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making it work

Evaluation Report

Summary

Interviews were conducted with the partners in Making It Work to ascertain their views on the evaluation. In retrospect, partners felt the original evaluation plan set out in the Making it Work application was too ambitious, and too prescriptive. It was reliant on the collection of accurate recruitment statistics, and these were not always available. In some case study sites, where partners had control over management processes, it was possible to collect useable data. Each partner country produced a detailed case study report which showed what had been achieved in their part of the study.

All partners had been concerned about the lack of direction about the evaluation as it progressed. The team learnt lessons from the process that are valuable to others, and, in the end, Making It Work project delivered a substantial product -the Framework for Remote Rural Workforce Stability, using evidence from existing research, and the data collected on the case studies undertaken within the project. The case studies are the core of what was produced in Making it Work and there is really useful information detailed within these, which, as they stand, will be useful to recruiters across the Northern Periphery and beyond. These, along with the Making it Work framework, will maximise the impact of Making It Work.

Methods

The activity in the evaluation work package did not match what was planned at the outset of the study. Therefore, interviews were conducted with the partners in each country to examine the pros and cons of the planned evaluation, and to demonstrate the value of what was actually undertaken. The five interviews with each partner country took place in February and March 2019.

Structured evaluation

At the outset of the project, a structured evaluation plan was constructed. The hope was to collect recruitment and retention statistics in each case study site, and to demonstrate the quantitative impact of each intervention. Each partner country developed a business case. what happened in practice was that local evaluations were conducted which suited the needs of the local business case, where appropriate, and where possible, using baseline data.

Internal Products and Services Evaluation

The Canadian partners conducted an Internal Products and Services Evaluation at four regular intervals throughout the project. Team members from each partnership were asked to complete an online survey, on their satisfaction with progress in each work package, and whether they were satisfied with overall leadership. The reports produced were useful for driving the project forward; they identified early issues which were rectified and they highlighted more persistent issues such as data collection.

Norway

The intervention was originally focussed on a small number of rural municipalities in the western and northern parts of Norway, and therefore it was possible to set up an analysis of the baseline, and the impact of the intervention. The Norwegian partners were satisfied with the quantitative element of the evaluation but felt that there was more analysis that could have happened with the interviews they conducted, although these were useful as a tool of engagement.

In all three case study municipalities the teams were able to demonstrate an impact, they succeeded in employing more GPs and lowering the rate of locums. This is detailed in the Norwegian case study report.

The Norwegian partners found the emerging Making it Work framework useful as a way of structuring their thinking. They had not found the previous seven-point business plan from Recruit and Retain useful, in fact it had been a barrier to progress.

Norway took an action research approach to the intervention, and would have been uncomfortable with any prescriptive evaluation. They held workshops, and adopted a participatory process, with monthly meetings, which in themselves generated data, and understanding of the context.

Their conclusions were there is no quick fix to improving recruitment and retention in rural areas.

> *"we didn't come with a recipe, we came with curiosity, and courage"*

They also came with a research background, knowledge about the topic, networks, and transnational support from the Making it Work team. It also took high level communication skills to get the project attention, to anchor it in the media. That said, the process belonged to the local municipalities, and therefore could not be prescribed in advance.

The Norwegian team insisted that top management had a high level of participation in the initiative in each of the case municipalities. This level of engagement had been uncommon in all the case municipalities.

There has been pressure on GPs and a crisis in service, in urban areas too, and now, as a result of Making it Work, rural municipalities are ahead as they have formed solutions. There has been community engagement, the processes are owned by the municipality, planning and assessing the service was incorporated in, and sustainability was considered. Municipalities had autonomy to reach a common agreement, with underpinning principles, that they met, communicated across the network.

During the project, significant additional funding was secured which complements and sustains the Making it Work case study in Norway. Two new projects (ALIS-Vest and ALIS-Nord) are

established to secure good opportunities for both rural and urban GPs to specialise in family medicine and for municipalities to arrange for this to happen.

Canada

The Canadian team felt that the structured evaluation looked good as an idea, but that often it is challenging to access such data, and this is often the downfall of such projects, so perhaps it was optimistic at best to take the structured approach. The approach of qualitative evaluation would have been grounded more in reality, and perhaps the MIW team should have done more early in the project to have fixed this issue. The process that was planned did not follow the interventions being put in place.

The Canadians feel the framework is now in a very good place, and if the recommender portrays the framework in the form of an app, this could be very useful as a mechanism to knowledge exchange, showing the way for others. Plugging in numbers won't provide answers, it's not enough, you need to listen to the local context, and build change from there. Lessons were learnt during Making it Work: and we achieved something that a structured evaluation alone would not have achieved. Differences were found, but not statistical differences.

Implementation times were too short, this was always going to be the case, particularly for any attempt to impact on retention. How do we measure short term things that might predict retention? At the local level, frontline services are running the treadmill and only thinking of recruitment.

The logic model was seen as an important step in thinking.

In Canada, there was a lack of systematic data between localities, there was disconnection between services. In the local municipality, where data is collected, it is collected for another purpose. It is often a difficulty in this kind of work, you depend on sufficient data, and then getting the numbers for statistical meaning, but neither are achievable. To examine process, make an impact, and measure outcome in three years is overambitious, but further down the track, perhaps this is possible.

The Canadians conducted a contract review in Nunavut as the baseline, and it is built into the sustainability plans so that this will be repeated in the near future. There are now new contracts in place, this is a major achievement, and a new local chief of staff who will hopefully be able to demonstrate a difference, using the baseline collected in MIW.

In retrospect, building Partnership and dialogue between the Government of Nunavut, and with Inuit organisations was key, it took a lot of time and effort. There was a new chief of staff and a new Director of Medical Affairs, and the value of linking these all up was immense. The very fact that Making it Work was there generated change *(this is very similar to what Norway said)*. Previously there had been distrust and hostility. There were, for example, complex issues over

land settlement. The MIW mechanism overcame a disconnect, even amongst the physicians themselves. MIW promoted collegiality – professional development sessions were attended by the Government, a new thing, and it was discovered that the Government people weren't so bad. It was the start of a collaborative relationship, and with a change of personnel, these things made it a better place. There have been other developments, and they are starting to spend resources to foster change.

Setting up health careers camps in Nunavut raised the possibility for other groups in health and education. There was a deepening relationship between lots of tangible things.

In Nunavut, it maybe was not the what, but the how, that NOSM brought. The engagement allowed relationships to develop in effective workshops, and as such was a step forward, and fits with the social responsibility mandate.

There has subsequently been much interest and support. The forum brought in a large audience in northern Canada, with interest in the European work. The level of engagement was high and the evaluation positive. The Forum summary is an excellent document, very clear, and a good way of "getting the message out there". The Canadians stressed the importance of this, that we capitalise on the work we have completed.

Iceland

The Icelandic team reported always feeling slightly outside the evaluation process; they had limited resources to participate in the project, their intervention was focussed on recruiting physicians to one hospital, and hence, their evaluation was limited. However, this worked well for them. They were able to collect workforce data, as they had jurisdiction over it. They also constructed a series of semi-structured interviews with new recruits so were able to deliver an evaluation appropriate to the intervention they undertook. They were concerned that the project team as a whole were "overthinking" the evaluation.

The Icelandic team used the basic questions raised in the first project "Recruit and Retain" to derive an intervention that aligned with the goals of their organisation. The aim was to increase the number of physicians in fixed positions, and to encourage regular locums instead of single visits. The intervention consisted of co-operation from the local municipality, who interacted with new recruits to the hospital, and helped them to find their feet and integrate into a new community. By and large, those targets were achieved, the number of permanent positions and the number of long-term contacts increased, as reported in their case study report. Data collection in Iceland was straightforward, the numbers were easy to get, a baseline and a final figure was achieved. This also meant there were relatively few staff to interview. The remit was deliberately narrow, and realistic, so that it could be achieved.

The interviews with new recruits widened the view of the project team. The interviews were mainly with people who had moved to Iceland, but it should be noted that while Icelanders may know where Akureyri is, some had never been there before. The interviews showed that financial decisions are only one small part of decision making about applying for posts. Family and personal factors are important too. The project team learnt not to take anything as given, and to consider more carefully how they sold their workplace. To retain staff, people need to be happy in their work, and professional isolation is important to consider. It is important to think about widening the scope of retraining. For example, young specialists were sent to Bergen for more training.

One of the strengths is size: small hospital means workforce is small, and it's easier to individualise processes to align with needs, and still keep an overview. Larger organisations need a stricter framework, whereas the team were able to be nimble.

The methods used in the Icelandic case study can now be used for other staff groups, nurses in the hospital, and GPs in the local district. The team were getting involved in the health care of general practitioners, always an issue in rural areas. Working together with the local municipality, who are state funded, and interaction between physicians and the local major has generated a lot of interest, and got the municipality thinking about recruitment and retention too – previously the municipality was concerned that the hospital was trying to get them to pay for services. The health minister and others have expressed interest. Working with Universities, there are new solutions for education being proposed.

Iceland feel it is important that Making it Work produce one document which can convince funders, and others in charge, that we maximise good outputs.

Sweden

In Sweden, there was a serious attempt to follow the evaluation plan.

However, there was not a good system behind data collection across the region, data collection was out of the partners control, and the data came from several sources.

Ideally, when changing processes, continuous, routine, reliable data would be available to allow an assessment of its impact. This never happened, that data being collected was not specifically for the project, and those collecting it were not part of the project and had their commitments elsewhere. They were informed about the project and knew it well, but data collection systems were not prioritised by externals. The team tried to work to collect data, and worked with managers, and found that working at a local level was much better. The learning from working between sectors has been essential.

The Swedish team also conducted interviews, including exit interviews of nurses who left the area, interviews with students, and interviews with new recruits.

Achievements in the project included a register of all people who have lived in the area and who have moved out, and the team have set up a system of keeping in touch with them, most specifically through postcards sent out to all “Storuman” people on the register, asking if they would consider returning. The community is much more engaged. A relocation officer is in place to help new recruits to the area. The relocation officer is responsible for coordinating actions among different companies, municipal operations as well as voluntary organisations including sports and outdoor organisations.

The web tool developed during Recruit and Retain, was maintained, consolidated and spread from two municipalities to ten. It takes a lot of work to maintain such information, to keep it relevant and up-to-date.

A recommender has been developed which will put the framework and examples of it working into a digital interactive interface.

Finally, the Swedish team identified the development of a rural stream for medical education as a major achievement – this was for medical students from Umea University. The team worked jointly with the university set up a new pathway for medical students, offering them more than 90 days at rural clinical practice (before it had been 12 days). When setting up this system, the project team had control over data and a well-structured evaluation system has been implemented. This is described in the case study report.

The top level of management has been engaged at local, regional and national level, and made more aware of recruitment.

In all, the Swedish team have worked with multiple dimensions of the framework which will impact on the future model for service provision. One participant at the Final Forum Workshop said “This framework makes it evident, for organisations and the entire community, that recruitment is much more than putting an add in the paper”.

The team themselves have learnt a lot, and used what they have learnt. They feel there are lessons for the Northern Periphery and Arctic in raising the capacity of attracting and keeping quality staff into rural areas, that international collaboration is essential. It is important to stress that evaluation is the key to support change management. And it works, even in rather rigid and complex systems, when the project is the holder of the data, and not relying on outside organisations to provide data.

Scotland

In Scotland, routine recruitment data is available, in theory. However, it is not collected for analysis, it is collected from a number of sources, and for different reasons, so there is not one person or organisation responsible, and it is not collected consistently or accurately. MIW, like other recent projects, found it almost impossible to collate data. Therefore, when the Scottish team went to collect baseline data they ran into difficulties, which meant they would be unable to look at the quantitative impact of any intervention, at scale. Therefore, the team designed a local plan for evaluation, which would fit the interventions, and be feasible. Like other countries, it was not known what the interventions would be until work was undertaken with organisations on the ground. Making It Work Team had a multi-agency approach, working with Remote and Rural Healthcare Alliance, Scottish Rural Medicine Collaborative, Scottish Rural Health Partnership, NHS Highland, Orkney, NHS Shetland and the Scottish Government. This made it difficult at the outset but this approach paid off over the course of the project. Personnel changes in NHS Highland hampered progress, as did ongoing crisis in recruitment, complicated by a recruitment freeze in NHS Highland due to austerity cuts, and debates over a new contract for GPs.

The Scottish team wanted to take an approach of monitoring change, by interviews with public, communities, staff and GPs, in total 41 people were interviewed, and this underpinned understanding of issues and the interventions selected.

In Scotland, interventions were guided by the fact that the Scottish Rural Medicine Collaborative were setting up in parallel to MIW. As they were focussed on the recruitment of GPs this allowed us to work on interventions which impacted on other staff groups.

A number of outputs were produced

1. Community designed brochures – interaction with the community was valuable and they have produced an output which has a legacy for the community itself, and the potential to be used elsewhere; the learning should be shared.

2. Staff designed brochures – the process of team designed brochures was a positive experience, that galvanised the team, and has led to an increase in the number of applications to posts. It has been used twice since design, whereas before they had one applicant, now they get 13.

3. E book was produced and tested for use in rural areas where wifi/internet/signal was not always available, for use by health professionals in this setting. It evaluated positively.

4. Staff buddying scheme – a framework has been designed in the Small Isles – again improving team cohesion in its production of information and a video, there have been lots on enquiries, and there are lessons to share internationally.

5. Educational initiatives were developed by the MIW team which allowed medics and non-medics to train together

The learning points were that ideally there should have had more time to develop initiatives, in part this was because the start was delayed for several issues. The Scottish team were delighted to achieve international sharing, and learnt a lot from this interaction. There are products that can be shared with communities, staff, other health boards and Scottish Government. Staff in NHS Highland can help and can have a role in the recruitment and retention process, previously they didn't have a place, as it was viewed to not be in their remit. There is a hierarchy in who should be on an interview panel. These changes, that are beginning to occur, have benefit to all sides.

There remains an inertia in HR systems within the NHS - they are not yet dynamic, flexible, or responsive. The Scottish team underestimated the hard work needed to make, and sustain even small changes. (They also, as an aside, identified the loneliness of some individual staff). Nonetheless, at the strategic level, a collaborative approach in Scotland has emerged. There has been a change in behaviour, and there is a confidence in exploring innovative solutions in a practical manner, and there is now better mechanisms and tools to take things forward. MIW took the opportunity to apply new methods, and to add to knowledge. The team felt this is a landmark piece of work, within the time and resource available and will stand the test of time. The MIW Framework can drive things forward.

It would be good to continue to exchange knowledge on the rural workforce on an ongoing basis at the international level. One idea the team put forward was developing a rural educational framework for multi-disciplinary learning. Another was to review progress after 2 years. It was very useful task producing the sustainability plan, it would be important to see that partners implement it.

Conclusions

In some case study sites, where partners had control over management processes, it was possible to collect useable data. This happened where the focus was on one hospital, or on a targeted number of sites. In cases where the focus was broader, and the partners did not have jurisdiction over data collection, the available information was not usually suitable for project purposes. It had been collected for other reasons, and was not fit for our purposes. Often, information was needed from more than one database, and there was little evidence of standardisation of data collection methods.

Local evaluations were conducted which suited the needs of the local business case. At the outset of the project, it was not clear what the interventions would be, so designing a standard evaluation would have acted as a straightjacket. In each site, the local service providers and local

communities were engaged, and interventions designed to fit local circumstances. At the outset, some of the teams were not clear on what the intervention would be, as they awaited input from local communities and service providers. In other cases, the interventions changed, or expanded, during the project period, again in response to local circumstances.

Evaluation was designed to fit local business cases.

> *"we didn't come with a recipe, we came with curiosity"*

Often, the best method of collecting data was through interviews, which gave rich information about local situations.

Community engagement was a theme that ran through all the case studies, perhaps this was not very visible, as each case study was different, but it did drive forward much of what was undertaken.

This flexible approach to intervention and evaluation meant that each case study had different characteristics, but this diversity meant that it allowed a stronger output to develop, the Making it Work Framework. The MIW team just need to ensure that they capitalise on what has been produced.

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