluation explores the relationship between contexts, mechanisms, and outcomes within a structured theoretical framework [4] in order to describe what type of intervention works for whom, and in what circumstances. Realistic methodologies are most appropriately used to understand and evaluate social programs. ACS is in essence a social program which embraces and engages with the interplay of individuals and institutions, agency and structure and of micro, meso and macro social processes [4].

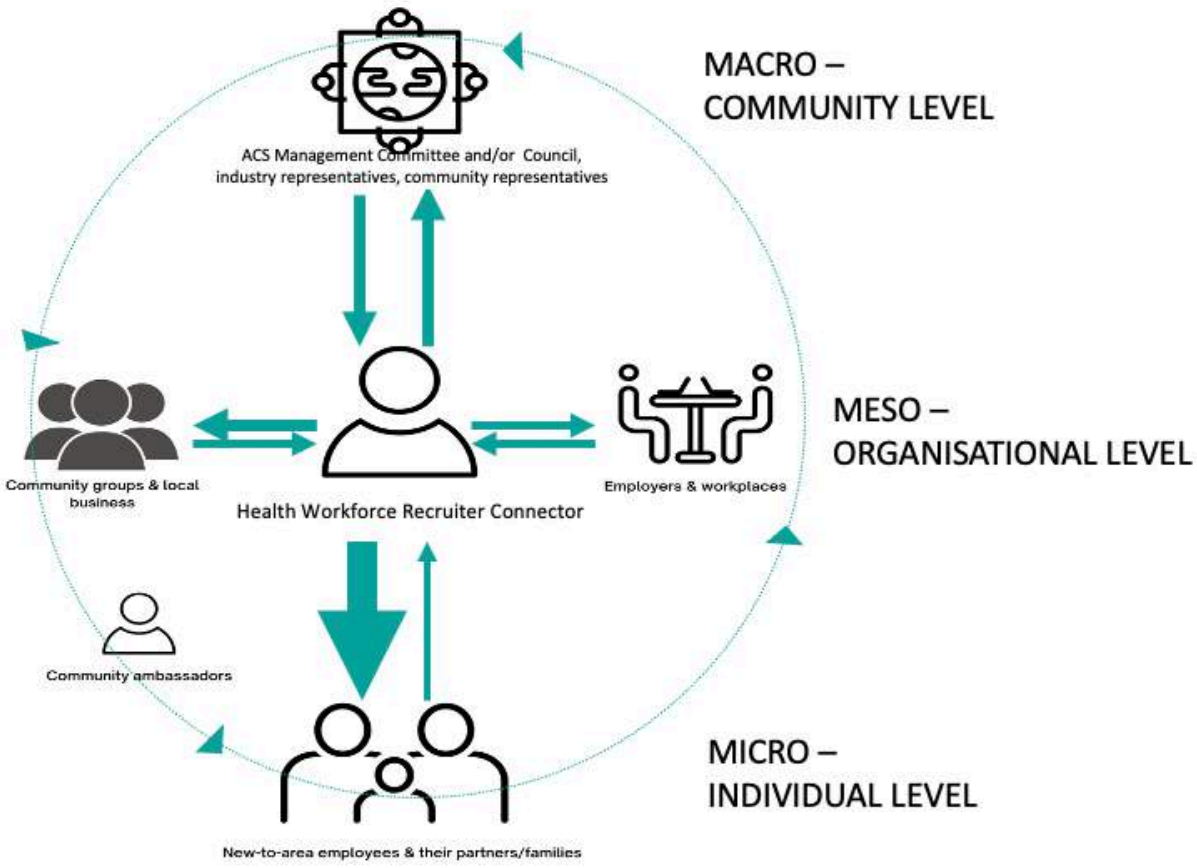
Realism, and its application to realistic evaluation, seeks to 'position itself as a model of scientific explanation which avoids the traditional poles of positivism and relativism' [4] (p55). As such, realism's key feature is its stress on the mechanics of explanation and the contexts in which these occur [4].

A 'mechanism' attempts to explain why change occurs or why a particular outcome is observed. Mechanisms capture the essence of 'what it is about a program that makes it work' [4] (p66). In this report, barriers and facilitators to implementing the ACS solution were identified. Often (but not always) the barriers and facilitators are the opposite of each other, and when written as a positive statement, they become the mechanisms to support change [28].

## Methods

A multi-level data gathering approach was used to respond to the evaluation questions. The development and implementation of a HWRC role requires activities to be undertaken at multiple tiers of rural communities [11, 13, 16, 22, 26]. Data were therefore gathered and analysed at three different levels: Community (Macro), Organisational (Meso) and Individual (Micro) levels, to provide a full understanding of the contexts and mechanisms contributing to and the impact of the HWRC positions and the Blueprint. Figure 4 illustrates the benefits of approaching the evaluation in this way in terms of the ways in which the HWRC position relates to different groups of people and the physical, material, organisational and/or social environments (contexts) in which HWRC activities are taking place.

### Figure 4 The HWRC relationship to Macro, Meso and Micro level contexts




A range of data were obtained and used to measure the extent to which success was achieved in relation to the project goals. Data sources included documents and outputs produced by the project implementation team; surveys and interviews with stakeholders from pilot communities; website engagement and marketing analytics, and locally derived data showing impacts on pilot community HWRC success indicators (Table 4).

Success indicators were developed for each project phase to identify the extent to which success was achieved in relation to the overarching goals of the project (Table 3).

Data were analysed and synthesised to identify success (attainment of goals) and impact (outcomes). The relationship between key activities, contexts and mechanisms was then systematically explored in relation to the success of the ACS project and the outcomes observed to explain what worked and why [1, 2].

## Table 3 ACS project success indicators

| Associated Project phase | Goal | Success indicators |
|---|---|---|
| **Phases 1-3** | 1.0 Recruitment of and learning from pilot sites to inform the Blueprint | 1.1 Three pilot communities recruited to ACS project<br>1.2 Three pilot communities complete 'READY' phase and successfully progress to 'SET' phase<br>1.3 Three pilot communities complete 'SET' phase and successfully progress to 'GO' phase<br>1.4 Three pilot communities complete 'GO' phase |
| **Phases 1-3,5** | 2.0 Production of a Blueprint | 2.1 'Ready' Blueprint developed & launched<br>2.2 'Set' Blueprint developed & launched<br>2.3 'Go' Blueprint developed & launched<br>5.1 Iterative data gathering and input across the life of the project assists with refinement of the Blueprint |
| **Phases 3, 5** | 3.0 HWRC positions implemented in NSW and impact observed for these rural communities | 3.1 Three pilot communities implement HWRC positions in NSW; 5.2 Understanding of the impact of HWRC positions in rural NSW and identification of key contexts and activities that enabled success; |
| **Phase 4** | 4.0 Awareness, uptake and piloting of the Blueprint observed in Victorian rural communities | 4.1 There is awareness of / high levels of exposure to Blueprint website across Victorian communities<br>4.2 There is engagement with the ACS website and learning modules (HWRC Blueprint)<br>4.3 Those who engage with the ACS website and learning modules find the information useful and helpful<br>4.4 There is uptake of the ACS solution across Victorian communities<br>4.5 HWRC positions are developed and/or implemented in Victorian communities<br>4.6 Learning from Victorian sites contributes to refinement of the Blueprint |
| **Phase 5** | Understanding of the impact of the Blueprint and HWRC positions in rural NSW and Victorian communities and identification of key contexts, activities and mechanisms that enabled success | 5.1 Iterative data gathering and input across the life of the project assists with refinement of the Blueprint<br>5.2 Understanding of the impact of HWRC positions in rural NSW and identification of key contexts and activities that enabled success<br>5.3 Understanding of the impact of the Blueprint on Victorian sites and identification of key contexts and activities that enabled success<br>5.4 Understanding evidence gaps for future consideration |

## Table 4 Evaluation data collection

| Phase | Data gathering techniques |
|---|---|
| **1 – READY** | Review of ACS documents and outputs (n=11 documents reviewed - Project Advisory Group minutes x 2; Project implementation team minutes x 2; Expression of Interest forms received from pilot communities x 3; Community presentations & workshops from lead implementor x 4 [Engagement and information workshops; problem identification and visioning workshops]; READY website and learning module material)<br>Surveys of workshop participants from three pilot sites (n=34)<br>Weekly interviews with lead implementor (CC) (n=15, 12 Aug 2021-10 May 2022)<br>Interviews with pilot stakeholders from READY phase (n=5) |
| **2 – SET** | Review of ACS documents and outputs (Project implementation team minutes x 2; Community presentations & workshops from lead implementor x 2 [Evidenced strategies for establishing HWRC]; SET website and learning module material)<br>Weekly interviews with lead implementor (CC) (n=15, 12 Aug 2021-10 May 2022)<br>Interviews with pilot stakeholders from READY + SET phase (n=6)<br>Final interview with implementation lead (CC (n=1)) |
| **3 – GO** | Review of ACS documents and outputs (Project implementation team minutes x 2; Community presentations & workshops from lead implementor x 1 [WoP-RIF overview for GP clinics]; GO website and learning module material)<br>Interviews with stakeholders who implemented the HWRC position (n=4)<br>Interview with new-to-area health care professional (n=1)<br>Brief interview/survey with local healthcare businesses (n=3)<br>Final interview with implementation lead (CC) (n=1) |
| **4 – Promote and Pilot in Victoria (and more broadly)** | Final interview with Implementation lead (n=1)<br>Website analytics (impressions, click through rates)<br>Interview with a NSW community currently using the Blueprint (site D) (n=1)<br>Webinar transcript of ACS community sites sharing insights of key wins and key enablers (n=3 sites)<br>Analytic Data from marketing campaign (e.g., video impressions, engagement, completed views, target audience reach, impressions, followers)<br>ACS website membership growth<br>Learning module sign ups (number, growth)<br>Learning module engagement analytics for each module (READY, SET and GO)<br>ACS learning module participant feedback on READY, SET and GO learning module content (survey x 2, interview with Victorian rural community representative x 1) |
| **5 – Impact Evaluation** | Interview with pilot site HWRC (n=1)<br>Interview with pilot site stakeholders from membership committee (n=4)<br>Analysis of locally collected data against locally derived success indicators from pilot sites<br>Interview with healthcare professionals supported by HWRCs at pilot sites (n=1) |

| | |
|---|---|
| | Webinar transcript of ACS community site sharing their insights around key wins and key enablers<br>Final interview with implementation lead (n=1) |

# 3. Findings

# Question 1. To what extent did the ACS project achieve its goals?

What were the contexts, activities and mechanisms that enabled this to happen?

**Of the five ACS project goals, three were fully achieved and two partially achieved.**

GOAL 1.0 FULLY ACHIEVED - Recruitment of and learning from pilot sites to inform the Blueprint

GOAL 2.0 FULLY ACHIEVED - Production of a Blueprint

GOAL 3.0 FULLY ACHIEVED - HWRC positions implemented in NSW and impact observed for these rural communities

GOAL 4.0 PARTIALLY ACHIEVED - Awareness, uptake and piloting of the Blueprint observedin Victorian rural communities

GOAL 5.0 PARTIALLY ACHIEVED - Understanding of the impact of the Blueprint and HWRC positions in rural NSW and Victorian communities and identification of key contexts, activities and mechanisms that enabled success

See Table 8 (appendix) for full information.

Three communities (sites A, B, C) had their Expressions of Interest (EOI) accepted and were recruited to inform the development of the Blueprint. Two communities did not successfully complete the READY phase, resulting in one site formally withdrawing (site B) and the other stalling (site C). This left one pilot site (A) that successfully completed the READY phase. This site subsequently progressed through all ACS steps to implement a HWRC into their rural community with significant impact within a short period.

Following completion of the EOI process for NSW pilot sites, another NSW site (referred hereafter as Site D) joined the program at the end of the funding period and is currently working through the READY phase.

The required output, the online Blueprint, was produced and has been widely promoted and engaged with across NSW, Victoria and Australia more broadly. The Blueprint guides rural communities interactively through the three enabling HWRC phases: Readiness assessment ('Ready'), planning the process and the HWRC role ('Set'), and implementing the HWRC role ('Go').

While the Blueprint was promoted and engaged with across several Victorian communities, it was not piloted in any specific Victorian sites during the project period.

# GOAL 1 Recruitment of and learning from pilot sites to inform the Blueprint

## Success indicator 1.1 - Three pilot communities recruited to ACS project and learning around recruitment process is codified

# Achieved

**Evidence of success**

- Five communities expressed interest in participating in the pilot.
- Four expression of interest forms received.
- Three of the four communities were recruited as pilot sites [Pilot sites A, B, C].
- After the EOI process for NSW pilot sites was completed another NSW site (Site D) joined the program at the end of the funding period and is currently working through the READY phase.
- Key learning from Phase 1 codified used to inform development of the Blueprint.

**Key activities, contexts and mechanisms enabling achievement of goals**

The most important 'READY' elements that created the necessary pre-conditions to successfully proceed to 'SET' included:

- Using evidence, especially asset-based community development principles, to inform engagement, the expression of interest requirements, and selection of rural communities.
- Engaging with 'the right' strategic stakeholders who had strategic leverage within the community, understood the problem from both a community and business perspective, and could see the potential for ACS to work in their rural communities.
- Attendance of key stakeholders from the community at ACS workshops.
- Requiring communities to submit an Expression of Interest form.

**These elements were captured, codified, and described in the 'READY' learning module on the ACS website. This phase specifically contributed to the writing of the ready checklist which can be found in the Blueprint and in the appendix of this evaluation.**

Evidence pointing to 'READY' enablers and contexts, especially the use of asset-based community development principles [13, 14, 16, 20, 22, 24-26] were key to engaging communities, building trust, illustrating the problem and describing the essential components for ACS to be successful.

*'Probably, I think the thing that's worked most well is the community's understanding, or operationalizing, the asset-based community development approach, and getting that they need to do that and do it well, to have success' [Implementation lead]*

The translation of 'READY' evidence and the project implementation team's on-the-ground experience into communications with Project Advisory Group (PAG) were key to ensuring the PAG could identify the "right" communities, or those who exhibited 'READY' elements, for the project implementation team to approach.

The composition of the Project Advisory Group and specifically the inclusion of key stakeholders who understood the needs of rural communities in NSW and had direct connections with these communities was also key to identifying communities who exhibited 'READY' elements.

Direct introduction by PAG members to key stakeholders in 'READY' rural communities was key to the project implementation team's success in promoting ACS.

*In [Pilot site A] I was introduced by [PAG member] to the economic development manager and community development manager. And she brought with her [to the meeting] the mayor at the time, the general manager at the time. And her boss, I think. [Implementation Lead}*

*So, when I first came across [implementation lead, Dr. Cath Cosgrave] it was actually through Cath [Chief Executive Officer] from SARRAH' [Stakeholder, site D]*

The above factors meant that the project implementation team were able to undertake early engagement with the "right" key stakeholders at nominated rural LGAs and build relationships with these stakeholders.

*'I don't know how initially it started, but [key community stakeholder] had been working with Dr. Cosgrove. And I don't know how their interaction started or what happened or who approached who but it was obviously a solid foundation from the beginning. … And we wanted, well I think the community also supported it, but [key stakeholder] and I were particularly passionate about wanting it to happen.' [Pilot Site A]*

*‘So, we need to identify key champions, and then I need to work with them. And then we need to sort of teach and understand and build on that community momentum. It's really for them to do that. And I’m really like their coach’. [Implementation Lead]*

*‘So, that is someone pretty senior who's across the whole footprint that we're talking about and already understands the problem at a quite systematic …. I was looking for senior leaders in these communities who I knew could answer -* ***Have you identified this as a problem? Do you understand the problem? And is it in your planning? Because if those things aren't there, then I'm trying to convince you and that's not good community development. And I'm not here to convince anyone.*** *[Implementation Lead]*

The ’right’ people around the table needed to include people of influence in the community who understood the ACS solution from both a community health and business perspective. Site D struggled to gain sufficient momentum in the early stages of the project and as such did not submit an expression of interest. Whilst they remained in contact with the implementation Lead throughout the funding period and continue to be informed by ACS, this issue continues. They reflect that engagement with the ‘right people’ is problematic as their intention to use the ACS solution is driven by a lack of Allied Health professionals (rather than doctors).

*You have to have the right people in the room. You have to have people who are influential with strong connections in community. That absolutely has to happen. I realised the group that I had Cath [implementation Lead] first present to were all people in Allied Health, but they really weren't decision makers or influential. [Stakeholder, site D]*

*The other struggle has been Allied Health itself. We're talking about a bunch of clinicians who don't necessarily understand business. And the two are very separate, very different beasts. It has taken us as business people to say, ‘look, we're going to make this work for you’. But we still, even the last time Cath [implementation Lead] was up here, had kickback from some Allied Health professionals saying, ‘why are you business people involved in this?’. And we responded that we are trying to drive this for you on behalf of you. We are not trying to take over Allied Health. We are just trying to make this work for the benefit of all. [Stakeholder, site D]*

The structure of the workshops, informed by a community development approach, allowed workshop participants to work through information to actively understand whether their LGA was ready to implement a HWRC role and to take ownership of the process from the outset.

*Probably, I think the thing that's worked most well is the community's understanding, or operationalizing, the asset-based community development approach, and getting that they need to do that and do it well, to have success. And I think I've both been very confident and skilled in communicating that. [Implementation Lead]*

*Her presentation was fantastic. She spoke to it as well as having slides. And because she was talking about the experience that she had going over to Canada and could put it into practical sense. It was fantastic. [Stakeholder, pilot site A]*

*'A lot of issues came to light' [Workshop survey respondent, pilot site C]*

Pilot site stakeholders indicated that workshop material being informed directly by contemporary research evidence and vignettes, showing what enabled the successful introduction of HWRC roles in other rural townships, created a level of trust and buy-in to the ACS project. It was seen as having robust evidence base demonstrating success.

*And just having the great evidence base that we had because of Dr. Cath's research ... I think that really has been a success of it because people are always wanting to know or just have that bit of reassurance that something's gonna work and if you can say this is evidence-based then you sort of go "okay. I'm not just backing a horse that might not win". There's actually a little bit of bit more confidence that this is something that could possibly work. [Stakeholder, Pilot site A]*

Workshops and ACS meetings needed to be well attended by community members from diverse and important parts of the community to ensure success during this phase.

*Attendance at workshops ranged from 8 (Pilot site B) to 25 participants (Pilot site A). [Workshop documentation]*

Key stakeholders with influence and leverage in the community also had to attend the workshops to move through this phase successfully (Table 5).

## Table 5 Composition of attendees at ACS workshop (pilot site A)

| Attendees |
|---|
| Primary Health Network |
| Council - Director |
| Council - Mayor |
| Local Doctors |
| Aged Care representative |
| Bushfire Recovery |
| Community members |
| Council - Director |
| Council - GM |
| GROW THINK TANK member |
| GROW THINK TANK member |
| GROW THINK TANK member |
| Local Developer |
| GROW THINK TANK member |
| GROW THINK TANK member |
| Infants School representative |
| Education representative |
| Hospital representative |
| Council - Mgr Economic Development |
| Retire GP / Just moved to rural community |
| Medical Centre - Practice Manager |
| High School representative |
| Councillor |
| GROW THINK TANK member |
| Community Centre representative |

The Implementation lead's knowledge, capabilities and attributes were used to provide clear, strong direction and leadership and to build relationships with potential communities. Whilst this was an enabler for the one site that proceeded to implement a HWRC, one pilot community did not receive Dr. Cosgrave's direction and strong leadership so positively. Combined with a number of other 'READY' factors not being in place, this contributed to the pilot community not proceeding past the READY phase:

*Letter of withdrawal from pilot site B.*

Translation of 'READY' evidence and the project implementation team's on-the-ground experience into an expression of interest [EOI] process and EOI screening process was paramount to the screening and selection of 'READY' communities as well as requiring potential communities to demonstrate their READY-ness via the expression of interest process.

*It [submitting an EOI] wasn't really something that was thought about, rather it was - you would be silly not to participate. Why would we not? [Stakeholder, pilot site A]*

This step was complemented by the composition of the project implementation team's skills, knowledge and experience of working with rural communities with workforce issues, enabling the 'right' rural communities to be recruited to the project.

*All of it was intentional. The whole team that's here is intentional, every bit has been like we've been building a house. And here's the house and people go 'Isn't that beautiful? So simple'. But it isn't simple it's ... hard work. And you know, it's everyone, it's all of us believing that it's a missing piece. And so, I see myself as leading a team of people who all are passionate about rural health, equity. [Implementation Lead]*

.

## Success indicator 1.2 - Three pilot communities complete 'READY' phase and successfully progress to 'SET' phase

# Partially achieved

**Evidence of success**

- Three communities had their EOIs accepted; however, two communities did not successfully complete READY, resulting in one site formally withdrawing (site B) and the other stalling (site C).
- One pilot site, pilot site A, completed READY phase and successfully progressed to SET phase.
- After the EOI process for NSW pilot sites was completed, another NSW site (Site D) joined the program at the end of the funding period and is currently working through the READY and SET phases.
- Key learning from Phase 1 was codified and used to inform development of the READY Blueprint.

**Key activities, contexts and mechanisms enabling achievement of goals**

Communities who exhibited very strong 'READY' elements proceeded to 'SET' phase. Those pilot communities that did NOT exhibit these elements failed to move into the SET phase, demonstrating the absolute importance of communities exhibiting ALL of the 'READY' elements to ensure overall success (Table 7).

**The most important 'READY' elements that created the necessary pre-conditions to successfully proceed to SET included:**

- Trust was built between key community stakeholders and the Implementation Lead.
- Community members led the decision making about committing to ACS.
- The community had strong community-mindedness and were open to a new way of approaching the problems they faced.
- The assets of the community (including the range of gifts and skills of community members) were aligned to what was needed to bring ACS to life and these assets were valued and utilised.
- People willingly shared their gifts and assets to create connections to drive the project forward.
- There were significant, pervasive, and long-standing problems of recruiting and retaining healthcare workers.

- Community members had a deep and personal connection to the impact of health workforce struggles, especially in relation to doctor shortages.
- Expressions of Interest to participate demonstrated exemplary capacity and willingness of the community to rally together and oversee whole-of-community support and buy-in for the project.
- There was widespread and formal agreement across varied, independent community stakeholders around the need for the HWRC to be wholly governed by the community, independent of but with significant support from the local council.
- There was commitment to piloting the ACS concept as a standalone project, with no hybrid models.

**All elements were captured, codified, and described in the 'READY' learning module on the ACS website which covers the following key steps:**

1. Tools and information to assist communities to understanding the community development approach underpinning the ACS solution.
2. Tools and information to assist communities to assess fitness for implementing the Attract Connect Stay solution (detailed steps from the ready checklist).

Attract Connect Stay.

HOME ABOUT READY SET GO NEXT RESOURCES CONTACT

# Ready - Course Overview

Part 1 of the course *will give you an overview of the Attract Connect Stay solution and the community development principles underpinning it. It will help you decide if the Attract Connect Stay solution is a good fit for your rural community.*

Expressions of Interest to participate that demonstrated clear capacity and willingness of the community to rally together and to oversee whole-of-community support and buy-in for the project, was a key mechanism for success in this phase of the project.

*So, I feel, you know, very duty-bound, and feel part of the community [Pilot site A]*

This was partly enabled through communities having significant, pervasive, and long-standing problems recruiting and retaining healthcare workers and community members having a deep and personal connection with the impact of health workforce struggles, especially in relation to doctor shortages.

Community representatives from two of the pilot communities identified in their interviews that the presence or absence of doctors in their rural community was a key driver for motivation to join the ACS and to successfully progress through the READY stage.

One community described multiple events whereby doctor shortages had impacted on their loved ones. This, combined with an ongoing shortage of doctors, sowed the seeds for strong community buy-in.

*Well, one of the main reasons was the lack of doctors. The fact that there are over 300 people on waiting lists for doctors … We had my husband's brother's daughter pass away two years ago. She was taken to hospital and there were no doctors. [Stakeholder, pilot site A]*

*We came in [to the project] with dire circumstances (as) one of the practices was going to close last year … [Stakeholder, pilot site A]*

Conversely, the other community explained that the new arrival of three doctors into their town had reduced their motivation to pursue the program, even though they acknowledged that there were mental health and other issues in their community that would benefit from Allied Health and nursing input.

*Maybe 12 months ago, 18 months ago, we didn't have enough doctors, but that's actually changed now. We have new doctors come in that have recently started. So that's not such a big concern. [Stakeholder, pilot site C]*

A further significant contributor to ensuring successful progression to SET phase was the Implementation Lead investing in early identification of and relationship building with key community champions. These were individuals who demonstrated powerful understanding of the problem in their community, who quickly and completely understood the need for the ACS solution in their community, and who also understood what it would take for their community to successfully implement the solution.

Investing in powerful community champions at an early stage led to early engagement and buy-in from a diverse range of ‘enabling’ and influential

stakeholders across the community. Starting with key council staff seemed to be the most common strategy.

*You have to approach someone. So, starting with council is the right spot. But then again, you know, she could have approached medical people. But then they also, you know, are sometimes only really worried about their own centre, as opposed to the whole community... [Stakeholder, pilot site A]*

*The steering committee [established in pilot site A] I think really helped. The fact that we had some damn good people that came onto the initial committee. Everybody had skills and bought those skills to the fundraising and to the implementation, to the appointment of the HWRC. [Stakeholder, pilot site A]*

*So, everything's relational. And it's about building trust. So, if you think of the three sites [on the ACS webinar], all of those have a high level of trust in the concept and in me. I never got to build the relationship with [Pilot site B]. And I'm not sure who I was building the relationship with. [Implementation Lead]*

*You really need people who have a strong community influence from the outset to get behind this [ACS] because Allied Health clinicians have connections but don't have the leverage to pick this up and run with it. [Site D, Webinar transcript]*

During the pilot phase pilot site B was approached to be part of another health workforce initiative. The ACS project implementation team believed a hybrid model in which the ACS program was undertaken alongside another initiative would weaken the ACS strategy and not provide sufficient information for creation of the ACS Blueprint. As a result, the community withdrew from the pilot.

The expression of interest process was a key mechanism for success in phase 1. The process required potential communities to: a) mobilise their community to collectively apply for the program (demonstrating early community level buy-in and a capacity to mobilise the community for a common purpose), and b) assess their readiness to participate in the ACS pilot.

The Implementation Lead reflected that the failure of two of the three pilot sites to progress past the READY phase was present in the EOI process.

*The three [pilot sites] were important, because I thought, when we assess them, we pushed [Pilot site B] and [Pilot site C] over but ... actually they didn't really meet the criteria. So it's not meeting the criteria and just getting that it's actually being all over*

*the criteria. And Pilot site A was all over it, it was a really high quality, well thought out because [community champion] had already been thinking a lot about it.*

One community demonstrated varying levels of readiness to participate. They struggled to demonstrate whole of community support and buy-in. When interviewed, they acknowledged that the fly-in-fly-out workforce meant that community engagement was challenging. The Implementation Lead identified that it was also because they struggled to have strong community champions for the project.

*I mean, when you think about all the different industries, there's committees everywhere. It's almost like you have to draw those people out of those committees to establish another committee … I looked in the different places for the people that could be part of the committee. But I still couldn't get them over. They were already part of all the [other] committees. [Stakeholder, pilot site C]*

*There were no champions coming from it. So it was mainly sitting with [one person] and Council. But that's not enough …. And it [Pilot site C] was nothing like what [Pilot site A] had done in terms of having community ownership about identifying and it's a need. [Implementation Lead]*

Full community ownership of and commitment to the processes required to support and implement the HWRC position was key to success in this phase. Successful movement to SET was more likely in the case of Pilot Site A because the EOI process was community-led and gained widespread and formal agreement across a diverse range of independent community stakeholders regarding the need for the HWRC to be wholly governed by the community, independent of but with significant support from, the local council. The two remaining pilot sites, while they gained varying levels of community support, proposed to house the HWRC in Council, which seems to have been a contributing factor to not successfully progressing to further phases of the project.

*When we went to the community the first time, Dr. Cosgrave [Implementation Lead] was saying that it was an initiative that Council could remain included, or that the community could have and remove Council. And the community wanted to have it themselves without Council involvement, which was fine, but then they wanted to have a council rep. on there [Stakeholder, pilot site C]*

The above elements are illustrative of the five asset-based community development principles, which needed to be in place for success to be achieved (Table 7).

## Table 6 Asset Based Community Development principles [22]

| Group | Definition | Contribution |
|---|---|---|
| **Individuals** | Residents of the community are at the centre and have gifts and skills that need to be identified | Everyone has assets and gifts |
| **Associations** | Associations are small informal groups of people, such as clubs, working with a common interest as volunteers. Associations are critical to community mobilisation | People discover each other's gifts |
| **Organisations** | Organisations are the local businesses and employers. Organisation's assets help community capture valuable resources and establish a sense of civic responsibility | People organise around assets |
| **Physical assets and natural resources** | Place-based assets are a community's land, buildings, heritage, public and green spaces, Place-based assets are known and valued by residents | People live in a place for a reason |
| **Community Connectors.** | People sharing their gifts and assets creates connections, and these connections are a vital asset to a community. Every community has connectors who can help strengthen social relationships and build trust | Individuals connect into a community |

## Table 7 Key enabling factors to move from READY to SET for the three pilot sites

| Enabling factor | Pilot site A | Pilot site B | Pilot site C |
|---|---|---|---|
| Community members led the decision making about committing to ACS | ✓ | In part | In part |
| The community had strong community-mindedness and were open to a new way of approaching the problems they had | ✓ | ✓ | X |
| The assets of the community (including the range of gifts and skills of community members) were valued and utilised | ✓ | unsure | X |
| People willingly shared their gifts and assets to create connections to drive the project forward | ✓ | unsure | ✓ |
| There were significant, pervasive, and long-standing problems recruiting and retaining healthcare workers | ✓ | ✓ | X |
| Community members had a deep and personal connection to the impact of health workforce struggles, especially in relation to doctor shortages | ✓ | unsure | X |
| Expressions of Interest to participate demonstrated clear capacity and willingness of the community to rally together and oversee whole of community support and buy-in for the project | ✓ | X | ✓ |
| Widespread and formal agreement across varied, independent community stakeholders around the need for the HWRC to be wholly governed by the community, independent of but with significant support from, the local council | ✓ | X | X |
| Commitment to piloting the ACS concept as a standalone project, no hybrid models. | ✓ | X | ✓ |
| Key community champions with strong levels of influence were identified and built a trustful relationship with the Implementation lead | ✓ | X | X |

## Success indicator 1.3 - Three pilot communities complete 'SET' phase and successfully progress to 'GO' phase

# Partially achieved

**Evidence of success**

- One pilot site (A) completed SET phase and successfully progressed to GO phase.
- A second NSW site (E) re-joined the program at the end of the funding period and is currently re-working through the SET phase with the assistance of Dr. Cosgrave.
- Key learning from Phase 2 codified and used to inform development of the Blueprint.

**Key activities, contexts and mechanisms enabling achievement of goals**

The single community, pilot site A, which undertook ALL essential 'SET' activities proceeded to 'GO' phase.

The most important 'SET' contexts and mechanisms that created the necessary preconditions to successfully proceed to GO included:

- Exhibiting all 'READY' elements (Table 7).
- The project implementation team's use and translation of evidence and experience into 'SET' strategies to inform decision making.
- The community effectively self-organised, took maximum advantage of their skills and assets and took active ownership of developing and implementing necessary 'SET' strategies in order to proceed to 'GO'.
- The project implementation team's involvement shifted from that of leadership to mentorship.
- Adequate time for plans to come to fruition.

**All elements were captured, codified, and described in the 'SET' learning module on the ACS website which cover the following key steps:**

1. Tools and information to help rural communities decide (and implement) the ideal business structure for operating ACS.
2. Tools and information to understand how much ACS and a HWRC position will cost the community, types of expenses communities should expect to outlay and how to secure funding.
3. Tools and information to develop a job description, advertise for and recruit to a HWRC position.

Attract Connect Stay.

HOME ABOUT READY SET GO NEXT RESOURCES CONTACT

# Set - Course Overview

Part 2 of the course *will help you to decide on the appropriate business structure and funding arrangements and support you to appoint your community's Health Workforce Recruiter Connector.*

Translation of pertinent evidence and the project implementation team's on-the-ground experience [10, 11, 13, 14, 16, 25, 26] into a collection of 'SET' strategies and information was an important enabler of progression to GO. These enabled the local community to have confidence in and make evidence-informed decisions about governance of the HWRC position and sustainable funding of the HWRC position:

*I think the thing that's worked most well is the community's understanding, or operationalizing, the asset-based community development approach, and getting that they need to do that and do it well, to have success [Implementation Lead]*

*What I really know, and why I have confidence about this [the ACS solution] is that we had the pleasure of evaluating Shepparton. And so, I absolutely know the model works. Settle/Connect, that the part that I've identified is problematic and needed to be attended to, which is the first 12 months. So, we can get them to stay 12 months. So that's great. And with the intention to stay for longer than that. [Implementation Lead]*

The community was gradually facilitated and mentored to 'own' the process of bringing ACS to life. This required the project implementation team's role to shift from active leadership to that of support and mentoring. In particular, the Implementation Lead worked closely with the community to enable them to identify and use their capacities and assets to drive the HWRC position to fruition. This translated into the ACS committee using ACS material to run their own speaking circuit around the community in order to gain widespread engagement with and commitment to ACS. In turn, this led to a significant number of community memberships and the capacity to fund the HWRC position.

*The first six months really was the community engagement phase, and that has been very successful. It's been successful in that that speaking circuit that I went on, was really, really valuable. It built community understanding about what the project was about and the parameters. It raised awareness and it raised a lot of support. Initially, of course, it raised our initial memberships, because most people that I spoke to did join up. Our membership is still sitting at about 200. [Stakeholder, pilot site A]*

The community effectively self-organised and took active ownership of developing and implementing the necessary 'SET' strategies in order to proceed to 'GO'. It maximally utilised its capacities and assets to establish a context-appropriate ACS governance/business structure; develop and implement strategies to raise the necessary monies to fund a HWRC position, and create context-appropriate processes in order to recruit and implement a HWRC position.

*The team, I think that was really instrumental. In particular [Pilot site A committee chair]. She had been out and about and noticed people.... she said as soon as she met me, she just filed me away thinking oh, we'd be able to use this individual down the track .... We also had an [accountant] move to town and to have his expertise...to have sort of an accountant of that caliber come to town and be encouraged by his employer to be involved in something and for him to walk up to the [ACS] counter and say, how can I help ... [Stakeholder, pilot site A]*

*I went out and spoke to every health professional business that would speak to me just to find out what was out there and what their needs were and to tell them about Attract, Connect, Stay. And that was really very interesting. Just through the connections. We actually picked up a speech therapist that wanted to move to the area., I was able to put her in contact with two of the practices that were working in [Pilot site A] that needed a speech therapist. And ultimately, she went with [business in neighbouring town] and she's still there and still loving it and I think is starting to do some work in [Pilot site A] as a speech therapist next year— so that's really exciting [HWRC, pilot site A]*

This stage was the most complex and took far longer than the project implementation team had planned. Taking the necessary time at this stage, however, was imperative to being able to successfully implement a HWRC that would be sustainable in the longer term. As identified by the Implementation Lead, taking the time to ensure there is an exceptional level of community support and a governance framework set up ensures the success of the HWRC position.

*The steps are all simple. But because they're so tailored to the specific needs of the community, you never get to repeat any particular formula. There are systems, but [the HWRC needs to] listen. Listen to what's in front of you and attend to that, and ask when you don't know. How do you do that? So, I think that [Pilot site A] is really well set up for that, for when the HWRC doesn't know something there's a good governance structure around the site, the community to support her and make sure that she can be guided in the right direction. [Implementation Lead]*

**Key activities in this stage that enabled successful movement to 'GO' included:**

- The project implementation team's critical review of key evidence-based strategies and information that could be used to help communities in this phase. Evidence on how to establish appropriate business strategies and funding of the position was especially imperative. Key to the success of this was the Implementation Lead's experience of leading other communities through this process and her learning from Marathon.

- The community effectively self-organised, took maximum advantage of their skills and assets and took active ownership of developing and implementing necessary 'SET' strategies in order to proceed to 'GO'.

- Assisting communities to make good, evidence-informed decisions around the structure of the governance committee/designated business structure; funding of the HWRC position; fundraising activities; development of a HWRC position description, and recruiting to the HWRC position.

*If you put the right person into that position [HWRC] they love being helpful and connecting people up. So, it's usually in their skill set, they've been doing it forever, but now they get paid for it. So, there's that part. And the other one is they're developing expertise, because all of them are pretty smart and have these good strategic brains because you need that. And they can see where the barriers are, and begin to work on these and the opportunities [Implementation Lead]*

Supporting the community to make good evidence-informed decisions was achieved through the Implementation Lead providing ongoing support and mentoring and attending ACS committee meetings.

*Trying to give advice based on their context, and their community in place, and their particular challenges and assets. By the time I'm doing that work, we've got to know each other quite well. And there's quite a bit of trust. [Implementation Lead]*

Use of FRRR funding to design the ACS logo allowed pilot communities to leverage the work that had been already done so that a locally-appropriate ACS logo and merchandise could be produced at a lower cost to the community. Stakeholders identified that having a smart, formal, and consistent logo, branding and merchandise contributed to their ability to encourage the community to fund and support the program.

## Success indicator 1.4 - Three pilot communities complete 'GO' phase

# Partially Achieved

**Evidence of success**

- One pilot site (A) progressed to and completed GO phase and implemented a HWRC position into their community.
- Key learning from Phase 3 codified and used to inform development of the Blueprint.

**Key activities, contexts and mechanisms enabling achievement of goals**

The single pilot community that undertook ALL essential 'GO' activities proceeded to implement a successful HWRC position into their community.

The most important 'GO' activities, contexts and mechanisms that created the necessary pre-conditions to successfully implement a HWRC included:

- Undertaking all 'SET' elements (see above).
- Continuing to effectively self-organise and take active ownership of the necessary processes and actions to manage and sustain a HWRC position.
- Utilising capacities and assets to strategically target HWRC activities to areas of community priority and to assist the HWRC in supporting new-to-area health professionals and helping local health services and businesses to attract and retain these staff.
- A significant level of trust and confidence being developed between the pilot site stakeholders and the Implementation Lead.
- Ongoing mentoring and support from the Implementation Lead.

*What's working really well is teaching and mentoring [HWRC]. And that initially was at least once a week and all the time, and now we're down to twice a week because she's got going and gained more confidence. And I've linked her to other [HWRCs] who have good systems. [Implementation Lead]*

*She's [Implementation Lead] been immensely supportive to the committee. Yes, it's been a huge support for me. She and I have had a very good relationship and I feel that she won't cut me loose. She gave me the freedom some time ago once she had confidence. And when I had confidence to let her go as well. And I know now when to talk to her*

*when not to talk to her and when it's needed. So, I feel supported, and I think she feels confident, certainly, in my leadership. [Stakeholder, pilot site A]*

- Gaining insights and support from other HWRCs in Australia and internationally (Marathon)

**Key activities in this stage that enabled successful implementation of the HWRC included:**

- Review of key evidence-based strategies for successfully supporting HWRCs in their positions and ensuring sustainability of the position past one year.
- The Implementation Lead working closely with the community to enable them to identify and use their capacities and assets to drive the HWRC position to fruition.
- The Implementation Lead and evaluator assisting the community to devise a context-appropriate one-year workplan to guide the direction, prioritisation, and impact measurement of HWRC activities.
- The Implementation Lead assisting communities to make good, evidence-informed decisions around the one-year workplan and sustainable funding options.
- The Implementation Lead assisting the HWRC to educate local healthcare businesses on their responsibilities for attracting and retaining healthcare professionals using the WoP-RIF.
- The Implementation Lead assisting the HWRC to develop systems for identifying and addressing new-to-area professionals' needs.
- Mentoring and development of a community of practice for the HWRC to engage with and be supported by other HWRCs in Australia.

**All elements were captured, codified, and described in the 'GO' learning module on the ACS website which covers the following key steps:**

1. How to create and develop a short- to medium-term ACS Workplan that allows for prioritization of HWRC activities and planning for future sustainability.
2. Guidance on how to assist the HWRC to support new-to-area health professionals and local health services and businesses.

This module comes with several important, evidence-informed checklists that help the HWRC to identify and troubleshoot new-to-area health professional early settle/connect needs as well as local healthcare business needs in terms of how to retain their new (and current) staff (see the 'stay/retain' checklist for example.

Attract Connect Stay.

HOME ABOUT READY SET GO NEXT RESOURCES CONTA

# Go - Course Overview

Part 3 of the course *will support your newly appointed Health Workforce Recruiter Connector to achieve impactful health workforce outcomes and help your Management Committee to realise financial sustainability. It includes case studies of the Health Workforce Recruiter Connectors and Attract Connect Stay Management Committees in operation.*

# GOAL 2 Production of a Blueprint

## Success indicator 2.1 - ‘Ready’ Blueprint developed & launched

# Achieved

**Evidence of success**

- ‘READY’ Blueprint content developed
- Live ACS website with 'READY' information & learning modules launched

**Key activities, contexts and mechanisms enabling achievement of goals**

- Learning from all three pilot sites, including those who withdrew from the project, was codified and incorporated into READY content. Key evidence and the Implementation Lead’s experience with other sites was also leveraged.
- The codification of information and learning from undertaking the EOI process, and from reflecting on which communities demonstrated the strongest adherence to ‘READY’ principles, were imperative to the development and content of the ‘READY’ learning module.
- FRRR funding enabled a team of experts to be contracted and software licenced to build, design the look and feel of, and write content for the website.

## Success indicator 2.2 - ‘Set’ Blueprint developed & launched

# Achieved

**Evidence of success**

- ‘SET’ Blueprint content developed.
- Live ACS website with 'SET' information & learning modules launched.

**Key activities, contexts and mechanisms enabling achievement of goals**

- Learning and evidence from the single remaining pilot site, along with the Implementation Lead’s experience from other sites, was codified and incorporated into SET content.
- The codification of information and learning gained from supporting the remaining pilot site to develop and implement an incorporated association model to house ACS locally was especially imperative to the development and content of the ‘SET’ learning module. Equally as important was the codification of learning gained from supporting the pilot site to appropriately cost and fund the position.

## Success indicator 2.3 - ‘Go’ Blueprint developed & launched

# Achieved

**Evidence of success**

- ‘GO’ Blueprint content developed.
- Live ACS website with 'GO' information & learning modules launched.

**Key activities, contexts and mechanisms enabling achievement of goals**

- Learning and evidence from the single remaining pilot site, along with the Implementation Lead’s experience from other sites, was codified and incorporated into GO content.
- The codification of information and learning from supporting the HWRC to: a) identify and address new-to-area healthcare professionals’ settle/connect needs, and b) to assist local healthcare businesses to identify and address organisational issues with regard to retaining new (and current) staff, were especially imperative to the content of the ‘GO’ learning module. Equally important was the process of developing a work plan and success indicators.

## Does your rural community struggle to attract and retain health professionals?

Successfully recruiting and retaining health professionals is essential to maintaining an adequately sized and skilled health workforce to meet local healthcare needs.

Chronic health workforce shortages and high turnover of health professionals are a common challenge facing many rural communities.

READ MORE

## What needs to change?

There is an urgent need for a 'fundamental reframing' of the rural health recruitment and retention problem. We need to move from a narrow economic model of recruitment towards a more person-centred and holistic approach.

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## The Attract Connect Stay Solution

Attract Connect Stay is a proven, grass roots, bottom-up program, mobilising the passion, knowledge and practical skills of residents, community groups and local organisations to better attract and retain health workforce professionals. The Attract Connect Stay solution is to establish a locally-funded, locally-recruited and community-managed Health Workforce Recruiter Connector.

READ MORE

## Establish Attract Connect Stay in your community

If you're thinking the Attract Connect Stay solution might be what your rural community needs, we have developed a FREE 3-part course facilitated by Dr Cath Cosgrave to help you decide if your community is ready.

READ MORE

# GOAL 3 HWRC positions implemented in NSW and impact observed for these rural communities

## Success indicator 3.1 - Three pilot communities implement HWRC positions in NSW

## Partially achieved

**Evidence of success:**

- One pilot site implemented HWRC position in NSW.

# Goal 4 Awareness, uptake and piloting of the Blueprint observed in Victorian rural communities

## Success indicator 4.1 - There is awareness of or high levels of exposure to the ACS/HWRC Blueprint website across Victorian communities (and other rural communities)

# Achieved

**Evidence of success**

- A marketing and promotion plan was produced for the period 1 August–31 October 2022. The following evidence relates to the impact of implementing the plan over this period.
- The ACS solution / Blueprint was promoted widely across Australia and Victoria with good reach into target audiences.
- The ACS website was highly accessed during the marketing period, with 1600 views.
- The ACS popup website survey, completed by 35 respondents, revealed that 80% of those landing on the website were from rural communities who had rural health workforce problems (52%).
- ACS LinkedIn gained 111 followers, of which 37% were from Victoria, and had 226 visitors in total, of which 29% were from Victoria.
- ACS Facebook gained 12 followers, had 84 page visits, and a reach of 1756 during the marketing period.
- ACS Twitter posted 28 tweets, gained 30 followers and had 2773 profile visits.
- ACS Instagram had 136 page visits and a reach of 288 during the marketing period.
- The ACS website gained 44 subscribers, the majority of which were from Victoria (50%) and NSW (43%).
- Twenty-two individuals (including 4 from the ACS team) signed up for the ACS learning modules in Teachable.
- Fifty-five people attended the ACS webinar, with an additional 58 views of the recording.
- There were 105 views of the Glen Innes case study video.

**Key activities, contexts and mechanisms enabling achievement of goals**

The most important mechanisms that enabled widespread exposure to the Blueprint included:

- Speaking about ACS at large rural health conferences, events, and webinars.
- A shift from face-to-face to online promotion format.
- Developing and executing an online marketing campaign targeting specific groups of stakeholders in rural Victorian communities.

**Key activities in this stage that enabled successful promotion of the Blueprint included:**

Development of a marketing plan and engagement of a digital marketing specialist to advise and implement a digital marketing plan.

In response to COVID-19 restrictions, the project implementation team shifted from promoting the Blueprint using face-to-face forums and targeted meetings with Victorian communities, and instead adopted a digital marketing and promotional campaign. This specifically targeted rural local government agencies, rural business chambers, rural workforce agencies, rural communities and rural health and care organisations in Victoria.

*And, you know, that's been, I think, a real advantage of COVID. How much this [online delivery] has become acceptable, the Webinar [format] is really acceptable to people, which means our reach is way more. I go back to when I wrote the grant. And we were talking about me (and the project implementation team) doing road shows through Victoria. What an inefficient way to do it. COVID enabled less face to face, and a greater acceptability to online, and once the relationships get up and rolling, I'm then able to build them offline. And I did so, it's both cost efficient and time efficient. [Implementation lead]*

The Implementation Lead also attended four rural health conferences, contributed to rural workforce webinars, and ran an ACS webinar with Professor Ruth Stewart, the Rural Health Commissioner and three ACS-informed community sites. **Specifically, these activities included:**

1. Speaker at the National Rural Health Conference (NRHC) in Brisbane, Queensland (August 2022).
2. Guest speaker at the Western Alliance Annual Symposium in Dunkeld, Victoria (November 2022).
3. Workshop facilitator at the National Rural Allied Health Conference (November 2022).
4. Invited panelist on 'Workforce' at the Ignite Mid North Coast business conference in Woolgoolga hosted by Regional Development Australia MNC (November 2022).

5 Keynote speaker at the Allied Health Primary Care Solutions Online Forum run by Rural Workforce Agency Victoria (May 22).

6 Organiser, speaker, and facilitator of the 'How to attract healthcare workers to your rural community' ACS Webinar (October 2022).

7 Guest contributor to a blog post produced for AHP Workforce and promoted to their 531 followers.

At these conferences and events, Dr. Cosgrave delivered addresses that drew attention to the ACS project and requested interested parties to visit and subscribe to the ACS website. Further exposure to ACS was driven by two keynote presenters at the National Rural Health Conference who drew the audience's attention to ACS and WoP-RIF (Dr Susan Wearne, Department of Health, Health Workforce Division; Dr. Gabriele O'Kane, National Rural Health Alliance) when presenting on the Rural Area Community Controlled Health Organisation). Further, Dr. Cosgrave was interviewed by Toowoomba news and the online newspaper Medical Republic, and Attract Connect Stay was featured in the Guardian newspaper and on the Australian Broadcasting Commission (ABC) news app providing further, more widespread exposure to the ACS project.

## Success indicator 4.2 - There is engagement with the ACS website and learning modules (the Blueprint)

# Achieved

**Evidence of success**

- Since its inception in May 2022 the ACS website received more than 1600 unique views and 44 subscribers.
- 22 individuals (4 from ACS team) signed up for the READY ACS learning modules; 5 (1 from ACS team) signed up for the SET modules.
- 6/18 completed all content in the READY & SET ACS learning modules.
- ACS LinkedIn had a total of 7984 post impressions across 25 posts and17 shares for the ACS webinar.
- ACS Twitter posted 28 tweets and saw 6175 tweet impressions.
- 22 (4 from ACS team) signed up for the ACS learning modules.
- 55 people attended the ACS Webinar, with an additional 58 views of the Webinar recording.
- There have been 105 views of the Glen Innes case study video.

**Key activities, contexts and mechanisms enabling achievement of goals**

The most important activities, contexts and mechanisms that enabled engagement with the Blueprint included:

- Speaking about ACS at large rural health conferences, events, and webinars.
- Developing and executing an online marketing campaign that targeted specific groups of stakeholders in rural Victorian communities.

Unfortunately, there were no respondents to the ACS learning module surveys so it was not possible to gauge reasons why the learning modules were not highly accessed or completed. One website subscriber who was available for interview commented that it was unclear whether the learning modules were free to access.

As part of the iterative evaluation, the three learning modules were reviewed and recommendations made to the project implementation team to streamline movement between modules and the main website. When the modules were launched, they were discrete, stand-alone modules that did not flow into one another or back to the ACS website. This has recently been corrected and the learning module platform software has been changed from Teachable to Zenler to support this.

## Success indicator 4.3 - Those who engage with the ACS website and learning modules find the information useful and helpful

# Achieved

**Evidence of success**

- The ACS solution / Blueprint has been well received.
- Website subscribers describe the content of the website as helpful, engaging and fit for purpose. In particular, the use of case studies was found to be useful.
- 67% of 14 website subscribers who responded to the survey reported that it was easy to find the information they needed; Three quarters (74%) found the information very useful or somewhat useful.

`

**Key activities, contexts and mechanisms enabling achievement of goals**

The most important activities, contexts and mechanisms that enabled engagement with the Blueprint included:

- Having an engaging and helpful website.
- Expert graphic design and web design input.
- Use of case study material.
- That people take the time to read the content.
- That there is access to evaluation or impact data to understand if and to what extent the ACS solution works.
- That it is clear the Blueprint resources (learning modules, checklists etc.) are free to access.

*I found the personable approach from Cath very engaging. She was 'available' as a person on the website and encouraged on-going contact or take-up of the offering. It made me want to find out more - and we now have an interview booked in to see if our community might be able to succeed with the Attract Connect Stay model. [open comment from a website subscriber]*

*I think the ingredients are all on the website. What I'm now dealing with is, people don't read. And that's very challenging. [Implementation lead]*

*In terms of your offering, it is still a little unclear to me … I thought the 'READY' was free but the SET and GO you had to pay for. I think you could probably start at the outset by stating that this is a free resource. [Rural community representative in Victoria]*

## Success indicator 4.4 - There is uptake of the ACS solution across further NSW and Victorian communities

# Partially Achieved

**Evidence of success**

- While some learning module participants are from Victorian communities, the ACS solution / Blueprint has not been formally taken up by any Victorian communities.
- Fifty percent of website subscribers, half of which are from Victoria, indicated a likelihood they would use the ACS solution / Blueprint information to address their health workforce issues. Forty-two percent were undecided.
- The ACS solution / Blueprint has been adopted by the Mid Coast (Taree, NSW)

*We are now seeking Mid Coast health and community service partner organisations who would like to make an investment in this service with the aim of directly benefiting from it.' [LinkedIn post from ACS advocate in Taree]*

**Key activities, contexts and mechanisms enabling achievement of goals**

The project implementation team identified that the time required to ensure success in the first three development phases (Ready, Set, Go) was significant and took longer than anticipated.

There was a reticence from the project implementation team to rush the development of the 'Go' phase of the Blueprint so that it could be implemented across Victorian sites. Whilst the Blueprint was therefore promoted and engaged with by a number of Victorian communities, there was insufficient time to work directly with Victorian communities to road-test the Blueprint and use it to develop and implement further HWRCs.

There is a clear call-to-action on the website to book a call with the Implementation Lead to discuss whether the ACS solution is likely to work for the website visitor's rural community. Some have taken up this call-to-action – the Implementation Lead spoke with approximately 6 interested communities since website launch (1 from Queensland, 1 from New Zealand, 2 from NSW and 2 from Victoria).

Many website subscribers were mainly interested in understanding more about the program, rather than trialling the program in their own communities:

*To learn about the exemplar workforce recruitment and retention program to see if this is suitable for the rural communities I work with'*

*'Interested in finding out more about the program and applicability to my region*

*Registered for a webinar - hoped there'd be practical support and solutions for workforce challenges'*

Others expressed that the Blueprint website was not an easy way to quickly address their workforce problems:

*Just need to find a doctor, without all the paraphernalia that I don't have time for!*

## Success indicator 4.5 - HWRC positions are implemented in Victorian communities

# X Not achieved

## Success indicator 4.6 - Learning from Victorian sites contributes to refinement of the Blueprint

# X Not achieved

**Key activities, contexts and mechanisms enabling achievement of goals**

As described in success indicators 1.1 and 1.2 (above), key factors in the success of the HWRC in the NSW pilot site were a) significant investment in phases READY and SET, and b) not progressing from one phase to another prematurely. The time taken to implement HWRCs in the NSW pilot site took considerably longer than anticipated, leaving insufficient time to design and roll out the Blueprint in Victoria.

A key recommendation of this evaluation is that the Blueprint needs to recognise the importance of and include access to facilitation, mentoring and support, similar to that provided by the Implementation Lead (Dr. Cosgrave) to the successful pilot site during the project. The evidence points to mentoring and support being a core component of the Blueprint which helps ensure a good fit between evidence-informed decisions and activities and context-appropriate decisions and activities.

This is important for success because, as the Implementation Lead states, 'every community differs'. Adapting the Blueprint to a particular community takes a considerable amount of mentoring to ensure the community is moving in the right direction.

*It [the ACS program] is deceptively simple, but it is really hard to do. And sometimes I think they just need to talk to someone who's got a bird's eye view on it. And I kind of know what stations we need to arrive at, and help them to think about a way we might get there, a pathway that might get them there. [Implementation Lead]*

The re-investment in implementing the ACS solution by Taree (NSW, Mid Coast LGA), an original pilot site who declined to participate in further stages at the beginning of the ACS pilot, helps confirm that early bespoke mentoring from the Implementation Lead earlier would have improved engagement. Taree could see that the ACS solution was broader than just health and were concerned that involvement in the pilot would restrict their freedom to implement the solution across sectors:

*Cath [Implementation Lead] came back to our community and presented [for the third time] to another dozen people that all agreed they wanted to make it [ACS] happen. But then we realized, a bigger group of people really need to know about this [ACS] because it's a community thing, not just us driving it and now how are we going to sell it? …. That dozen people did not feel comfortable. They felt like the pilot would be restrictive. They didn't want to get bound up into the research because they wouldn't have had the flexibility to be able to add on to the broader system. Their initial thoughts were that this is way bigger than Allied Health. This is our whole town. We know accountants, lawyers who are desperate. They would do anything to jump on board with this. We all came back to needing to make this work in just one setting before we jumped on every setting. But they wanted to do that rapidly. And I think had it in their head, we can knock this over in 10 minutes flat. But it's actually taken way longer because the other thing was getting people of influence in a room. We're all busy. And trying to get us together and trying to get us to coordinate who's going to do what was a struggle.*

Although the Blueprint is an excellent introductory resource for communities, it would seem that successful implementation of the program requires strategic mentoring and support from the Implementation Lead and the flexibility to consider application of the Blueprint to industries other than healthcare.

**Bree Katsamangos** • 2nd
Enabling communities to drive social change
1mo •

+ Follow ...

Today the Mid Coast welcomed Dr Cath Cosgrave who is providing planning support for a community driven 'Community Connector' role as a key strategy to address the shortage of allied health professionals in the region. This role takes its inspiration from attract connect stay and is a 'proven, grass roots, bottom-up program mobilising the passion, knowledge and practical skills of residents, community groups and local organisations to better attract and retain health workforce professionals'.

We are now seeking Mid Coast health and community service partner organisations who would like to make an investment in this service with the aim of directly benefiting from it.

Is what you are doing to attract, recruit and retain allied health professionals currently working?

Is your business prepared to invest in a new approach that is tried, tested and successful?

Connect with us so we can share this opportunity with you.

#barringtoncoast #lovewhereyoulive #lovewhereyouwork #alliedhealth #alliedhealthprofessionals #collaboration #opportunity #business #community #investment #strategy

## GOAL 5 Understanding of the impact of the Blueprint and HWRC positions in rural NSW and Victorian communities and identification of key contexts, activities and mechanisms that enabled success

## Success indicator 5.1 - Iterative data gathering and input across the life of the project assists with refinement of the Blueprint

# Achieved

**Evidence of success**

- Review of ACS documents and outputs (11 documents reviewed - Project Advisory Group minutes x 2; Project implementation team minutes x 2; Expression of Interest forms received from pilot communities x 3; Community presentations & workshops from lead implementor x 4; READY, SET, GO website and learning module material).
- Surveys of 34 participating pilot sites.
- Weekly interviews with lead implementor (CC) (15 between 12 Aug 2021 and May 2022).
- Interviews with 8 pilot stakeholders.

**Key activities, contexts and mechanisms enabling achievement of goals**

Data were used iteratively over the life of the project to provide information for improving the content of the Blueprint. This information was fed back to the project implementation team at regular intervals.

For example, weekly narrative interviews with the lead implementor in the first year of the project enabled weekly reflection on the following questions:

- What activities did you undertake this week?
- What key decisions did you make about the direction of the ACS project this week?
- Why did you make these decisions and what was the intended outcome?
- What will you do differently in future?

This allowed for continuous reflection around what was working, why this was the case, and what needed to be changed, for use in developing the Blueprint. The following quote from the Implementation Lead illustrates this:

*Take home for the Blueprint from [pilot site B] - if potential participants can't get a diversity of stakeholders around the room to discuss ACS as a solution – then they are not ready. In particular, there is a need for strong representation from all sectors and*

*types of health services. GPs are really important representatives. [pilot site] didn't have that. They didn't have readiness to engage. It is not worth it if you are not ready and 100% committed. ACS needs participants to buy in and own the process. They [rural communities] are very much leading and I am facilitating. I work to their agendas, not the other way around.*

Survey feedback from pilot sites in the first phase of the project, as well as stakeholder interviews during the second phase of the project, informed small but important additions to the Blueprint.

For example, pilot sites indicated that early information needed to be provided regarding the pros and cons of hybrid-funded health workforce strategies in the READY and SET Phases. This has been incorporated into the SET learning module.

## Success Indicator 5.2 - Understanding of the impact of HWRC positions in rural NSW and identification of key contexts and activities that enabled success

# Achieved

**Evidence of success**

HWRC position and ACS program fully implemented in Pilot site A.

Full information below (Question 2, section 5.2)

## Success Indicator 5.3 - Understanding of the impact of the Blueprint on Victorian sites and identification of key contexts and activities that enabled success

# X Not achieved

In lieu of data from Victorian sites, we interviewed one of the original NSW sites which had previously withdrawn from the pilot study, Mid Coast LGA (Taree). This Mid Coast LGA has since re-connected with Dr. Cosgrave and will be using the Blueprint along with Dr. Cosgrave's mentoring to implement the ACS solution in NSW.

## Success Indicator 5.4 - Understanding evidence gaps for future consideration.

# Achieved

**Evidence of success**

Ethics approval was received to undertake a qualitative study titled 'Exploring the community-engaged approach in Attract Connect Stay' [QUT Ethics Approval Number 5418]. Semi-structured interviews have been conducted with pilot sites and key data from the study has been included in this evaluation.

# Question 2: What was the impact of the HWRCs on rural communities?

What were the contexts, activities and mechanisms that enabled this to happen?

The HWRC position was fully implemented in one pilot site (A) in NSW. The development and implementation of the HWRC and the business structure to host the position, incorporation of ACS-Glen Innes, took approximately 18 months to realise. The HWRC position has formally been in place for 5 months.

**Year 1 success indicators that were submitted as part of the EOI process were all achieved. These included:**

- Recruitment and Appointment of HRWC aligned to the program objectives and insights with clear and flexible job description.
- Identification of workforce needs across the healthcare sector.
- Commence attraction of required healthcare professionals.
- Secure healthcare professionals supported in their transition.

In the short time frame since inception, the HWRC position has been extremely impactful at a community, workplace, and individual level.

**At a community level:**

There has been a whole-of-community commitment to undertaking strategies to attract skilled professionals to the rural area/township, demonstrated by more than 200 ACS-Glen Innes community members and over $50,000 funding raised to support the HWRC position.

Seven health professionals and their families have been supported to move to and/or settle/connect into the rural community. This includes 2 GPs, 1 Pharmacist, 1 Exercise Physiologist, 1 Diabetes Educator, 1 Nurse Practitioner, and 1 Speech Pathologist.

The addition of the first GP in August 2022 has led to 70 patients being moved off the waiting list, equating to 224 hours of additional clinical care provided to the community over a 3.5-month period. The second GP will commence in mid-November, enabling the Glen Innes Highlands to move at least 70 more patients off the waiting list and provide significantly more hours of clinical care.

With 70-140 more residents of Glen Innes Highlands able to access GP care, as well as care from extra Allied Health and nursing professionals, residents will be more likely to receive appropriate preventive care, early diagnosis and early treatment for health conditions [29, 30]. This will improve the overall health of the community, and increase workforce participation and economic productivity [30, 31].

While not a focus of ACS-Glen Innes in Year 1, the addition of two GPs is also helping to address some local challenges in continuity of care between the hospital and primary care and reduce unnecessary hospital admissions. Evidence shows that better support for and use of general practice is associated with lower emergency department presentations and hospital use, decreased hospital re-admission rates and improved continuity of care [32, 33]. The Royal Australian College of General Practitioners conservatively estimates that well-coordinated GPs could manage nearly one-third of all emergency department presentations [34].

The net movement of seven healthcare professionals and their family members (2 adults and 3 children) to Glen Innes Highlands represents a (conservative) approximate gain of $520,000 to the community based on annual average household spending for a typical Australian resident [35]. This estimate does not include the potential increased revenue and downstream economic benefits to the community generated by local healthcare businesses that are able to provide additional services due to an increase in employees. Further, a net movement of 12 persons to Glen Innes Highlands provides a welcome injection of new ideas and contributions to the community fabric as summarized by an ACS-Glen Innes Inc. Member:

*Not only do we get a new GP - we get an additional pharmacist, 3 children for the schools AND a job for a Nanny. And everything that goes with bringing new people into our community.*

**At a workplace level:**

There has been recruitment into hard-to-fill healthcare roles, an improved understanding of the type of services offered by other healthcare providers in the community, and an improved understanding and application of retention (WOP-RIF) principles within the three local GP practices.

**At an individual healthcare professional level:**

There has been deep satisfaction with the program and gratitude to the community from the overseas trained GP and his family. This has led to a positive experience of the community from the outset, early engagement with the community and early signs of the family having the support they need to settle into and connect with the community.

*I feel really excited, and comfortable too. So, I think we are really prepared and we are planning to stay for the long term. [New GP, pilot site A]*

# Activities, contexts and mechanisms underpinning success

**In the 18-month time frame since recruitment to the ACS project, members of the Glen Innes Highlands community and the ACS-Glen Innes Incorporated (Inc) management committee have undertaken the following activities:**

- Identified key influential stakeholders across the community and secured their agreement to join a group which undertook early work to formalise a governance structure for the development and implementation of the HWRC position.
- Developed and implemented an incorporated association structure within which the HWRC sits and is governed.
- Developed ACS-Glen Innes Inc branding, marketing and promotional material.
- Promoted ACS-Glen Innes Inc throughout the community using talks, distribution of marketing and promotional material and media coverage.
- Enlisted 200 ACS-Glen Innes Inc community members.
- Planned and ran multiple fund-raising events in the community.
- Applied for and was granted funding from a community grants program for hardware and other materials (banners, flyers, gazebos etc.).
- Developed an advertising campaign, position description and recruitment process for a HWRC.
- Recruited a HWRC.
- Established ACS-Glen Innes Inc sub-committees.
- Developed a 1-year workplan to implement the HWRC.
- Developed success indicators to understand the impact of the HWRC in the first year of operation.
- Developed and implemented a regular newsletter for ACS-Glen Innes Inc members to be kept informed about progress in their community.
- Held the inaugural Annual General Meeting and elected role holders in January 2022.

**In the five months since formally starting the position, and in the five months preceding formal appointment, the HWRC has undertaken the following activities:**

- Regularly engaged with the GP practices and organisations in the community to understand their workforce and service capacity needs and problems.
- Brought all GP organisations in the community together to build further understanding of and commitment to undertaking WoP-RIF.
- Engaged with all healthcare businesses in the community and begun to map the different services offered, their service capacity, their workforce needs and how they relate to one another.
- Supported one GP practice to undertake a self-assessment of WoP-RIF and to identify areas where improvement needs to be targeted.
- Supported a GP clinic to provide clinical supervision and mentorship to their newly recruited GP.
- Supported a newly recruited GP to find meaningful and appropriate social activities and connections and a local property to purchase.
- Supported a GP clinic to undertake the necessary steps and paperwork to sponsor an overseas trained GP.
- Engaged with multiple local businesses and organisations to promote the ACS cause and to facilitate connections that will support new-to-area health professionals and their families move to and connect with the community.
- Supported an overseas trained GP and his pharmacist wife and family to find suitable housing, schooling, childcare, healthcare, and a nanny.
- Supported a Speech Pathologist to find work in the region.
- Supported a Nurse Practitioner and her partner to secure a rental property and information about community activities that match her and her partner's interests.
- Supported an exercise physiologist to find meaningful and appropriate social connections and provide introductions to the other local healthcare businesses and organisations.
- Supported a diabetes educator to settle into the community and to explore opportunities to establish a diabetes education service in the community.
- Connected with other HWRCs on the advice of the Implementation Lead.
- Participated in ACS-Glen Innes Inc. committee meetings and working group meetings.
- Began to plan social activities for new-to-area healthcare professionals and other professionals in town.

**These activities in combination with the following mechanisms have enabled the realisation of the identified outcomes:**

- Glen Innes as a community exhibited exemplar 'READY' elements.
- Strong relationships with the local GP practices were formed.
- The business and governance structure, membership and activities undertaken by the ACS Glen Innes Inc. management committee.
- High levels of community understanding, awareness of and support for the goals of ACS-Glen Innes (attributable to the above point).
- Mapping and connecting local healthcare businesses and organisations.
- Forming strong relationships with local supporting businesses and organisations.
- Strong, trusting relationship formed with the Implementation Lead, enabling gradual ownership of ACS process to be transferred to the community.
- Connection to other HWRCs.
- The community committed to, trusted the process, and did the hard work.
- Securing ongoing funding.

Glen Innes as a community was 'READY' to participate from the outset. A series of council-led think tanks had been held with the community around the big issues they were facing, and health workforce was identified as a key area of concern to the community. Additionally, as identified in Section 1, the ACS project via Dr. Cath Cosgrave came to Glen Innes at a time of crisis. One of the three GP's was going into retirement which, in the words of an ACS-Glen Innes Inc. member, 'would release several hundred clients back into an already overloaded system'. The Expression of Interest process required potential ACS pilot site communities to clearly identify the problem and start to unpack how they would address it. This, in the words of an ACS-Glen Innes Inc. member 'allowed us to do some significant thinking and analysis which worked towards giving us a good foundation' prior to starting the process.

*The community had already been talking about the problem and was ready to embrace a potential solution. [Stakeholder, pilot site A]*

As identified in Section 1, Glen Innes self-initiated community-led awareness raising initiatives such as a speaking circuit to educate the community about ACS and how the program would not solve the problems of the health system, but would try to solve the health professional problem from 'the bottom up'.

Having a relationship with the GP surgeries, mapping their needs, and understanding what they had to offer has enabled the HWRC to work with potential new GPs who are looking to work in the region and to identify which practice they would best suited to.

*We were able to start that conversation about what was available in Glen Innes and what her needs were. Then I could go to different doctor surgeries and the Aboriginal Health Service and say, I've got this person and this is what they need, do you think you'd be able to do that? So that's been good. [HWRC, pilot site A]*

*I have just been trying to get a picture of what their practice is like as far as the facilities, doctors that they have, how many hours the doctors are working, how many consulting rooms they have, when are they full and working out what the practices' GP full time equivalent is. And then getting them to work through the WoP-RIF self-assessment to see where they're up to. And then helping them create some personas for who they want. [HWRC, pilot site A]*

The structure of ACS Glen Innes – Management Committee to include two smaller working parties as well as the HWRC means that the community and the HWRC are connected. This has significant benefit for all stakeholders.

*The two big things I got out of being part of the committee is just the importance of connecting and networking and for everybody to know what's going on. [HWRC, pilot site A]*

Mapping the healthcare businesses in the community, identifying their needs, and doing work to bring them together has in one instance led to a speech pathologist moving to the region and providing in-reach services to Glen Innes, and an exercise physiologist being better connected to existing local healthcare providers. The HWRC also identified that connecting healthcare businesses would allow for improved services being provided to the community.

*I went out and spoke to every health professional business that would speak to me — just to find out what was out there and what their needs were and to tell them about Attract, Connect, Stay. And that was really very interesting. Just through the connections, we actually picked up a speech therapist that wanted to move to the area. I was able to put her in contact with two of the practices that were working in [the town] that needed a Speech Therapist.*

*I also found out that even though [Town] is a small place a lot of the health services didn't know about each other. There was a psychologist that has now left the area but when I was talking to her, she was saying, she didn't know why, but she just wasn't getting any referrals. Talking to the other service providers, they were all saying, we need more psychologists, and I thought that's something that needs to be addressed as well. [HWRC, pilot site A]*

The HWRC's medical background has been a key enabler to the success of the position, given that a key first year goal of the position is to recruit GPs to the region. Karen's background as a retired GP has enabled good relationships to be built with local GP practices and organisations, and provides the necessary knowledge and skills to be able to offer supervision and support to new GPs.

*I think the fact that [HWRC] has a medical background, even though it's not a requirement, has been very helpful in this instance here, because we are so deeply embedded in the doctor [attraction] bit not the Allied Health. Our two [general] practices are so struggling for their own capacity to manage their services. And [HWRC] has the capacity to do things for them in terms of chasing up registrations and other technical things. I think that has been an advantage to us [Stakeholder, pilot site A]*

ACS was set up as a community-led organisation with a membership of highly skilled people including a solicitor, chief financial officer, a retired senior government worker, and a Human Resources officer who together had significant reach into multiple parts of the community. Combined with a management committee structure that enabled a good flow of communication between key community stakeholders and the HWRC, this allowed the HWRC to successfully attract and recently support an overseas trained GP and his family to move to Glen Innes.

In the first instance, the HWRC identified an opportunity to support the overseas GP to move to the community through a conversation with the GP and his wife at a local museum. His wife had been a pharmacy locum in the region and both expressed how much they had enjoyed their time in Glen Innes. The HWRC immediately followed up with the family and the local GP practices to see if there was an opportunity to bring the doctor to Glen Innes more permanently.

*That's the other thing that happened at the end of last year. We found out about a overseas trained doctor. I rang them back about another thing and also to ask his wife, who's a pharmacist, about her experience of working in Glen Innes. That's when she said, 'Oh, my husband's a GP and we'd love to move there'. [HWRC, pilot site A]*

*And actually, on the last day we were visiting museum and we met [HWRC]. We started to talk to her and then she discovered my wife is a pharmacist. And then my wife introduced me to her and I explained to her my situation and she said to me we need many GPs. So, after that, she told me ok, she can speak to the general practice.. That's how it started actually. [New GP, pilot site A]*

This was also the case for the diabetes educator who the HWRC met at a Christmas function. This person has since moved to the area and is exploring opportunities to provide diabetes educator services locally.

*She said, I'm thinking about starting up with my diabetes educating now. So I was able to meet with her and find out what she's looking for as far as a room to hire and rang around and found rooms for her to look at. [HWRC, pilot site A]*

Once the process of overseas registration had commenced, the HWRC used her connections and relationships in the community to secure a suitable property for the re-locating GP, who required very specific needs to be met for one of his children. As there was a long lead time between securing the property and the GP re-locating to the community, the HWRC along with the employing GP clinic were able to secure the property using support from multiple community stakeholders including the Council, which contributed towards rent.

*I was able to find the house talking to him and his wife about what their needs were and what the deal breakers were. I went out and had a look at two houses. One of them was just right. It was just tick, tick, tick. They agreed when they saw the photos, but the problem was, it was available for rent back in the middle of September, and we knew this [registration process with APRHA] was going to take forever. Anyway … with the intervention of the practice asking council and then us [Management committee] asking council, we were able to broker so that council paid for one or two months of his rent to hold the property. So that was really good. [HWRC, pilot site A]*

*She was a great help. She did a lot because I was coming to Glen Innes only for two days or three days to be more familiar with the community. So, I couldn't spend more time looking for a house. She did that. We were lucky to find a house for my son with special needs, so we needed the house with specific facilities. It's tough to find good house that is clean and suitable for our family. She was the major support and she managed to get more assistance from the council. Then she helped me with our hobbies and activities. She helped us to find a nanny. She put advertisements everywhere. So now we have 2-3 candidates [New GP, pilot site A]*

By connecting and liaising with local businesses, in particular real estate agencies, the HWRC has enabled healthcare professionals to secure housing in a challenging rental market. Contributing to this was the significant amount of work the ACS-Glen Innes' management committee and HWRC have done to promote the ACS cause widely among the community, generating awareness of what they were trying to achieve and how that would benefit everyone in the community.

*Well, I guess the second biggest thing, after actually getting the people to the area is accommodation. But so far, that has been good. It's a challenge but the real estate agents, particularly the ones that have found these last two houses for me, have just been fabulous. They negotiated with the owners and explained to them the situation. So that so that's been really good. [HWRC, pilot site A]*

Ongoing guidance and strategic direction from Dr. Cath Cosgrave and access to an evaluator was identified by Glen Innes as being 'the robust structures that you need to succeed'.

In terms of what needs to happen moving forward for ACS-Glen Innes, sustainability of funding for the HWRC was a significant concern for the management committee. One key barrier to ongoing community-led funding is that many local community organisations have already contributed to ACS and there is only so much, in a community the size of Glen Innes Highland, that community members are willing or able to contribute.

*Yes, it is very difficult. Because what we are trying to do is build that community ownership. If only we could try to get the community to see that if they invested money in it, it would benefit them.... But I think fundraising has stalled at the moment because we have exhausted the supply of community groups to approach... Therefore, membership numbers have also plateaued, as we are unsure how to contact and tap in to people we haven't already met with. [Stakeholder, pilot site A]*

*We need to be mindful that there are organisations in this town who have been fundraising here for 25 years. And there is a limit to the to the pool of funds available. [Stakeholder, pilot site A]*

Future plans for the sustainability of the HWRC include looking for 1-2 year small grants from several local economic development and NSW state funding programs and identifying further opportunities for local businesses to support the program financially.

# Question 3: To what extent does the Blueprint enable rural communities to design and implement place-appropriate health workforce attraction, recruitment and retention strategies?

**What were the contexts, activities and mechanisms that enabled this to happen?**

The *Blueprint* clearly articulates the crucial ingredients that are required for the ACS solution to be successful in a rural community. Its focus is laying the essential foundations for future success in retaining healthcare professionals in rural communities. In doing so it has concentrated on what the Implementation Lead describes as 'the missing piece', or the 'Community and Place' aspect of the Whole of Person Retention Improvement Framework (WoP-RIF).

The available evidence indicates that, while the Blueprint includes all the important information needed by rural communities to implement a HWRC position in their community, it is challenging to implement without support from the Implementation Lead to guide decision making, and it falls short of addressing the remaining workplace/organizational and role/career domains of the WOP-RIF.

*If I had my time again. I would probably reinforce WoP-RIF from the very beginning, but because it was a project, and we were trying to get something up and running within two years, I feel we've over emphasized the 'community and place' section … It's only one solution of three really important components, I actually think the … organisational culture part is probably more important, because it's about all staff, whether they're newcomers or not. And we know that in health culture is challenging. [Implementation lead]*

**As such, the Blueprint functions primarily as a critical reference resource to allow rural communities to:**

- Assess their readiness to undertake the solution.
- Address any gaps that would impede its capacity to lay the important groundwork prior to undertaking the active implementation steps as described in the SET and GO modules.
- Understand the commitment and amount of work that are required for it to be successful.

The READY module, in which foundations are laid for success in future stages, is therefore one of the most important modules for rural communities to understand and take action on, prior to seeking assistance or pursuing the subsequent learning modules. The Blueprint clearly describes and guides the user through these essential READY steps. It is plausible therefore that rural communities could successfully work through the READY modules independently in order to be prepared for considering the later phases of the ACS solution.

In light of these findings, and to ensure the Blueprint remains useful, cost efficient and publicly accessible to rural communities, the Implementation Lead has suggested provision of ongoing input in the form of small user-paid workshops with rural communities that have engaged with the website, understand the problem, understand the solution and are ready to begin the process.

*My plan is to develop the learning modules into a cheap user pay course that takes people through a six-week program. I would guide them through READY and SET modules which are the bulk of the work. And this will be run perhaps a couple of times a year. The course will have video resources and a weekly webinar. This will allow rural communities to still be able to access the content but in a more interactive way that is affordable. [Implementation lead]*

Further, the implementation lead identified that there is an appetite for being more directive in the Blueprint around what types of governance or business structure and funding mechanisms are most suitable.

*I think I think the main missing piece now, in terms of what's up on the website … there's a real appetite for us to tell users the best governance model and the best funding mix. I think I've covered governance — you've got to be an incorporated association for all the reasons I point out, but you could create one or join an existing one, and there are strengths and weaknesses to both. But the main one is, how do you get it to be sustainable and funding?*

The Implementation Lead agrees with the successful pilot community, that 100% funding from the community is problematic and exhausting to achieve. There is some hope that state and federal governments can find a way to support communities that do this for example through …

… matched funding for the communities that do this hard work. Government money could be channelled through FRRR.' [Implementation Lead]

# Conclusion and recommendations

The Attract Connect Stay (ACS) project sought to develop, promote, and implement an evidence-based and place-informed online Health Workforce Recruiter Connector (HWRC) Blueprint, providing rural communities with a publicly available resource that would enable them to successfully develop and implement a contextually viable and suitable HWRC position into their community.

Funding was received from the Foundation for Regional and Remote Renewal (FRRR) for a project implementation team, led by Dr. Cath Cosgrave, to develop and implement the Blueprint across pilot sites in New South Wales (NSW) and Victoria (VIC) over a two-year time frame (December 2020-December 2022).

The ACS project successfully achieved all project objectives except for recruiting sites across Victoria to use the Blueprint to implement HWRCs in their communities. The time taken to effectively develop the READY and SET phases of the Blueprint took significantly longer than was planned, leaving no time to roll out the Blueprint across Victorian communities.

Key learnings from the project included a deep and thorough understanding of the critical activities and mechanisms required to successfully implement a HWRC into small (population 8,000 - 20,000) rural communities in Australia. These have been codified in the Blueprint.

Adherence to and execution of these activities and mechanisms enabled one NSW rural community to implement a HWRC and observe significant impact at the community, workplace and health professional level over a short period of time. As the Blueprint was not used to implement the ACS solution in further communities, it was not possible to evaluate the impact of the Blueprint on other communities.

Findings of this evaluation are limited by data from only one pilot community (A) who realised all steps in the ACS program. Pilot site B did not accept an invitation to participate in the evaluation so there is limited information available to fully understand and learn from their withdrawal from the program. The Blueprint was also not piloted in further communities in Victoria.

**Recommendations for further action include the following:**

- There is a need to understand the impact of the Blueprint on communities that use it to implement the ACS solution locally and to incorporate this information into future revisions of the Blueprint.
- There is a need to further incorporate the remaining two components (workplace/organisation and role/career) of the Whole of Person Retention Improvement Framework into the Blueprint.
- Further work is needed to improve health workforce literacy [3] especially to understand how the ACS solution and the Blueprint can be improved to support communities with a dominant need for healthcare workers outside of

the medical workforce. Strategies for communities to implement ACS when they identify a particular need for Allied Health professionals are required.

- Further options for communities to secure appropriate and sustainable funding to undertake the ACS solution also require further exploration.

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# Appendices

## Table 8 Extent to which project goals were achieved and mechanisms contributing to success

| Associated Project phase and goal | Success indicators | Extent to which goal was achieved | Evidence of success | Key mechanisms contributing to success |
|---|---|---|---|---|
| **Phases 1-3**<br><br>**GOAL 1.0 Recruitment of and learning from pilot sites to inform the Blueprint** | 1.1 Three pilot communities recruited to ACS project and learning around recruitment process is codified | Fully achieved | Five interested communities.<br>Three pilot communities recruited<br>Key learning from Phase 1 codified | Using evidence, in particular asset-based community development principles, to inform engagement, the expression of interest requirements and selection of rural communities<br>Engaging with strategic stakeholders who understood the problem and could see the potential for ACS to work in their rural communities<br>Attendance of key stakeholders from the community at ACS workshops<br>Requiring communities to submit an Expression of Interest form |
| | 1.2 Three pilot communities complete 'READY' phase and successfully progress to 'SET' phase | Partially achieved | Three communities had EOIs accepted, however two did not successfully complete READY, resulting in one site formally withdrawing (site B) and the other stalling (site C)<br>One pilot site completed READY phase and successfully progressed to SET phase<br>After the EOI process for NSW pilot sites was completed, another NSW site (D) joined the | Building trust between key stakeholders in the community and the Implementation lead<br>Community members leading the decision-making about committing to ACS<br>The community had strong community-mindedness and were open to a new way of approaching the problems they faced |

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| | program at the end of the funding period and is currently working through the READY phase<br>Key learning from Phase 1 codified | The assets of the community (including the range of gifts and skills of community members) were aligned to what was needed to bring ACS to life and these assets were valued and utilised<br>People willingly shared their gifts and assets to create connections to drive the project forward<br>There were significant, pervasive, and long-standing problems recruiting and retaining healthcare workers<br>Community members had a deep and personal connection to the impact of health workforce struggles, especially doctor shortages<br>Expressions of Interest to participate demonstrated exemplary capacity and willingness of the community to rally together, and oversee whole-of-community support and buy-in for the project<br>There was widespread and formal agreement across varied, independent community stakeholders around the need for the HWRC to be wholly governed by the community, independent of |

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| | | | | but with significant support from, the local council<br>There was commitment to piloting the ACS concept as a standalone project, no hybrid models |
| | 1.3 Three pilot communities complete 'SET' phase and successfully progress to 'GO' phase | Partially achieved | One of the three NSW pilot sites (Site A) completed SET phase and successfully progressed to GO phase. A second NSW site [site D] remained in contact with the implementation lead throughout the funding period but only formally committed to the program in October 22. This site is currently working through the final stages of the READY and SET phases<br>Key learning from Phase 2 codified | Exhibiting all 'READY' elements<br>The project implementation team's use and translation of evidence and experience into 'SET' strategies to inform decision making<br>The community effectively self-organised, took maximum advantage of their skills and assets, and took active ownership of developing and implementing necessary 'SET' strategies to proceed to 'GO'<br>The project implementation team's involvement shifted from that of leadership to mentorship<br>Sufficient time for plans to come to fruition |
| | 1.4 Three pilot communities complete 'GO' phase | Partially achieved | One pilot site (site A) progressed to, completed GO phase, and implemented a HWRC position into their community<br>Key learning from Phase 3 was codified | Undertaking all 'SET' elements (see above)<br>Continuing to effectively self-organise and take active ownership of undertaking the necessary processes and actions to manage and sustain a HWRC position |

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| | | | | Utilising community capacities and assets to strategically target HWRC activities to areas of community priority and to assist the HWRC in supporting new-to-area health professionals and local health services and businesses<br>A significant level of trust and confidence being developed between the pilot site stakeholders and the lead implementor<br>Ongoing mentoring and support from the lead implementor<br>Gaining insight and support from other HWRCs in Australia and internationally (Marathon) |
| **Phases 1-3, 5**<br><br>**GOAL 2.0 Production of a Blueprint** | 2.1 'Ready' Blueprint developed & launched; | Fully Achieved | 'READY' Blueprint content developed<br>Live ACS website with 'READY' information & learning modules launched | Leveraging learning from the pilot site, especially from the EOI process, key evidence, and the Implementation Lead's experience with other sites<br>The use of FRRR funding which enabled a team of experts to be contracted and software licenced to build, design the look and feel of the website, and create two promotional videos |
| | 2.2 'Set' Blueprint developed & launched; | Fully Achieved | ACS -HWRC 'SET' Blueprint content developed | Codification of learning from the single remaining pilot site was imperative to developing |

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| | | | Live ACS website with 'SET' information & learning modules launched | the SET content. This included learning from the incorporated association model adopted, alongside evidence and the Implementation Lead's experience from other sites |
| | 2.3 'Go' Blueprint developed & launched; | Fully Achieved | 'GO' Blueprint content developed<br>Live ACS website with 'GO' information & learning modules launched | Learning from the single remaining pilot site, in particular codifying information around how the HWRC can address new-to-area needs and local business needs, alongside evidence and the Implementation Lead's experience with other sites, was essential for producing the GO content |
| | 5.1 Iterative data gathering and input across the life of the project assists with refinement of the Blueprint | Fully Achieved | See below. | |
| **Phases 3, 5**<br><br>**GOAL 3.0**<br>**HWRC positions implemented in NSW and impact observed for these rural communities** | 3.1 Three pilot communities implement HWRC positions in NSW | Partially achieved | Pilot Site A successfully implemented a HWRC position into their rural community. | See section 5.1 |
| | 5.2 Understanding of the impact of HWRC positions in rural NSW and identification of key contexts and activities that enabled success | Fully Achieved | NSW Pilot Site A developed and achieved their place-informed success indicators<br>Evaluation was completed.<br>Impact of pilot site A's HWRC measured according to their community-developed success indicators and understanding of enabling contexts explored | See section 5.1 |

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| **Phase 4**<br><br>**GOAL 4.0 Awareness, uptake, and piloting of the Blueprint observed in Victorian rural communities** | 4.1 There is awareness of/high levels of exposure to ACS / HWRC Blueprint website across Victorian communities (and other rural communities) | Fully Achieved | The ACS solution/Blueprint was promoted widely across Australia and Victoria using social media, conference attendance and webinars, with good levels of reach into target audiences | Speaking about ACS at large rural health conferences, events, and webinars.<br>Shifting from face-to-face to an online/digital media promotion format<br>Developing and executing an online marketing campaign targeting specific groups of stakeholders in rural Victorian communities |
| | 4.2 There is engagement with the ACS website and learning modules (HWRC Blueprint) | Fully Achieved | Following the marketing and promotional campaigns, the ACS solution/Blueprint website gained 44 subscribers and 18 learning module participants. At least 6 community representatives completed all learning modules | Speaking about ACS at large rural health conferences, events, and webinars.<br>Developing and executing an online marketing campaign targeting specific groups of stakeholders in rural Victorian communities<br>Making it clearer to users that the learning modules are free to access<br>Having further evidence of the impact of the ACS solution readily available on the website. |
| | 4.3 Those who engage with the ACS website and learning modules find the information useful and helpful | Fully Achieved | Survey data identifies that the ACS solution/Blueprint information was well received by website subscribers | Providing evidence that the website is engaging and helpful<br>Use of expert graphic design and web design input<br>Use of case study material<br>People taking the time to read the content |

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| | 4.4 There is uptake of the ACS solution across further NSW and Victorian communities | Partially Achieved | 50% of website subscribers, of which half were from Victoria, indicated a likelihood they would use the ACS solution/Blueprint information to address their health workforce issues. 42% were undecided<br>While some learning module participants were from Victorian communities, the ACS solution/Blueprint has not yet been formally adopted by any Victorian communities | Unable to assess due to lack of respondents |
| | 4.5 HWRC positions are implemented in Victorian communities | X Not achieved | | n/a |
| | 4.6 Learning from Victorian sites contributes to refinement of the Blueprint | X Not achieved | | n/a |
| **Phase 5**<br><br>**GOAL 5.0**<br>**Understanding of the impact of the Blueprint and HWRC positions in rural NSW and Victorian communities and identification of key contexts, activities and mechanisms that enabled success** | 5.1 Iterative data gathering and input across the life of the project assists with refinement of the Blueprint | Fully Achieved | Evaluation data collected throughout life of project and fed back to ACS project implementation team at regular intervals | n/a |
| | 5.2 Understanding of the impact of HWRC positions in rural NSW and identification of key contexts and activities that enabled success | Fully Achieved | HWRC position and ACS program fully implemented in Pilot Site A<br>> 200 ACS-Glen Innes community members<br>Establishment of an ACS-Glen Innes management committee to oversee governance of the HWRC position | Glen Innes as a community exhibited exemplar 'READY' elements<br>Forming a strong relationship with the local GP practices<br>The structure, composition, and activities of the ACS Glen Innes Inc. management committee |

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| | | | Over $50,000 funding raised to support the HWRC position and the ACS-Glen Innes Incorporated Association<br>7 healthcare professionals and 5 family members supported to move to and/or settle/connect into the community in the initial 6 months of the position being active [2 GPs, 1 Pharmacist, 1 Exercise Physiologist, 1 Diabetes Educator, 1 Nurse Practitioner, 1 Speech Pathologist]<br>The addition of the first GP in August 2022 led to 70 patients moved off waiting list, equating to 224 hours of additional clinical care provided to the community over a 3.5-month period | High levels of community understanding, awareness of and support for the goals of ACS-Glen Innes Inc. (attributable to the above point)<br>Mapping and connecting with local healthcare businesses and organisations<br>Forming strong relationships with local supporting businesses and organisations<br>Support and mentoring from the Implementation lead and being connected with other HWRCs<br>Securing ongoing funding |
| | 5.3 Understanding of the impact of the Blueprint on Victorian sites and identification of key contexts and activities that enabled success | X Not achieved. | In lieu of data from Victorian sites, we interviewed at Site D. This site (mid coast, Taree) used the Blueprint along with mentoring by Dr. Cosgrave to implement the ACS solution in the final months of the ACS project | n/a |
| | 5.4 Understanding evidence gaps for future consideration. | Fully Achieved | Ethics approval was received to undertake a qualitative study titled 'Exploring the community-engaged approach in Attract Connect Stay'<br>[QUT Ethics Approval Number 5418] | n/a |

*Key information from Expression of Interest forms form pilot sites*

| Site | Key information from EOI |
|---|---|
| A | **CONTEXT**<br>• Modified Monash Model (MM) 4, Rural Zone 5<br>• Local Government Area (LGA) is home to 8,873 residents<br>• The Healthcare industry contributes to $40,000,000 of Gross Regional Product (GRP) and employs 411 people<br>• Forecast growth in the number and proportion of older residents in the region.<br>**PROBLEM DEFINITION:** Access; Equity, Lack of patient centred approach: Lack of consistency; Limited options for patient driven health care; Lack of options for End-of-Life care; and Lack of options for consistent and wholistic maternity care. Specifically described as:<br>• Limited number of GPs with nil private practice taking on new patients - patients; known 350 patient waiting list<br>• New residents travelling 50+ mins to other centres for basic GP care<br>• Appointments booking 4-6 weeks in advance<br>• Nil or limited availability to urgent appointments for current patients in all private practices<br>• Current GP's covering private practice plus ED/hospital on rostered basis<br>• Current GP's ageing and nearing retirement – risk of burning out with long hours and workload<br>• Allied Health – booking well in advance, with physio position being vacant for approx. 12 months<br>• 50+ mins travel is required for many specialist appointments and most ultrasound and imaging needs<br>• 50+ mins travel is required for dialysis and chemo<br>• Socio economic factors limit private Allied Health viability<br>• Having to travel to [4 different regional centres] for specialist consultations and treatment (these are typically >3hour drive).<br>**VISION:** A community that thrives emotionally and physically from local healthcare services that are accessible anytime and pivots to meet the needs of the community now and in the future. A community that feels secure and confident they are safe and have peace of mind that whatever ailment they encounter they won't be also burdened with travel and cost.<br>**COMMUNITY SUPPORT:** 25 representatives from across the heath sector, community, business, and local government attended the ACS facilitated workshop. GROW [town A] THINK TANK registrants are included in this number. Additionally, letters of support were received from all GP clinics, council mayor, family & youth |

support services including community associations, community members and volunteers, manager of economic development from the local council.

**PROPOSED BUSINESS/GOVERNANCE STRUCTURE**: Independent Local Healthcare Governance Group (ILHGG) – it was preferred that this was not Council and instead a community-based employer that could deliver the governance requirements of the position.

**FUNDING COMMITMENT:** Pilot site A Council and participants of the workshop from across the industry and community committed in kind and financial support to the value $50,000 for salary and expenses for a part-time flexible HWRC position.

**YEAR 1 MEASURES OF SUCCESS:**

1. Recruitment and Appointment of HRC aligned to the program objectives and insights with clear and flexible job description.
2. Identification of workforce needs across the healthcare sector with KWNG and reported to first quarterly ILHGG meeting
3. Commence attraction of required healthcare professionals
4. Secured healthcare professionals supported in their transition

**B** **CONTEXT**

- Modified Monash Model 5
- Local Government Area (LGA) is home to 5080 residents, 2135 in the labour force
- Ageing population
- Population expected to decrease by 0.5% yearly.

**PROBLEM DEFINITION:** Pilot site B has a real shortage of general practitioners and other health professionals. There is too currently much reliance on locums and visiting services. The demand is more than supply. There are chronic levels of mental health issues and a lack of continuity of medical care. We need health professionals to discover the *[pilot site B] Good Life* and choose to stay and become part of our community. We need to increase our number of professionals so our existing exhausted professionals can achieve a quality and positive work/life balance. For our residents we need to foster the continuity of care so that they receive the best medical advice and ongoing monitoring

**VISION:** To ensure that the Council's long-term role is viable and sustainable by meeting the needs of our residents in a responsible and caring way. The vision for us is to prosper, to be positive and to live ***the good life***. We need to develop innovative ways to attract and retain medical professionals to our area.

**COMMUNITY SUPPORT:** The Council and the [pilot site B] Health Committee Alliance receive constant feedback from its members at the regular meetings and required reporting. The Alliance is a committee of Council and is required to meet at least quarterly. Letters of support were received from local GP practices, Local Health District, local health committee, local aged care facility, the Alliance and Council general manager, and local residents. The following groups are represented in the Alliance:

- Rural and Remote Medical Services
- NSW Rural Doctor's Network

- Hunter New England Health
- Town and Town MPS
- Town and Town Aged Care Services
- Local Area Health Advisory Committee
- Australian Unity
- NSW Ambulance Service
- Four members of the public from town and town
- Councillors of Pilot site B Shire Council
- Deputy General Manager of Pilot site B Shire Council

PROPOSED BUSINESS/GOVERNANCE STRUCTURE: The Alliance will hold governance and oversight responsibilities. Council will employ the Health Workforce Recruiter & Connector person. The Health Workforce Recruiter & Connector employee will report to the Alliance, and in turn the Alliance will report to Council.

FUNDING COMMITMENT: Concurrently, Council and the Alliance will actively seek external funding through funding applications, support of the NSW Government, and donations from business and individuals.

**YEAR 1 MEASURES OF SUCCESS:**

1. Liaise with Dr. Cath Cosgrave and other Pilot Towns.
2. Recruit HWRC.
3. Promote the ACS Pilot Program
4. within GSC area.
5. Learn from Marathon model and promote our Shire.
6. Establish and foster networks and attract health professionals.
7. Creation of concierge portal

**C**

- MM 5
- Local Government Area (LGA) is home to 13,484 residents
- Ageing population
- Fly in Fly out community
- Expecting a significant influx in the local population due to state significant projects commencing in the next 12-18 months
- Increasingly ageing population

**PROBLEM DEFINITION:** Currently in the LGA the Health and Social Assistance Sector is the third highest employment sector following Mining and Agriculture, Forestry & Fishing. Recruitment and retention continue to be challenges across the sector, with low retention rates.

The specific challenges for [C] LGA were:

- Attracting skilled Allied Health workforce to a rural/regional setting, perception of rural can be negative
- Short term funding is a barrier and contributes to employment insecurity
- Using a recruitment agency to recruit staff is cost prohibitive but the only way to sometimes find staff

- Long term vacancies across the health sector including Doctors, Nurses (including Midwives), Occupational Therapists
- Contractor/private Occupational Therapists are limited and do not meet demand
- Physiotherapy, Occupational Therapists and Speech Pathologists are difficult to recruit (this caused a local Physiotherapy practice to close recently due to failure to recruit)
- Paediatrician, Psychiatry outreach positions vacant and cant be filled but have funding for 3 years
- Midwifery positions at hospital have been vacant long term
- GPs in Wee Waa are limited, one doctor only 4 days per week, generally only accessible via telehealth
- No/limited VMO access at Wee Waa Hospital – there has been a vacancy for a number of years
- Lack of capacity in private therapy sessions, eg. Access to a private speech pathologist in Wee Waa is limited to some schools and not widely available
- Nurses are leaving the area due to limited access to speciality jobs, ie. Midwives in Wee Waa and surrounding areas
- Education - address perception of local community towards NHS in particular – Local Council to help manage up the profile and support the NHS with staffing shortages/recruitment strategies to improve performance/image and profile of this integral component of the town and potential draw card for attracting skilled employees/business investments.
- People will not move if they cannot be assured of services for their needs and that of their family – regardless of the structure of the family unit.
- Employment opportunities for spouse/significant other
- CHILDCARE – access, affordability, flexible options including casual and flexible hours to assist with shift working parents
- Recruitment – complicated and prolonged process

Being unable to attract and retain health professionals to the area influences the level of service that can be provided and maintained within the affected community.

**VISION:** Access to childcare which has consistent availability and flexibility; Supportive and healthy workplace and team environment and recognition for work being undertaken; Accommodation – choice and availability; Recognition for work being undertake; Lots of interest/applicants for vacant positions; Flexibility in work hours & Attractive remuneration; Increase in childhood developmental outcomes (Allied Health); Team of professionals; School has enough teachers so that they can focus on their chosen expertise; Enough staff so we can have flexible work arrangements; Social determinants optimal for all community; Streamline system to enable overseas trained professionals the ability to work in Australia; Everyone feel and is safe; Sufficient housing availability; Incentives provided – HECS, accommodation, guaranteed contract, super, A/L, CDP ( applied to all areas, education, health, emergency services, agriculture); Sufficient childcare availability; After Hours GP Services; More sporting outlets; Access to timely medical appointments and follow up; More cultural representation and outlets; Parks, environment to promote healthy lifestyle; Availability for partners to gain employment; Provisions of basic shopping (Narrabri does not have a Target/Best &

Less/Big W etc); More inclusive events and participation in events; Public transport availability; Avenues to fast-track social connections; Better transport connectivity

**COMMUNITY SUPPORT**: Broad community support, including GP Clinics, [LGA] Health, [C] Shire Council, Nurse Partitioners from a range of health sectors, Allied Health, community health, community members and the business community. Specifically, this project is supported by Council's strategic planning, including the Community Strategic Plan 2017-2027, Local Strategic Planning Statement 2040, Resourcing Strategy 2017-2021 and further supported by NSW Health Strategic Priorities (Supporting and Developing our Workforce) and the Local Health District Strategic Plan (Looking Forward to 2021).

**PROPOSED BUSINESS/GOVERNANCE STRUCTURE and FUNDING:** Council hosted and governed position with financial support secured from industry and appropriate grant funding. In kind contributions from other community organisations e.g., office space, a computer and mobile phone for the successful applicant.

**YEAR 1 MEASURES OF SUCCESS:** Establishment of working group that is dedicated to the success of the project who will become the governance for the project; Successfully attain grant funding or sponsorship for the Recruiter Connector position; Development of terms of reference for the governance of the group; Successful development of position description; Successful recruitment for the Recruiter and Connector role.

***Suggested NEXT STEPs if excluded:***

If your target community's population size is less than 3K, consider whether it is feasible (in terms of boundaries of social relationships and networks), to increase your 'target community's geographical boundaries to include another major township and/or more nearby villages and hamlets?

If you are a remote community and it is unlikely it is feasible to extend your geographical boundaries, there are examples of remote communities undertaking successful health workforce strengthening activities similar in focus to Attract Connect Stay. Please make contact to discuss.

## 2.2 Suitability Assessment

Once you are familiar with the terms **primary healthcare** and **persistent health workforce shortages**, assess your community's suitability for implementing Attract Connect Stay solution by answering YES or NO to the following questions:

1. Do residents in your target community mostly rely on primary health care services?
   - ☐ Yes
   - ☐ No
2. Are persistent health workforce shortages experienced in your target community to the extent that providing basic primary healthcare (and possibly some secondary care) is challenging?
   - ☐ Yes
   - ☐ No

Attract Connect Stay.

*Results*

If you answered YES to both questions— please go to the next step 3.3 Does your target community meet the readiness criteria?

If you answered NO to either—the Attract Connect Stay is either not needed ( ie health workforce shortages are not an issue) and/or healthcare for your community is mostly being provided at the secondary and tertiary levels or some other way e.g. fly in fly out services. In such situations, the whole of community practice and asset-based community development approach underpinning the Attract Connect Stay solution is unlikely to be suitable. However other health workforce strengthening activities might be appropriate. Please make contact to discuss

## 2.3 Readiness Assessment

Assess your community's readiness for implementing the **Attract Connect Stay** solution by completing the attached survey

**The readiness criteria for community is:**

1. To what extent does the target community demonstrate strong social capital? [demonstrated by the number and activity of community groups, extent of community participation and degree of community cohesion]

**The readiness criteria for primary healthcare services are:**

1. To what extent are professional and/or service links operating between primary healthcare services operating in your community?

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2. To what extent have the primary healthcare services operating in your community worked collaboratively to address a local health care service need or shortage?
3. To what extent do primary healthcare service' owners and/or executive/senior healthcare staff demonstrate interest in taking an active role and working collaboratively with the local community in developing and implementing a community-engaged health workforce strengthening strategy?

**The readiness criteria for local government are:**

1. Has your local council identified strengthening the local health workforce as a key priority for economic development and community sustainability?
2. To what extent do local council's counsellors and senior management demonstrate interest in taking an active role and working collaboratively with the local community in implementing a community-engaged health workforce strengthening strategy?

**The readiness criteria for local businesses and employers are:**

1. Have local businesses and employers demonstrated commitment to strengthening the health and wellbeing of their workforce through investment in community health services and /or infrastructure?
2. To what extent have local businesses and employers demonstrated their interest in making a sustained investment (financial or in-kind) to support the implementation of a community-engaged health workforce strengthening strategy?

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Consider each criterion and apply this 4-point rating scale:

4. Very strongly meets
3. Strongly meets
2. Moderately meets
1. Doesn't meet
0. Not applicable

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1. Community
    - ☐ 4. Very strongly meets
    - ☐ 3. Strongly meets
    - ☐ 2. Moderately meets
    - ☐ 1. Doesn't meet
    - ☐ 0. Not applicable
2. Primary healthcare services
    - ☐ 4. Very strongly meets
    - ☐ 3. Strongly meets
    - ☐ 2. Moderately meets
    - ☐ 1. Doesn't meet
    - ☐ 0. Not applicable
3. Local government
    - ☐ 4. Very strongly meets
    - ☐ 3. Strongly meets

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- ☐ 2. Moderately meets
- ☐ 1. Doesn't meet
- ☐ 0. Not applicable

4. Local businesses and employers
   - ☐ 4. Very strongly meets
   - ☐ 3. Strongly meets
   - ☐ 2. Moderately meets
   - ☐ 1. Doesn't meet
   - ☐ 0. Not applicable

A notes section is provided to include evidence that you used to support your rating and results

### *Results*

If you scored either 4 or 3s against all of the eight readiness criteria – WELL DONE!!!! Your target community is READY to begin planning to implement the Attract Connect Stay solution — please begin the next **Attract Connect Stay** course: SET

If you scored 2s or 1s against any of the eight readiness criteria— Your target community is currently NOT yet ready to implement the **Attract Connect Stay** solution. While improving readiness can take time, we can provide suggestions to help you work with particular stakeholder groups to strengthen readiness. Please make contact to discuss.

Attract Connect Stay.

## Contact

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