



Recruitment and Retention of the Health Workforce in Europe

8 case studies on selected topics addressing recruitment and retention of health professionals

Annex 5

EUROPEAN COMMISSION

Directorate-General for Health and Food Safety
Directorate D — Health Systems and Products Unit
Unit D.2. — Healthcare system

*European Commission
B-1049 Brussels*

Recruitment and Retention of the Health Workforce in Europe

***Europe Direct is a service to help you find answers
to your questions about the European Union.***

Freephone number (*):

00 800 6 7 8 9 10 11

(*) The information given is free, as are most calls (though some operators, phone boxes or hotels may charge you).

LEGAL NOTICE

This report was produced under the EU Consumer Programme (2014-2020) in the frame of a specific contract with the Consumers, Health, Agriculture and Food Executive Agency (Chafea) acting on behalf of the European Commission.

The content of this report represents the views of the authors and is their sole responsibility; it can in no way be taken to reflect the views of the European Commission and/or Chafea or any other body of the European Union.

The European Commission and/or Chafea do not guarantee the accuracy of the data included in this report, nor do they accept responsibility for any use made by third parties thereof.

More information on the European Union is available on the Internet (<http://europa.eu>).

Luxembourg: Publications Office of the European Union, 2014

© European Union, 2015

Reproduction is authorised provided the source is acknowledged.

Annex 5

8 case studies on selected topics addressing recruitment and retention of health professionals

**Written by the Consortium for the Study of Effective Health
Workforce Recruitment and Retention Strategies**

1	European Health Management Association (coordinator)	EHMA	Ireland
2	Catholic University Leuven	KUL	Belgium
3	Institute of Hygiene and Tropical Medicine	IHMT	Portugal
4	King's College London	KCL	United Kingdom
5	Royal Tropical Institute	KIT	the Netherlands

Table of Contents

Executive summary	11
Most interventions have multiple actors involved	11
Most interventions were not part of a coherent package	11
Legal barriers are not unmanageable	12
Coalition building and pilot testing are important steps	12
Not many interventions have explicit goals that can be evaluated	12
Top 8 facilitators.....	12
1. Introduction	14
1.1. Background	14
1.2. Objective	14
1.3. Research questions.....	14
2. Methodology	16
2.1. Case study approach	16
2.2. Data collection methods	16
2.2.1 Desk research	17
2.2.2 Telephone and/or email interviews	17
2.2.3 Case site visits	17
Box 1: Topic guide for in-depth interviews	17
2.3. Data analysis.....	19
3. Selection procedures for case topics and case sites	20
3.1. Selection procedure for the eight case topics	20
Table 1: Topics identified under the five main types of interventions	21
Figure 1: Horizontal theme and eight case study topics.....	22
3.2. Selection procedure for case sites	22
Table 3: Overview of all recruitment and retention interventions included in WP423	
Figure 2: European countries from which R&R interventions were included in the	
case studies	25
4. Findings.....	26
4.1. Attracting young people to healthcare.....	26
Table 4: interventions focused on attracting young people to healthcare.....	26
4.2. Attracting and retaining GPs to strengthen primary care in underserved areas	35
Table 5: interventions focused on Attracting and retaining GPs to strengthen	
primary care in underserved areas	35
4.3. Providing training, education and research opportunities for a life-long career	48
Table 6: interventions focused on providing training, education and research	
opportunities for a life-long career	48
4.4. Attracting nurses through the extension of practice and development of	
advanced roles	57
Table 7: interventions focused on attracting nurses through the extension of	
practice and development of advanced roles	57
4.5. Providing good working environments through professional autonomy and	
worker participation	64
Table 8: interventions focused on providing good working environments through	
professional autonomy and worker participation.....	64
4.6. Making the hospital workplace more attractive by improving family-friendly	
practices.....	71
Table 9: cases focused on making the hospital workplace more attractive by	
improving family-friendly practices.....	71
4.7. Return to practice for healthcare professionals.....	77

Table 10: Cases focused on return to practice measures for healthcare professionals	77
4.8. Providing supportive working environments for the ageing workforce.....	80
Table 11: Cases focused on measures to support the ageing workforce	80
5. Conclusions.....	85
5.1. Answers to the scientific questions	85
5.2 Possibilities for replicability	95
5.3. Strengths and weaknesses of the study	96
References.....	98
Appendix 1.1. Case report 1.1	99
1. Summary of the intervention – <i>Salzburger Pflegeoffensive</i> , Austria	100
2. Rich description of the intervention	102
3. Results of the intervention	110
References.....	111
Appendix 1.2. Case report 1.2.....	112
1. Summary of the intervention – ‘De Zorgambassadeur’ [The Care Ambassador], Belgium.....	113
2. Rich description of the intervention	115
3. Results of the intervention	124
References.....	128
Appendix 1.3. Case report 1.3.....	130
1. Summary of the intervention – ‘NHS Tayside Healthcare Academy’, Scotland ..	131
2. Rich description of the intervention	133
3. Results of the intervention	144
References.....	149
Appendix 1.4. Case report 1.4.....	150
1. Summary of the intervention – “Ich Pflege, weil...”campaign, Germany	151
2. Rich description of the intervention	152
3. Results of the intervention	154
References.....	154
Appendix 1.5. Case report 1.5.....	155
1. Summary of the intervention – Hvid Zone campaign, Denmark.....	156
2. Rich description of the intervention	158
3. Results of the intervention	161
References.....	162
Appendix 1.6. Case report 1.6.....	163
1. Summary of the intervention – Zorgtrailer, the Netherlands	164
2. Rich description of the intervention	166
3. Results of the intervention	168
References.....	169
Appendix 2.1. Case report 2.1.....	170
1. Summary of the intervention – Pacte Territoire Santé, France	171
2. Rich description of the intervention	173
3. Results of the intervention	185
References.....	188
Appendix 2.2. Case report 2.2.....	189
1. Summary of the intervention – The University of Queensland Rural Clinical School, Australia.....	190
2. Rich description of the intervention	191
3. Results of the intervention	196
References.....	197
Appendix 2.3. Case report 2.3.....	198
1. Summary of the intervention – Financial compensation for GPs to work in remote areas, Bulgaria	199
2. Rich description of the intervention	201

3. Results of the intervention	206
References.....	207
Appendix 2.4. Case report 2.4.....	208
1. Summary of the intervention – Financial support for young doctors, Estonia....	209
2. Rich description of the intervention	210
3. Results of the intervention	214
References.....	215
Appendix 2.5. Case report 2.5.....	216
1. Summary of the intervention – Resident scholarship programme, Hungary	217
2. Rich description of the intervention	219
3. Results of the intervention	223
References.....	224
Appendix 2.6. Case report 2.6.....	225
1. Summary of the intervention – Finnmark intern support project, Norway	226
2. Rich description of the intervention	228
3. Results of the intervention	231
References.....	232
Appendix 2.7. Case report 2.7.....	233
1. Summary of the intervention – Framework Contract, Romania.....	234
2. Rich description of the intervention	235
3. Results of the intervention	239
References.....	240
Appendix 3.1. Case report 3.1.....	241
1. Summary of the intervention – Professional training to Bachelor level for nurses and midwives via bridging courses, Poland.....	242
2. Rich description of the intervention	244
3. Results of the intervention	250
References.....	252
Appendix 3.2. Case report 3.2.....	253
1. Summary of the intervention – Graduate Nurse Programme, Calvary Health Care ACT, Australia	254
2. Rich description of the intervention	256
3. Results of the intervention	259
References.....	260
Appendix 3.3. Case report 3.3.....	261
1. Summary of the intervention – The opportunity to perform research as a form of Continuing Professional Development, Sweden	262
2. Rich description of the intervention	263
3. Results of the intervention	266
References.....	267
Appendix 3.4. Case report 3.4.....	268
1. Summary of the intervention – Flying Start NHS, Scotland, United Kingdom....	269
2. Rich description of the intervention	271
3. Results of the intervention	276
References.....	277
Appendix 3.5. Case report 3.5.....	278
1. Summary of the intervention – Flying Start Queensland Health, Australia	279
2. Rich description of the intervention	281
3. Results of the intervention	287
References.....	289
Appendix 4.1. Case report 4.1.....	290
1. Summary of the intervention – Huhtasuo Haltuun-project, Finland	291
2. Rich description of the intervention	293
3. Results of the intervention	300
References.....	308

Appendix 4.2. Case report 4.2.....	309
1. Summary of the intervention – Extension of nurses’ roles and functions, Australia	310
2. Rich description of the intervention	312
3. Results of the intervention	315
References.....	316
Appendix 4.3. Case report 4.3.....	317
1. Summary of the intervention – Subsidized education for nurse specialists, Czech Republic	318
2. Rich description of the intervention	320
3. Results of the intervention	323
References.....	326
Appendix 4.4. Case report 4.4.....	327
1. Summary of the intervention – Advanced Nursing Practice in relation to recruitment and retention, France	328
2. Rich description of the intervention	330
3. Results of the intervention	335
References.....	336
Appendix 4.5. Case report 4.5.....	337
1. Summary of the intervention – The function of ‘verpleegkundig specialist’ [nurse specialist], the Netherlands.....	338
2. Rich description of the intervention	340
3. Results of the intervention	346
References.....	347
Appendix 5.1. Case report 5.1.....	348
1. Summary of the intervention – Buurtzorg the Netherlands	349
2. Rich description of the intervention	351
3. Results of the intervention	361
References.....	363
Appendix 5.2. Case report 5.2.....	365
1. Summary of the intervention – Self-managing teams of the home care organisation WGK Oost-Vlaanderen.....	366
2. Rich description of the intervention	368
3. Results of the intervention	374
References.....	375
Appendix 5.3. Case report 5.3.....	376
1. Summary of the intervention – ‘We Care Teams’ Wit-Gele Kruis Vlaams-Brabant	377
2. Rich description of the intervention	379
3. Results of the intervention	386
References.....	389
Appendix 5.4. Case report 5.4.....	390
1. Summary of the intervention – Grannvård Sverige, Sweden	391
2. Rich description of the intervention	392
3. Results of the intervention	397
References.....	398
Appendix 6.1. Case report 6.1.....	399
1. Summary of the intervention – Kindergarten General University Hospital Prague, Czech Republic	400
2. Rich description of the intervention	402
3. Results of the intervention	409
References.....	410
Appendix 6.2. Case report 6.2.....	411
1. Summary of the intervention – Kindergarten Thomayer Hospital Prague, Czech Republic	412

2. Rich description of the intervention	414
3. Results of the intervention	417
References.....	418
Appendix 6.3. Case report 6.3.....	419
1. Summary of the intervention – <i>Dr DOC programme</i> , Rural Doctors Workforce Agency, South Australia.....	420
2. Rich description of the intervention	422
3. Results of the intervention	427
References.....	429
Appendix 6.4. Case report 6.4.....	430
1. Summary of the intervention – NUH Health and Wellbeing programme, Nottingham University Hospitals, United Kingdom.....	431
2. Rich description of the intervention	433
3. Results of the intervention	441
References.....	443
Appendix 7.1. Case report 7.1.....	444
1. Summary of the intervention – Return to Practice course Northumbria University, United Kingdom.....	445
2. Rich description of the intervention	447
3. Results of the intervention	453
References.....	455
Appendix 7.2. Case report 7.2.....	456
1. Summary of the intervention – Midwifery Refresher Programme, Mater Misericordiae Mothers’ Hospital, Australia	457
2. Rich description of the intervention	459
3. Results of the intervention	462
References.....	463
Appendix 7.3. Case report 7.3.....	464
1. Summary of the intervention – ‘Return to Nursing Practice’ course, Tallaght Hospital Dublin, Ireland	465
2. Rich description of the intervention	467
3. Results of the intervention	471
References.....	473
Appendix 7.4. Case report 7.4.....	474
1. Summary of the intervention – Return to nursing practice measures, Malta.....	475
2. Rich description of the intervention	477
3. Results of the intervention	479
References.....	480
Appendix 7.5. Case report 7.5.....	481
1. Summary of the intervention – Return to Practice course – Teesside University, United Kingdom.....	482
2. Rich description of the intervention	483
3. Results of the intervention	486
References.....	487
Appendix 8.1. Case report 8.1.....	488
1. Summary of the intervention – Programma de Atención Integral al Médico Enfermo (PAIME), Spain	489
2. Rich description of the intervention	491
3. Results of the intervention	496
References.....	498
Appendix 8.2. Case report 8.2.....	499
1. Summary of the intervention – ‘Wir sind älter als 50, na und?’ [‘We are older than 50, so what?’], Germany	500
2. Rich description of the intervention	502
3. Results of the intervention	509

References.....	510
Appendix 8.3. Case report 8.3.....	511
1. Measures taken in the Italian healthcare sector to improve the working conditions of the aging workforce, Italy	512
2. Rich description of the intervention	514
3. Results of the intervention	518
References.....	518
Appendix 8.4. Case report 8.4.....	519
1. Summary of the intervention –Life Stage Policy, Aalborg University Hospital, Denmark	520
2. Rich description of the intervention	522
3. Results of the intervention	527
References.....	528

Executive summary

Building on the work conducted in WP2 and 3, this case study research offers insight into a series of recruitment and retention (R&R) dimensions such as: how R&R interventions in Europe are developed and implemented, under which conditions, what the role of various actors is, and what the facilitators and barriers are throughout the process, at both policy and organisational levels. Based on the results of the mapping review, input from country respondents and experts on R&R, eight case study topics were selected. The eight selected topics follow approximately a professional life cycle and are:

- Attracting young people to healthcare
- Attracting and retaining GPs to strengthen primary care in underserved areas
- Providing training, education and research opportunities for a life-long career
- Attracting nurses through the extension of practice and development of advanced roles
- Providing good working environments through professional autonomy and worker participation
- Making the hospital workplace more attractive by improving family-friendly practices
- Return to practice for healthcare professionals
- Providing supportive working environments for the ageing workforce

The eight case studies are united in the overarching horizontal theme “Context specific R&R: matching professional needs and health system priorities”. This theme draws attention to the context-specificity of R&R interventions, relevant for both source and destination countries, and points out the significance of R&R interventions in contributing to the sustainability of healthcare systems. For each topic, multiple case sites from multiple countries were included, resulting in a total of 40 interventions from 21 countries. Data were collected via desk research, telephone and/or email interviews. Nine site visits were conducted to obtain more detailed and concrete information. We performed within-case analysis and cross-case analysis based on the recruitment and retention dimensions that are the focus of this study.

Most interventions have multiple actors involved

Almost all interventions that were included in the study involved multiple actors, sometimes in complex configurations. Most often cooperation, to a greater or lesser extent, took place between national and regional policy levels (including executive agencies), individual healthcare institutions, educational providers and/or local workforce agencies. An important facilitating factor in cooperation is coalition and partnership building, among others to obtain (financial) support, preferably from the start of an intervention. Whether formal cooperation agreements are needed depends on whether or not partners have a ‘history’ with each other, i.e. whether they already collaborate (d).

Most interventions were not part of a coherent package

Many of the recruitment and retention interventions that were included in our study were ‘isolated’ measures and were not explicitly part of a coherent package of measures. Only three of the included cases constitute an explicit coherent package of

measures, namely the Pflegeoffensive Salzburg (AT), the Care Ambassador Campaign (BE) and the Pacte Territoire-Santé (FR). However, almost all cases do in some way (un)consciously connect to or build on existing measures and initiatives.

Legal barriers are not unmanageable

While legal barriers have been found, such as in the expansion of nurses' scope of practice to make the profession more attractive and thereby improving R&R, these do not seem to prevent the introduction of R&R interventions. What appears to be more common is that the introduction of measures becomes delayed (where legislation changes are required) or that the measures themselves are adjusted to fit within the legal framework.

Coalition building and pilot testing are important steps

Within organisations R&R interventions are developed in various ways. For new R&R initiatives, ideas are often further developed via coalition building, partly focused on obtaining funding. For R&R interventions which already exist, either in the own organisation or elsewhere, the most important steps in the development phase appear to be a thorough orientation phase and 'pilot testing' of the intervention.

Organisational interventions often work within national frameworks and are sometimes developed because of national rulings or initiatives. The policy level also executes considerable influence on organisational R&R interventions in some countries via labour market conditions and financial arrangements.

Not many interventions have explicit goals that can be evaluated

The large majority of R&R interventions that were included in our study do not explicitly evaluate the intervention and describe their goals fairly vaguely, using terms as 'increasing' or 'improving' instead of setting explicit targets. Yet most are in some way trying to look at the effects that they have on recruitment and/or retention numbers of staff, but they do so in different ways. Some interventions are evaluated by taking national or regional data as 'effect measure' (e.g. student enrolment numbers) while other interventions take the results of their own participants in terms of recruitment and/or retention as 'effect measure' (e.g. the number of participants that has found employment). The last method may give more biased results.

Top 8 facilitators

To increase the potential successfulness of interventions, our case study research identified the following factors and characteristics as being of significant importance:

- Individual champions: Especially in the developmental phase of interventions, individual champions can be of crucial importance through their passion, credibility as (former) healthcare professionals and their ability to build coalitions.
- Create a support base for the intervention, from its inception onwards: To achieve this, communication towards, and consultation with, all relevant stakeholders is a crucial factor.
- Resource management: Time and financial resources need to be made available and thoroughly managed.
- Financial incentives: For most interventions, a certain degree of financial incentives is indispensable for start-up and sustainability.
- Incremental process: Although, in the cases studied, this does not appear to be a well-tried approach in recruitment and retention interventions, the execution of a pilot can be extremely helpful in preventing problems during later stages of an

intervention. What is more common, and just as important, is that an incremental step-by-step implementation process is used for interventions.

- Action plan: To have an action plan from the start of an intervention, including some well-defined targets, ensures a certain dynamic and advancement in the running of the intervention.
- Input from external professionals: Recruitment and retention interventions sometimes hinge heavily on qualities that are situated with different professionals; for example, the development of promotional campaigns.
- Right framework: Interventions developed at organisational or local level need to be aware of the obstacles which regional or national legal and financial frameworks can raise and where possible adjust the intervention accordingly.

1. Introduction

1.1. Background

The case study research in this report complements the findings of the review of the available evidence (WP2 and WP3) that was performed at an earlier stage of the Recruitment & Retention study. Based on the overview of R&R interventions as identified in WP2 and WP3, a detailed analysis of how R&R interventions were developed and (successfully) implemented at both organisational and policy level is presented.

Given the inherent complexity of such interventions, eight in-depth case studies of recruitment and retention interventions were conducted, which are described in this report. An overview of the facilitators and barriers to the implementation of recruitment and retention interventions within specific policy and organisational contexts is provided, including an overview of contextual factors that shape the outcomes of interventions in terms of implementation and results. Moreover, the interplay between policy and organisational interventions as well as the roles and responsibilities of the actors involved is discussed. Where available, the outcomes (or proxy indicators) of the interventions on recruitment and retention levels are reported.

1.2. Objective

The main aim of WP4 was to gain further insight into how recruitment and retention interventions are developed and implemented, under what conditions, what the role of various actors is and what the facilitators and barriers are throughout the process.

1.3. Research questions

The following research questions guide the Recruitment and Retention study and will be addressed in this report:

- What are the roles and responsibilities of the various policy actors and stakeholders in the design and development of interventions to recruit and retain health professionals? How do they cooperate to shape strategies? How is the role of recruitment agencies governed?
- What is the interaction and coherence of various policy measures in health, education, employment and labour market to recruit and retain health professionals? Are there legal barriers to certain types of policy measures to recruit and retain health workers?
- How are strategies developed within healthcare organisations and how do national and regional policies frame those strategies?
- Is the "effectiveness" of interventions to retain health professionals defined, monitored and measured? If yes, what methods and indicators are used, for example, to monitor staff turnover and to measure the benefits of staff retention in terms of reduced costs, improved organisational performance and quality of care?

- What are the principles and processes that characterise successful as well as not successful initiatives? What can policy-makers and health managers learn from what works, what does not work and why?

This report starts with a description of the methods that were used in conducting the case studies, including the selection procedures for the eight case topics and the interventions. Subsequently, the findings of the case studies are discussed by topic. The report ends with a conclusion section that answers the main research questions of the study and discusses the results of the case study research.

2. Methodology

2.1. Case study approach

To answer the research questions, eight case studies on health workforce recruitment and retention were conducted. Case study research is well suited for studying complex phenomena and for answering 'how', 'what' and 'why' questions. It can for example offer insights on how an intervention is being implemented, what potential gaps exist in its delivery and why one implementation strategy might be chosen over another (Crowe et al., 2011; Yin, 2009). Considering that recruitment and retention interventions are complex phenomena, which can only be understood by taking into account the legal, policy, organisational, national and/or regional (problem) context in which they are implemented, the case study approach is well suited to studying health workforce R&R interventions on an in-depth basis. Moreover, case studies have been successfully applied to recruitment and retention of healthcare professionals before (Jelfs et al., 2014).

Stake (1995) has characterised three main types of case studies. One of them, the multiple case study, was used in WP4. The multiple case study involves studying multiple cases simultaneously or sequentially in an attempt to generate a broader appreciation of particular issues, in this case R&R interventions for health workers. In WP4 a case is defined as "An intervention or strategy that has been or is being used to recruit and/or retain health workers in either a 'source' country or 'destination' country".

While there is no ideal number of cases to study, a number between four and ten cases is generally considered to work well (Eisenhardt, 1989). WP4 studied eight case topics, providing for a satisfactory balance between practical feasibility and sufficient information and data gathering. The selection procedures for the eight topics and case sites are explained in Chapter 3 of this report.

2.2. Data collection methods

Case study research allows the researcher to draw on multiple sources of information, leading to information-rich cases and a thorough understanding of the case (Yin, 2009; Foerstl et al., 2010; Crowe et al., 2011). The case study approach usually involves the collection of multiple sources of data, using both quantitative methods (such as the analysis of routinely collected secondary data) and qualitative methods (such as interviews).

In WP4, a variety of research methods were employed and we drew on multiple sources of information. Data collection for each case site started with extensive desk research. Subsequently and where necessary, additional data gathering in the form of a telephone or email interview was conducted. Moreover, a number of case site visits was conducted. The decision as to which case site was visited depended on the perceived added value of a site visit as well as practical feasibility.

2.2.1 Desk research

Desk research was performed for each included case site. Via desk research, all available information on the R&R intervention from secondary data sources was gathered. This included policy documents, research papers, evaluations, communication material, websites, participant material, etc.

2.2.2 Telephone and/or email interviews

In addition to desk research, a telephone and/or email interview with key informants was conducted for those interventions for which more information was required. Interviews were conducted by a member of the research team. A shortened and customised version of the topic list that was used during the case site visits (see Box 1 below) was used to guide the questions during these interviews. In total, 31 telephone or email interviews were conducted during the study. For email interviews, a list of questions was sent to informants by email and informants returned their answers to us by email as well. Sometimes this process went back and forth a couple of times). In table 3 an overview of all the methods that were used per case is provided.

2.2.3 Case site visits

A total of 9 case site visits were conducted. The majority of case site visits was performed in teams of two researchers and included in-depth interviews with multiple key informants and additional data gathering. Interviews were conducted by one or more members of the research team, sometimes with a local informant. Additional data gathered included brochures about an intervention, policy documents and, in some cases, some quantitative process data.

Box 1: Topic guide for in-depth interviews

Opening questions

1. Can you explain in a few sentences what the [*name specific intervention*] encompasses?
2. Can you tell us a bit more about your role in terms of the [*name specific intervention*]?

The intervention

For all interventions:

3. When was this intervention introduced? When was it discussed for the first time? Who initiated/suggested this intervention? Who were involved in the decision making process concerning the introduction of this intervention? In your opinion, where all key stakeholders represented in the decision making process?
4. Why was this intervention chosen (and not another intervention)? What were the overriding factors in the choice for this intervention (e.g. financial considerations)? Did other organisations/regions/countries serve as an example in the choice of the intervention? Were other R&R interventions considered?

For interventions at organisational level:

5. How did national and regional policies frame the choice for the intervention? Were there any legal or policy barriers that needed to be overcome or taken into account? Were there any policy initiatives that helped or maybe even inspired the introduction of this intervention (such as special funding programmes for certain initiatives)?

Introduction of the intervention

6. Who were the key champions, sponsors and supporters for the intervention? Were there people/interest groups/stakeholders/organisations who opposed the intervention? If so, for what reason? How has this affected the introduction of the intervention? How was dealt with this opposition at the time of the development or introduction of the intervention (i.e. where special information meetings/discussion opportunities etc. created to achieve consensus on the introduction of the R&R intervention)? Was consensus for the introduction of the intervention achieved (or are there still opponents or 'neutral non-participants')? What was expected of the intervention about the time of its introduction? With what goals in mind was it introduced?

Process of implementation of the intervention

7. How has the intervention been implemented (top down, bottom up)? Was there an implementation strategy? If so, how and by whom was it developed? What were the roles and responsibilities of the various actors and stakeholders involved in the intervention in its implementation? How long did the implementation process of the intervention take (approximately)? What were facilitators and barriers in this process, at organisational level and at policy level? Who was responsible for the implementation of the intervention? Has this process been monitored/evaluated and if so, how and what were the outcomes?

8. What capacity is required of all involved actors to make the implementation of this intervention a success? Was additional capacity training required or were all skills present to execute the implementation process in a successful way?

Running of the intervention

9. Were there any problems that might be referred to as 'start-up problems'? If so, what were they? Were they solved? If so, by whom and in what way? How long did this take?

10. What are the roles and responsibilities of the various actors and stakeholders involved in the intervention in the day-to-day operation of the intervention? Do actors and stakeholders cooperate to shape interventions and if so, in what way?

If the intervention is run at organisational level: is there cooperation or coordination with overarching regional or national policy levels? If so, for what issues? How does this cooperation or coordination take shape? Does cooperation take place on a formalised basis (e.g. cooperation agreements, covenants, etc.)? Can this cooperation/coordination be further optimised?

11. Do you consider the intervention to run smoothly at this moment?

12. Are the same patterns observable in how the intervention is being used and/or the effects of the intervention for the different target groups (e.g. doctors and nurses, age groups, minorities, and underserved areas) or do they differ?

13. What are the results/outcomes of the intervention? Are they being monitored? How are they being measured? Has or will the intervention be evaluated?

14. In your opinion, what efforts need to be made to make sure that the intervention continues to run? What measures are in place to keep the intervention running and make it sustainable? Is there support among all relevant stakeholders to keep the intervention running? Are there enough financial, personnel and other resources?

Closing question

15. Are there any data available on either staff turnover rates, staff stability, vacancy rates and/or time taken to replace staff, enrolment numbers and/or total number of graduates in medical and nursing schools, job satisfaction levels and/or any other outcome measures related to staff recruitment and retention interventions that you can refer us to?

16. Is there anything that we did not ask that you feel is important for us to know and that you would like to add?

2.3. Data analysis

Data analysis began at an early stage for all included interventions, in order to tailor any additional information requests and interview questions as optimally as possible. We derived a number of core dimensions and variables from the main research questions of the study and analysed the included interventions among these dimensions. The dimensions of interest were: the main characteristics of interventions, actors involved (roles, responsibilities and cooperation), finances, facilitators and barriers and the effects of interventions. Additionally, we actively searched the data for other themes related to R&R that were not covered by the research questions but recurrently came up, such as the important role of 'individual champions' in the realisation and successful running of interventions.

We started our data analysis process for each case with within-case analysis. This involved detailed case study write-ups and careful description of the data for each intervention. The resulting individual case reports of all interventions can be found in the Appendices of this report (see Appendices 1.1 – 8.4).

The second step in the data analysis process involved cross-case analysis. For each topic, multiple case sites from multiple countries were included. Cross-case analysis was performed by identifying similarities and differences between the cases within the relevant recruitment and retention dimensions that are the focus of this study (i.e. actors, facilitators and barriers, etc.).

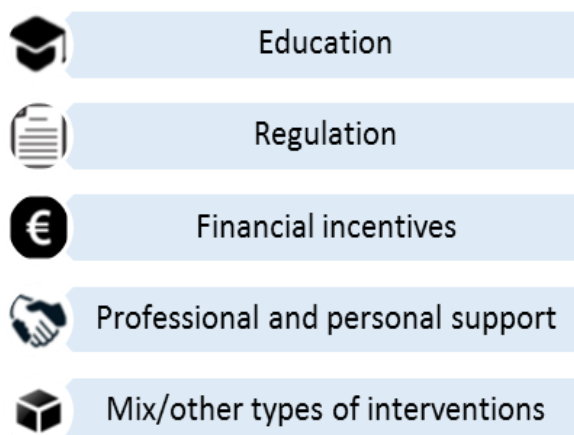
3. Selection procedures for case topics and case sites

3.1. Selection procedure for the eight case topics

In selecting the eight cases, a stepwise selection procedure was performed which is discussed below.

Step 1 – Listing of all identified interventions according to type of intervention

First, all recruitment and/or retention topics identified in the peer-reviewed and grey literature, in the country reports (WP2/3) and brought forward by experts on R&R were categorised according to type of intervention. In accordance with WP2/3, the typing of interventions took place based on the framework used in the 'Global policy recommendations on increasing access to health workers in remote and rural areas through improved retention' (WHO, 2010; Huicho et al., 2010). All identified recruitment and retention interventions were classified into the following types of interventions:



Step 2 – Further subgrouping of all identified interventions according to topic

After all identified interventions were listed per type of intervention, subgroups or topics of interventions were distinguished. So, for example, under the intervention type 'Education', interventions were further grouped under the topic headings: attracting young people; CP; reduce barriers to education; increase training capacity; change in education length/entry requirements; enhancing employability; and underserved areas. This allowed us to decide which topics provided sufficient interventions to explore further in the case studies (see table 1 for an overview of identified topics per type of intervention).

Eight selected case study topics

The eight selected topics take the order of a professional life cycle and are:

- Attracting young people to healthcare
- Attracting and retaining GPs to strengthen primary care in underserved areas
- Providing training, education and research opportunities for a life-long career
- Attracting nurses through the extension of practice and development of advanced roles

- Providing good working environments through professional autonomy and worker participation
- Making the hospital workplace more attractive by improving family-friendly practices
- Return to practice for healthcare professionals
- Providing supportive working environments for the ageing workforce

Table 1: Topics identified under the five main types of interventions

Topics of potential case studies →																			
Type of intervention		CPD	Attracting Young People	Reduce barriers to education	Increase Training capacity	Change in education length / entry requirements	Enhancing Employability	Underserved Areas	Attractive working environment	Changes in employment contracts	Intervention related to supply-demand	Career development	Extension of the use of / advanced roles for nurses	Family-friendly measures	Grouping difficult	Professional autonomy / status	Telemedicine / E-learning	Introduction of a new profession	Recruit or make entry health workforce easier
Education	Education Total	15	11	5	19	8	8	11			2	1			3			1	
	Education Possible Interventions	8	8	3	9	2	2	6			1	1			0			0	
Regulatory	Regulatory Total						1	1		7	8		15					6	2
	Regulatory Possible Interventions						1	0		0	4		9					2	0
Financial incentives	Financial incentives Total	2		2			1	18	1	15	8				1				
	Financial incentives Possible Interventions	2		1			0	13	0	2	1				0				
Professional & personal support	Professional & personal support Total	7					7	1	6	3		8	3	12	1	11	5		
	Professional & personal support Possible Interventions	3					6	1	3	2		3	3	8	1	7	3		
Mix/other	Mix/other Total		2				4	4	1	1	6	1			4				3
	Mix/other Possible Interventions		1				3	3	0	1	1	1			0				0
Total	Total	24	13	7	19	8	21	35	8	26	24	10	18	12	9	11	5	7	5
	Possible Interventions	13	9	4	9	2	12	24	3	5	7	5	13	9	1	7	3	2	0
Included as case study topics		Y	Y				Y	Y					Y	Y		Y			

Overarching theme for the eight case study topics

During the Expert Workshop that was conducted in May 2014, experts suggested choosing one overarching theme for all eight case topics. Based on the review of the findings from the literature, country correspondents and experts on recruitment and retention, as described above, a clear horizontal theme for the case studies emerged: “Context specific R&R: matching professional needs and health system priorities”. This theme draws attention to the context-specificity of R&R interventions, relevant for both source and destination countries, and points out the significance of R&R interventions in contributing to the sustainability of healthcare systems.

Figure 1: Horizontal theme and eight case study topics



3.2. Selection procedure for case sites

For each of the eight selected topics, case sites in multiple countries were included. On the basis of the Expert Workshop that was held in May 2014, the selection criteria for case sites to be included were adjusted and finalised. The following selection criteria were applied:

- The intervention must have been substantially evaluated
- The intervention must have run for a 'substantial' period of time, i.e. > 6 months
- The intervention must have high transferability potential
- Key actors who are or have been involved in developing and/or implementing the recruitment and/or retention intervention must be available
- The intervention must be practically feasible (e.g. ease of access through gatekeepers, language issues, et cetera)

As a first step, the effectiveness and running time of each of the interventions was assessed (selection criteria 1 and 2). This provided a first round in the selection process for the sites to involve, based on criteria that were included during the literature review analysis as well. The other three criteria for the selection of case sites were subsequently applied. Table 3 shows an overview of all included interventions, the 'source' of the intervention (literature review, country respondents or R&R experts), level of the intervention (policy and/or organisational) and the data collection methods that were applied.

Table 3: Overview of all recruitment and retention interventions included in WP4

Intervention	Country	Source	Level	Methods		
				Desk research (n= 40)	Email/tel. Interview (n=31)	Site visit (n=9)
Topic 1. Attracting young people to healthcare						
1.1. <i>Pflegeoffensiv Salzburg</i> – recruitment campaign	AT	CR	Pol.	X	X	X
1.2. <i>Zorgambassadeur</i> – recruitment campaign	BE	CR	Pol.	X		X
1.3. <i>Healthcare Academy</i> – education as road to work	UK	EXP	Org.	X	X	X
1.4. <i>Ich Pflege, weil..</i> – recruitment campaign	DE	EXP	Pol.	X		
1.5. <i>Hvid Zone</i> – recruitment campaign	DK	CR	Pol.	X	X	
1.6. <i>Zorgtrailer</i> – recruitment campaign	NL	EXP	Pol.	X		
Topic 2. Attracting and retaining GPs to strengthen primary care in underserved areas						
2.1. <i>Pacte Territoire-Santé</i> – package of measures R&R underserved areas	FR	LIT	Pol.	X	X	X
2.2. <i>Rural Clinical School</i> , Queensland	AU	LIT	Both	X	X	
2.3. Financial compensation for GPs to work in remote areas	BG	LIT	Pol.	X	X	
2.4. Beginner’s allowance for young doctors	EE	CR	Pol.	X	X	
2.5. <i>Resident scholarship programme</i>	HU	CR	Pol.	X	X	
2.6. <i>Finnmark</i> , rural intern support project	NO	LIT	Org.	X	X	
2.7. <i>Framework contract</i> – financial incentives	RO	LIT	Pol.	X	X	
Topic 3. Providing training, education and research opportunities for a life-long career						
3.1. Bridging courses; training to Bachelor level	PL	EXP	Both	X		
3.2. <i>Graduate Nurse Programme</i> , Calvary Health ACT	AU	LIT	Org.	X		
3.3. Research as CPD to recruit and retain	SE	LIT	Both	X	X	
3.4. <i>Flying Start NHS</i> , development programme for newly qualified staff	UK	CR	Org.	X	X	
3.5. <i>Flying Start Queensland Health</i> , development programme newly qualified staff	AU	CR	Org.	X	X	
Topic 4. Attracting and retaining nurses through the extension of practice and development of advanced roles						
4.1. <i>Huhtasuo Haltuun</i> -project, nurse-oriented care model in health centre	FI	LIT	Org.	X	X	X
4.2. Extension of nurses’ roles and functions	AU	LIT	Both	X	X	
4.3. Subsidized education for nurse specialists	CZ	LIT	Pol.	X	X	
4.4. ANP in relation to recruitment and retention	FR	LIT	Pol.	X	X	
4.5. Nurse specialist function	NL	CR	Pol.	X	X	
Topic 5. Providing good working environments through professional autonomy and worker participation						
5.1. <i>Buurtzorg</i> – autonomous working home care	NL	CR	Org.	X	X	
5.2. <i>Self-managing teams</i> – autonomous working home care	BE	CR	Org.	X		X
5.3. <i>We Care Teams</i> – autonomous working home care	BE	CR	Org.	X	X	
5.4. <i>Grannvard Sverige</i> – autonomous working home care	SE	CR	Org.	X	X	

Intervention	Country	Source	Level	Methods		
				Desk research (n= 40)	Email/tel. Interview (n=31)	Site visit (n=9)
Topic 6. Making the hospital workplace more attractive by improving family-friendly practices						
6.1. Kindergarten General University Hospital Prague	CZ	LIT	Org.	X	X	X
6.2 Kindergarten Thomayer Hospital Prague	CZ	LIT	Org.	X	X	X
6.3. <i>Dr Doc programme</i> – support rural doctors	AU	LIT	Org.	X	X	
6.4. <i>Health and wellbeing programme</i> – Nottingham University Hospitals	UK	EXP	Org.	X	X	
Topic 7. Return to practice for healthcare professionals						
7.1. <i>Return to Practice course</i> – Northumbria University	UK	EXP	Org.	X	X	X
7.2. <i>Midwifery Refresher Programme</i> – Mater Misericordiae Mothers' Hospital	AU	LIT	Org.	X		
7.3. <i>Return to Nursing Practice programme</i>	IE	LIT	Both	X	X	
7.4. Return to nursing practice measures	MT	LIT	Pol.	X	X	
7.5. <i>Return to Practice course</i> – Teesside University	UK	EXP	Org.	X	X	
Topic 8. Providing supportive working environments for the ageing workforce						
8.1. <i>Programmea de Atención Integral al Médico Enfermo (PAIME)</i>	ES	EXP	Org.	X		
8.2. <i>Sozial-Holding der Stadt Mönchengladbach GmbH</i> –health- and age management policy	DE	EXP	Org.	X	X	
8.3. Measures to improve the working conditions of the aging workforce	IT	EXP	Both	X	X	
8.4. <i>Life Stage and Senior Policy</i> , Aalborg Hospital	DK	EXP	Both	X		

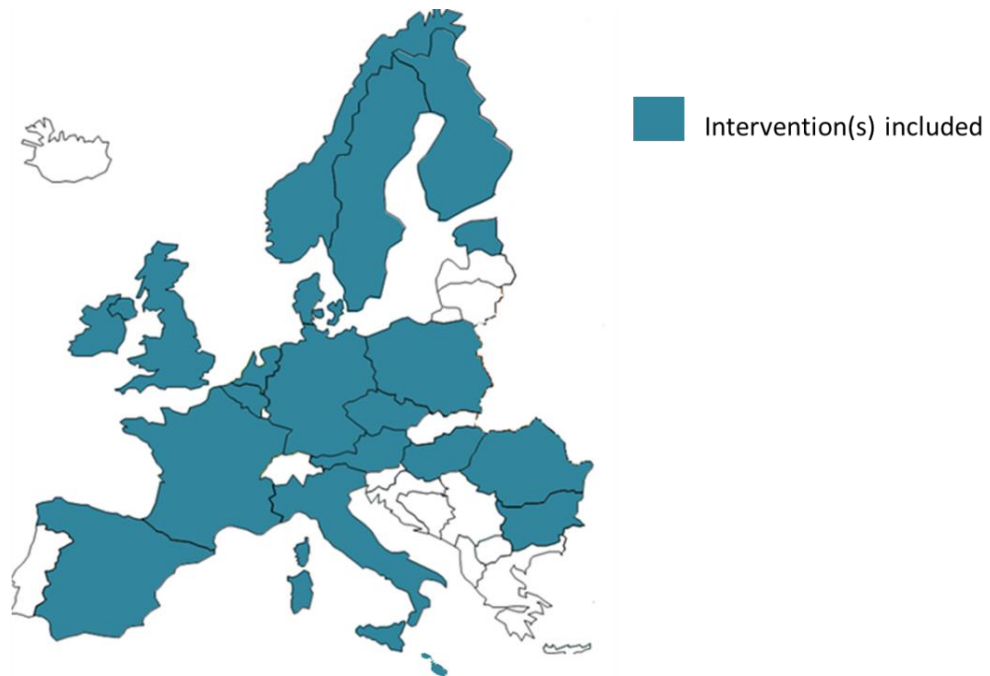
Legend: LIT = literature review (WP2); CR = Country respondent (WP3); EXP = expert on recruitment and retention

Level: Pol. = policy level; Org. = organisational level, both = both policy and organisational level.

A total of 40 recruitment and retention interventions across 21 countries were included in WP4. Figure 2 provides an overview of the European countries from which R&R interventions were included in the case studies. Most interventions were situated at organisational level (n=19), somewhat fewer at policy level (n=14) and 7 interventions were conducted at both levels.

For all 40 interventions, desk research was performed. In addition, 31 telephone or email interviews were conducted and a total of 9 case site visits was made.

Figure 2: European countries from which R&R interventions were included in the case studies













4. Findings

In this chapter, the findings of our study are presented by topic. The findings of the interventions that were studied are jointly discussed under each topic. Findings are organised around the main themes that were found through our data analysis and that relate directly to the main research questions of the study, i.e.: main characteristics of interventions, actors involved (roles, responsibilities and cooperation), finances, facilitators and barriers and the effects of interventions. Individual case study reports can be found in the Appendices of the report and references to these are provided at the start of each paragraph.

4.1. Attracting young people to healthcare

Table 4: interventions focused on attracting young people to healthcare

Case	Country	Intervention type	Running time	Case report
1.1. Pflegeoffensiv Salzburg	AT	  	2010 – no end	Appendix 1.1
1.2. Zorgambassadeur	BE	 	2010 – ?	Appendix 1.2
1.3. Healthcare Academy	UK	 	2006 – no end	Appendix 1.3
1.4. Ich Pflege, weil..	DE		2009 – ?	Appendix 1.4
1.5. Hvid Zone campaign	DK		2009 – 2011	Appendix 1.5
1.6. Zorgtrailer	NL		2010 – 2012	Appendix 1.6

Short description of interventions under this topic

Most of the included cases that try to attract young people, often high school students, to jobs in healthcare, take the shape of information and/or promotional campaigns. Other interventions are hybrids, combining such activities with broader interventions aimed at a wider constituency and age groups. Noteworthy in this regard are the *NHS Tayside Healthcare Academy* in Scotland and the *Pflegeoffensive* in Salzburg. The *NHS Tayside Healthcare Academy* reaches out to the unemployed and those with difficulty finding employment, having experienced some form of social exclusion and living in socially disadvantaged areas. The *Healthcare Academy* has a special focus on youth. Its target is not necessarily nursing but healthcare employment more generally. The *Salzburger Pflegeoffensive* is also geared towards recruiting new students and the unemployed and uses nursing and related care jobs as a vehicle to facilitate re-entry for candidates into the labour market. Finally, the *Care Ambassador campaign in Belgium* also paid attention to this by introducing 'Service Points Care', where everyone can get information about labour market conditions and labour regimes within the health care sector, his or her career opportunities in the sector, educational requirements to work in the sector, vacancies and, if they wish, support and guidance. However, the majority of included cases under this topic are campaigns focused on attracting youngsters to nursing, a profession which not only suffers from (expected) shortages in many countries, but also struggles with a negative image. Hence, the campaigns often have multiple aims; to increase the number of nursing students and to improve the picture of nursing, both in potential students but also in the wider society. Some campaigns, in addition to nurses, also focused on recruiting carers, nurse auxiliaries, radiographers, laboratory technicians and social workers.

In terms of chronology, most campaigns lasted three to four years and some were complex interventions combining several elements, such as promotional elements (e.g. TV advertisements) and educational elements (e.g. visits to healthcare institutions). The *Salzburger Pflegeoffensive (AT)* contained the most comprehensive package of measures across the span of recruitment and retention.

The campaigns encompass a variety of activities and try to combine the 'fun' elements with more 'informative' components. Most campaigns have multimedia strategies and actively use social media to get their message across. There were differences as well, for instance in the methods of engagement used in different campaigns. For example the *Healthcare Academy (Scotland)* and *Pflegeoffensive (AT)* used more experiential learning in which students were able to access placements and more extended competence based training than the *Dutch Zorgtrailer* and *German "Ich plege, weil..." campaign*, which were more of a light touch and with low intensity marketing. The *Belgian Care Ambassador* steered the middle course and worked with so-called 'inleefmomenten' [imagine-moments], which give people the chance to get a taste of the healthcare sector. During an imagine-moment, people get the chance to walk with a healthcare professional for one day in the institution of their choice to get a feeling for the ins and outs of the job.

The *Salzburger Pflegeoffensive* [in English: Salzburg Nursing Offensive] included a package of measures to recruit and retain nurses which has been extended in the years thereafter. The *Pflegeoffensive* is targeted at recruiting and retaining nurses and social professionals (i.e. carers) and recruiting people into appropriate educational pathways. Via the *Pflegestiftung*, part of the *Pflegeoffensive*, special attention is being devoted to people who are currently unemployed and women who are returning to work. The *Pflegeoffensive* has introduced measures in the area of recruitment (e.g. initiatives that make nursing more visible and popular), education (e.g. training of additional health and nursing school teachers) and retention (support facilities with the modification of the skill and grade mix).

The goal of the *Care Ambassador (BE)* is to support the (future) inflow of people in the healthcare sector, both quantitatively and qualitatively, by developing and running a coordinated campaign for the promotion of healthcare jobs in Flanders. The focus of the assignment is on the recruitment of nurses, carers and nurse auxiliaries. It is a promotional campaign consisting of lectures, consultations with the field and a campaign worked up with a marketing company, among others.

The *NHS Tayside Healthcare Academy (UK)* targets the long term unemployed, those on incapacity benefits and those from socially deprived backgrounds and aims to implement the philosophy of creating employment to sustain health by offering opportunities and preparing people for real jobs in NHS Tayside. Engagement with young people is regarded as a core element of the Academy. It opened with a 6 week Pre-Employment Programme which gave people all the essential training to come and work in the health sector in entry level jobs. Subsequently, based on the success of this programme, more and longer educational programmes were introduced.

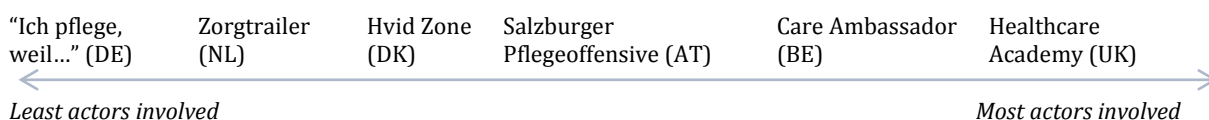
The German *"Ich plege, weil..." campaign* [in English: I work in nursing, because...] aims to increase the recognition within society for the nursing profession and to promote nursing education as a vocational choice for young people.

In Denmark a three-year recruitment campaign, called the '*Hvid Zone*' campaign [in English: White Zone Campaign], was designed to increase the number of people entering training in the fields of nursing, radiography and medical laboratory technology and to raise awareness of the career opportunities within each of these

fields. The campaign emphasised digital media, including social media like Facebook and TV. White Zone was also included in the existing websites for programmes and activities of professional schools.

Project Zorgtrailer from the Netherlands is an educational programme specifically aimed at young people. An important part of the programme is the purpose-built truck that visits schools.

Actors - roles, responsibilities and cooperation



Most initiatives involved multiple agencies, either as funders or sponsors, and cross-departmental working, sometimes in complex configurations. The exceptions are the *Zorgtrailer (NL)* and “*Ich pflege, weil...*” campaign (DE), in which relatively few actors were involved. The *Zorgtrailer* was sponsored by the Ministry of Health, Welfare and Sport but executed by the Dutch Florence Nightingale Institute. A youth marketing company YoungWorks was engaged to design materials, including a 3-D film, featuring actors from a popular soap series.

The other cases included under this topic involved considerable partnership working, sometimes on a formalised basis (*Care Ambassador (BE)*, *Healthcare Academy (UK)*) and sometimes informally (*Pflegeoffensive Salzburg (AT)*, *Hvid Zone (DK)*).

The *Hvid Zone campaign (DK)* was run by a consortium. This included the Ministry of Education [Undervisningsministeriet], the Ministry of Health [Ministeriet for Sundhed og Forebyggelse], Danish Regions [Danske Regioner], Danish municipalities, professional organisations [Dansk Sygeplejeråd, Danske Bioanalytikere, Foreningen af Radiografer i Danmark] and University Colleges [Professionshøjskolernes Rektorkollegium]. The parties met on an ad hoc basis. In the beginning there were quite a few organising meetings but, as time went by, meetings became less frequent and much was dealt with via email.

The *Salzburger Pflegeoffensiv (AT)* was an initiative from the Landesregierung, based on the predicted shortages in nursing. Once the Landesregierung had decided that something needed to be done about this, it started approaching other relevant actors in the field. Many parties were involved in the *Salzburger Pflegeoffensive*, including; Land Salzburg, city of Salzburg, Diakoniewerk Salzburg, the Salzburger Landeskliniken, several other healthcare institutions in the region and the Arbeitsmarktservice Salzburg. At the start of the discussion about the *Pflegeoffensive*, all parties were involved. Next to quasi-bilateral discussions, it was important that during crucial meetings all partners were literally sitting at one table. The fact that all partners were involved has been important for the development of the *Pflegeoffensive*. It eased the political decision process.

Although a complex set of arrangements prevailed with respect to the *Pflegeoffensive*, there was no Memorandum of Understanding signed between partners since most partners already had exchange and cooperation agreements in place with Land Salzburg in other areas. The view of the Arbeitsmarktservice Salzburg is that there should be lots of cooperation, but with as little overhead as possible and that money should be spent at the operational level.

The *NHS Tayside Healthcare Academy (Scotland)* originated from an idea of Ms Debbie Donald. When she first went in and did the profiling of the NHS workforce, she came

to the conclusion that it was quite 'elitist' and that it had a professional focus. At the same time, she found herself working in an environment where, across Tayside, there were real areas of urban deprivation. She then thought: the NHS is the greatest employer in the region and poverty is the greatest deterrent of ill health. The NHS could provide the kind of jobs that would allow people to move themselves out of poverty. To get this idea off the ground, Mr Alan Boyter, who was the HR Director at the time, and Ms Donald worked as a team. At Board level, Mr Boyter acted as the person who allowed Ms Donald access to the right people. When the Board was convinced, the struggle began to get the Healthcare Academy started and to get financing. Ms Donald and Mr Boyter went to the Government and pitched their idea. They persuaded the Government and received start-up pilot money for the programme.

The NHS Tayside Healthcare Academy currently works in close partnership with Jobcentre Plus (and their identified contractors Triage and Claverhouse Group), Skills Development Scotland, Dundee & Angus & Perth College; Angus Social Work and Health, Dundee City Council Social Work Department, Perth and Kinross Housing and Community Care, Barnardo's Scotland, representatives of the independent and voluntary sectors and NHS Tayside.

All the core partners get together on a two-monthly basis. They then do programme planning, review the past two months, look at new developments and share challenges. It is quite an informal group and more of a learning and development forum.

The roles that partners have within the Healthcare Academy is scoped out by their own organisations. So the colleges are the education providers, Jobcentre Plus' role is through their core function, which is getting people into employment and off benefits. Then NHS Tayside provides the placement and the learning and the Healthcare Academy team. So all partners are working in their own organisational commitments, but come together in the partnership.

NHS Tayside has a service-level agreement with all partners.

The function of *Care Ambassador (BE)*, as it currently exists in Flanders, originated because of two joint developments. When Lon Holtzer, the current Care Ambassador, was Nursing Director at the University Hospital Leuven (2006-2010), she came to the conclusion that the inflow of nurses needed to be increased. Therefore, she and Xavier Lemaitre brought together a group of people coming from the healthcare and educational sectors to see how the various initiatives that were already underway in different Flemish provinces could join forces. The group came to the conclusion that there needed to be somebody who would collect and coordinate all information concerning nursing. The group created a job profile and sent this to the Flemish Minister of Health.

The Flemish Minister of Health, Welfare and Family, Jo Vandeurzen, stated immediately at the beginning of his appointment in 2009 that work needed to be done in the health sector in view of the expected shortages. Hence, he was sympathetic to the proposal of Ms. Holtzer's discussion group to set up a coordinating role for nursing. In May 2010, the action report of the Minister 'To make work of work in the healthcare sector' [in Dutch: 'Werk maken van werk in de zorgsector'] was published and the need for a coordinating role in nursing was included. In November 2010, Lon Holtzer was appointed as Care Ambassador. She is supported in her role by various partners:

- At regional policy level, the Care Ambassador is supported in her work by the Flemish Minister of Health and his staff.
- Support also comes from the Flemish Consultation Platform Healthcare Professions (VOPZ). Together with the Care Ambassador and a professional communication

company, the VOPZ develops the Campaign and determines what the important messages should be.

- A level below the Flemish Consultation Platform Healthcare Professions is the Provincial Consultation Platform Healthcare Professions. It uses the campaign and the material and initiatives that are taken at central level, and apply and adjust them to their own local level, according to need.
- Additionally, the promotion campaign is supported by a commercial communication agency.

Hence, some organisations seem to have operated on a more ad hoc basis, testing the waters and building momentum as influence and interest began to increase, as in the case of the *Care Ambassador (BE)*. This is run with minimum bureaucracy. The *Hvid Zone campaign (DK)* seems to have started off as quite structured and then, as momentum built, began operating in a looser manner. *The Healthcare Academy (UK)* seems to have grown in staff and numbers across different organisations as demand for resources expanded, with more complex forms of governance emerging as funding was allocated and the project became embedded in everyday practice.

Finances

Different financial models operate in different organisations. For example, the *Healthcare Academy (UK)* evolved organically, from a pilot with funding from the Scottish Executive to being supported in more extensive ways. Additional financing was provided by the NHS Tayside Board, education funding and Jobcentre Plus funding, among others to sustain the initiative.

A lot of the money for the Healthcare Academy comes from education funding, which is drawn down centrally, and from the Jobcentre Plus funding.

Funding for the Pre-Employment training courses is supplied through the Training for Work Programme, supplied through Skills Development Scotland, and delivered by all partners, with particular reference to Angus, Dundee and Perth Colleges to reflect area profiles and identities.

The funding body requires that students funded through this initiative should achieve employment within 26 weeks of course completion in order to register as an employment outcome. The outcome must also involve the successful student working for 16 or more hours per week or 60 hours per month. Failure to achieve these targets for at least 50% of completing students may affect future levels of funding. The *36-Week SVQ2 Health and Social Care* course is funded through the Skills Development Scotland Employability Fund. The *36-Week SVQ2 Business and Administration* course is funded by Dundee College.

NHS Tayside funds the salaries of a dedicated team. A non-recurring payment was allocated in the first instance to provide uniform and marketing stock. Since its inception, the Academy has maintained its annual budget of £5,000 to address marketing, and purchasing and replacement of uniforms.

Specific funding comes from Job Centre Plus and Barnardos. This is mostly associated with particular clients.

The financing of the *Salzburger Pflegeoffensive (AT)*, more specifically the *Pflegestiftung*, is more complex. This is partly due to the number of contributing agencies involved and distribution of responsibilities in terms of which agency at which level (national or regional level) is responsible for which expense.

The *Pflegestiftung* is funded in part through the framework of unemployment insurance. The state of Salzburg assists the *Pflegestiftung* via its labour market policy funds. In this way, the state ties the *Pflegestiftung* to the already existing *Implacementstiftung*, through which 350 unemployed Salzburgers can find new career prospects annually. For 2013, the total budget that the state of Salzburg is investing

is €763.000, a budget for 350 people. The Land Salzburg pays the *Pflegestiftung* management, which lies with the regional *Arbeitsstiftung*. The Land also pays the *Arbeitsmarktservice* for what it needs to do in terms of the *Pflegestiftung*. In addition, training fees are paid for nursing places. The total costs for one nurse training place, i.e. for one participant via the *Pflegestiftung* are:

- €16.668: Training costs (costs paid by institutions)
- €7.200: Scholarship (costs paid by institutions)
- €2.180: Staff selection and supervision (costs paid by state of Salzburg)
- €19.980: Costs of living (costs paid by *Arbeitsmarktservice*)
- €6.364: Sozialversicherung [Social security insurance] (costs paid by *Arbeitsmarktservice*)
- €200: Stipendium [Subsidy amount] (costs paid by institutions)

The requirement for the participating institutions to pay participants a subsidy of €200 per month can be a financial burden for institutions, especially for longer education courses.

In addition to maintaining the *Pflegestiftung*, labour market resources were used to finance the training of nursing assistants to become qualified nurses. The state of Salzburg assumed the cost of the theoretical training of nursing assistants to become qualified nurses. This was established in July 2011. The costs are approximately € 7300 per person and 27 people have begun such training so far.

The financing arrangements of the other cases included under this topic are much less complex.

The function of *Care Ambassador (BE)* has two main costs: the salary of the Care Ambassador, which is a part-time function (0,5 FTE), and the costs of the promotion campaign (including costs for the commercial communication company, television ads and so on). The total budget for the campaign is approximately €250.000 annually. All costs are covered by the Agency Care and Health, a supportive service of the Flemish government. According to the Care Ambassador, the limited financial resources are not a disadvantage, quite the opposite: "It gives a different way of working. Actually the campaign floats on intrinsic motivation. Actually, that is a very powerful weapon."

In the case of the *Hvid Zone campaign (DK)* all partners made a pro rata contribution based on their membership number and a sliding scale. For example, the Danish Regions contributed 3 million Danish Kroner (€402.411) in total to the campaign, while the Radiography Council paid 67.500 Danish Kroner (€9.079) to this campaign.

The *Zorgtrailer campaign (NL)* from the Florence Nightingale Institute was financed by the Dutch Ministry of Health, Welfare and Sport. In 2010, the Institute received a 'project subsidy' of the Dutch MoH of €215.360. The *Zorgtrailer* was probably paid from this budget. The "*Ich pflege, weil...*" campaign in Germany was financed by the German Ministry of Health.

Facilitators and barriers

Facilitators

For most of the cases included under this topic, strong, transparent and committed partnership working seems to be of crucial importance in the smooth running of the interventions. For the *Salzburger Pflegeoffensive (AT)*, it was important that all

partners were involved from the beginning of the initiative. This eased the political decision process and considering the high number of different actors that are involved in this area, this is significant.

For the *NHS Tayside Healthcare Academy (UK)*, the fact that all partners are working in a role related to their own core function, within their own organisational commitments, makes the partnership successful and sustainable.

For the *Care Ambassador (BE)*, one of the main successes of the campaign has been the fact that the Provincial Consultation Platforms Healthcare Professions with which the Care Ambassador cooperates, can take the initiatives developed at central level and apply and adjust them to their own local level, according to need. Moreover, the campaign was spearheaded by a healthcare leader, who already had credibility in the field and was able to build from platform to reach out to the provinces.

A facilitating factor for the *Hvid Zone campaign (DK)* was that it brought together a 'coalition of the willing' together with a co-funding model, which eased the path to cooperation.

The Zоргtrailer was a highly focussed initiative with little overhead and targeting discrete activities and audiences.

Barriers

Few barriers have been reported in the running of the programmes. However, for the *Pflegeoffensive (AT)* it was mentioned that the training (levels) of the unemployed do not 'fit' the shortages that exist within nursing. This applies to education into nursing as well as nursing jobs. This makes it difficult to lead unemployed people into nursing. Also, even though the number of people that find a job through the Pflege Stiftung is high, it is not always easy for the institutions involved that are providing funding for the training. This is because they operate in a free market and once graduates have finished their education, they are free to choose their place of employment. This may cause a financial burden, especially on smaller institutions, if interns leave.

Replicability

Most cases included under this topic are fairly easily transferable to other countries/contexts in terms of methods used. While the content may need to be adjusted, based on specific contextual needs, the 'form' that the campaigns especially took is highly transferable. Moreover, these sorts of campaigns can be introduced by organisations of any size, although the scope of the campaigns may need to be adjusted to the financial resources available. For countries/organisations that are thinking about introducing a promotional campaign, it is important to make use of a commercial marketing or communication agency. The *Care Ambassador (BE)*, *Hvid Zone campaign (DK)* and *Care Trailer project (NL)* all made use of professional communication agencies to get their message across.

The *NHS Tayside Healthcare Academy (UK)* and *Salzburger Pflegeoffensive (AT)* were shaped by their context, but could be scaled up elsewhere. The success of the Healthcare Academy, for instance, could help combat prejudice elsewhere and indeed, as we have seen from Salzburger Pflegeoffensive, more particularly through the Pflege Stiftung, the widening access route to employability for underrepresented minorities was also part of a social justice initiative.

However, the *NHS Tayside Healthcare Academy (UK)* and *Salzburger Pflegeoffensive (AT)* are much more complex to replicate than the promotional campaigns. This is due to the high number of actors involved and the extensive package of measures that are being taken within the framework of these interventions. In replication, several factors appear to be of core importance and should be taken into consideration:

- Establishing a sufficient level of support for the initiative within the organisation.

- Strong partnership working, both inside and outside the organisation
- Keeping the initiatives at a manageable scale; when working with vulnerable groups, it is important that a sufficient level of support can be provided to these groups.

Effects of the interventions

Effects on recruitment and retention

The effects that the cases included under this topic may have a medium to long impact lag. For example, the *Hvid Zone campaign (DK)* must first reach youngsters. Then the youngsters, who want to follow education in one of the targeted areas, must wait till the beginning of the school year to start. Subsequently, it will take at least three years before they are able to enter the labour market and the effects on workforce numbers become visible.

Most of the included cases are looking at the effects that they have on recruitment and/or retention numbers of staff, but do so in fairly different ways. The *Care Ambassador (BE)* and the *Hvid Zone campaign (DK)* are looking at respectively provincial and national data on student enrolment numbers and vacancy rates. Both show successful results in this regard. While these are relatively 'easy' data to measure and/or gather, it is difficult to establish a direct link between on the one hand, these results on provincial and national level, and on the other hand the measures taken. Other variables, for example the economic crisis that has hit Belgium over the last few years, can also have had a significant impact on national recruitment and retention data.

The *Pflegestiftung* in Salzburg is looking at the recruitment rate of the graduates of its programme after three months and is able to report positive results. The *NHS Tayside Healthcare Academy* can only provide anecdotal evidence about the effects of the programme on vacancy rates in NHS Tayside, which are positive. Hence, for these cases it is easier to establish a direct link between reported effects and the measures taken.

For the *Zorgtrailer campaign (NL)*, no effects on recruitment and retention have been monitored.

No evaluation has taken place of the *Salzburger Pflegeoffensive (AT)* as a whole, but results are available for the *Pflegestiftung*, which offers education to unemployed people who are interested in working in nursing. Since the *Pflegestiftung* was established in 2011, 274 persons have started training or already completed their training. The AMS monitors graduates after three months to see whether they have found a job. The AMS doesn't do this any longer because a) the connection between education and employment is already questionable after one year, because of the number of other confounding factors, and b) the AMS is an operating institution and not a research institution.

The most important parameters by which the success of the campaign and the function of *Care Ambassador (BE)* are measured are the number of newly enrolled students in care and welfare education and the vacancy rates in the care and welfare sector. Since the start of the *Care Ambassador* campaign the increase in the inflow of 'generation students' – i.e. students who enrol for the first time in higher education immediately after finishing high school, mainly 18-19 year olds, in the Nursing Bachelor is spectacular. Between 2004 (n=1108) and 2013 (n=2234), their number more than doubled. The total number of nursing students also shows an upward trajectory for the same period as does the number of students studying Person Care in vocational secondary education (BSO) and technical secondary education (TSO). At the same time, the number of nurse/carer vacancies in Flanders decreased. The

number of nursing vacancies, for example, dropped from 1310 in March 2010 to 1069 in March 2014.

The contract introduced by the VDAB to help unemployed people who want to retrain has grown; for nursing education this number increased with 25% from 2010 till 2012 (from 2.585 to 3.219).

Since the *NHS Tayside Healthcare Academy (UK)* opened, almost 1000 people have accessed the range of programmes delivered by the Academy partnership; gaining skills, training and essential work experience (Donald, 2014). The growth of the Healthcare Academy over the years has been in the programmes it offers and not so much in the number of participants. This is because the Academy needs to be able to support the people on the programme and, if the numbers are too big, it can't do this. Even though the numbers of the Healthcare Academy are relatively small compared to the size of NHS Tayside, it does give the organisation a pool of people to fill up posts. This has had an impact on employment and vacancies as well, because NHS Tayside has got this cohort or pool of people, who are work-ready for entry-level jobs.

The goal of the *Hvid Zone campaign (DK)* was to increase the number of persons entering training in the fields of nursing, radiography and medical laboratory technology by 44%. An evaluation shows that in all three programmes, recruitment has increased by more than this. The results for the increased uptake of the three programmes are:

Bio-analyst training: 220 more applicants in 2011 than in 2008 (81% increase)

Radiography: 130 more applicants in 2011 than in 2008 (84% increase)

Nursing: 1.236 more applicants in 2011 than in 2008 (53% increase)

The evaluation also shows that the campaign has helped to increase the general knowledge of the three courses.

No evaluation has taken place of the extent to which the *Zorgtrailer project (NL)* increased the number of nursing students. At the beginning of Project Zorgtrailer it was expected that 180 schools in the Netherlands would participate and 30.000 students would attend the Zorgtrailer, but it is not known how many students actually visited the Zorgtrailer.

The impact of the visit that students made to the Florence Nightingale Institute was evaluated though and it showed that students were generally positive about the information they received during the visit. Yet on the basis of the research, no differences were found in terms of intention to opt for a career in the care sector.

Proxy measures/other effects

Process data for the *Care Ambassador (BE)* show that many efforts have been made in terms of communication. For example the Facebook page of the campaign was visited by 65.252 unique visitors between December 2001 and June 2012, who on average stayed on the page for 2 minutes. The impact of specific media action is clearly visible in these process data. For example, on the 6th of March 2013, the famous Belgian field rider Bart Wellens participated in an 'imagine moment' on a Flemish television show and the Care Ambassador explained the 'imagine-moments'. Subsequently, there was a peak in requested 'imagine-moments'.

The advantage of the process data as presented above is that they are easily measurable. For example in the case of the television programme with the famous Belgian field rider, it is immediately visible in the website visits and requests for 'imagine moments' that this is an effective way to reach many people and make them interested in the campaign. By looking at these process data, the effectiveness / success rate of certain sub-interventions or actions can be established. However, it should be noted that these data do not necessarily help predict the outcome data.

While many people may visit the website, for example, this doesn't tell you anything about whether they will start with a job or education in healthcare.

It has been stated by our informant that the 'success of the *Healthcare Academy* is not about the big things or the big numbers, it's about small things'. Managers report that Healthcare Academy graduates clearly understand the responsibilities of working in healthcare. Yet perhaps the greatest improvement for the candidate themselves is in greater confidence levels and the fact that they have achieved something.

Over the years, the NHS Tayside Healthcare Academy and its partners received various awards for their achievements. In 2007, the NHS Tayside Healthcare Academy picked up the 'Recruitment and Retention' award at the Health Service Journal Awards. In 2010, NHS Tayside and Dundee College were commended for the work on the Healthcare Academy at Scotland's Colleges Business to College Awards. In 2013, the Perth and Kinross Health and Social care Academy received the 'Supported Employment Provider of the Year' award at the Tayside Business Diversity Awards 2013.








The *Hvid Zone campaign (DK)* was also awarded. In 2009, it received an honorary award by the International Advertising Association. One of the main reasons that the campaign was awarded was because the campaign had showed positive results already shortly after its establishment.

Concluding remarks

Compared to the other seven case study topics, the cases focusing on attracting young people to healthcare are characterised by their homogeneity: all are promotional student recruitment campaigns focussed on education, some including some other aspects as well. They face few barriers and are easier to replicate than most other R&R interventions, partly because they can operate fairly independent from policy levels. Distinctive for the cases on attracting young people to healthcare is also their reliance on external expertise in designing/marketing the recruitment campaigns. For the other seven topics in the study, internal expertise is more often sufficient.

4.2. Attracting and retaining GPs to strengthen primary care in underserved areas

Table 5: interventions focused on Attracting and retaining GPs to strengthen primary care in underserved areas

Case	Country	Intervention type	Running time	Case report
2.1. Pacte Territoire Santé	FR		2012 – no end	Appendix 2.1
2.2. Rural Clinical School	AU		2000 – no end	Appendix 2.2
2.3. Financial compensation programme	BG		2008 – no end	Appendix 2.3
2.4. Medical doctors start-up grant	EE		2012 – no end	Appendix 2.4
2.5 Resident scholarship programme	HU		2011 – no end	Appendix 2.5
2.6. Finnmark intern support project	NO		1998 – no end	Appendix 2.6
2.7 Framework Contract	RO		1999 – no end	Appendix 2.7

Short description of interventions under this topic

We included seven interventions that focus on attracting and retaining GPs (and other medical professionals) to strengthen primary care in underserved areas. Three of the seven cases (BG, EE, RO) are purely financial interventions providing (young) doctors with financial benefits if they start working in an underserved area. The other cases are predominantly focused on providing (favourable) educational opportunities in rural areas and support. In contradistinction to the other six 'isolated' measures included under this topic, only France has introduced a comprehensive package of measures to increase the number of healthcare professionals, mainly doctors, in underserved areas. The majority of these seven measures are situated at policy level, with the exception of the *Finnmark intern support project* in Norway and (partly) the *Rural Medical School at the University of Queensland* in Australia. All of them focus on attracting and retaining either medical students or (young) doctors. Only in the extensive *Pacte Territoire Santé (FR)* are other healthcare professionals (indirectly) addressed as well.

The *Pacte Territoire Santé* is a formal agreement between the French Ministry of Health and various stakeholders to attract medical doctors (mainly GPs) to rural and underserved areas in France.

The problem lies not in the number of medical doctors in France, but in their distribution over the country. Because of freedom of settlement, there is a concentration of medical doctors in the coastal and town centres (e.g. Paris, Nice, etc.) and a lack of medical doctors especially in the suburbs and rural areas. To address this problem, the *Pacte Territoire Santé* was launched in 2012. This is a coherent package of incentives, rather than mandatory policies. The Pacte includes 12 significant reforms, divided among 3 main packages, to attract and retain human resources for health (HRH) in underserved areas across France. Box 1 summarizes the Pacte.

Box 1. Pacte Territoire Santé**Package 1. Changing the training and facilitate the establishment of young doctors**

- **Commitment 1: an internship in general medicine for all students**
This measure requires all medical students to do a mandatory internship in general practice. In addition, students will be financially encouraged to do their internship in remote areas.
- **Commitment 2: 1500 employment contracts for public service by 2017**
Encouraging medical students to serve in underserved areas after finishing their education by offering employment contracts in the public service. By signing the contract, students receive a fellowship while in medical school with the commitment to serve in an underserved area after they finish their education.
- **Commitment 3: 200 territorial general practitioner (PTMG) contracts**
Promote the activity of young graduated medical doctors in underserved areas by securing their first two years of installation by providing a minimum salary and guaranteeing social protection, such as sickness leave and maternity leave
- **Commitment 4: a reference system in each region**
To ease the installation of physicians, each region in France now has a person in charge to support students, interns and young professionals in installing themselves in the region.

Package 2. Transform the conditions of practice of health professionals

- **Commitment 5: develop teamwork**

Box 1. Pacte Territoire Santé

The aim of this measure is to support the organisation of health professionals, facilitate the comprehensive care of patients and create installation conditions that are especially attractive in underserved areas.

- **Commitment 6: bring primary health centers and universities closer to each other**

Improve the links between universities, health centres and health workers through the development of internships and research projects about primary health care.

- **Commitment 7: develop telemedicine**

Further development of telemedicine, so as to reduce the geographic and demographic constraints for young doctors, especially in underserved areas.

- **Commitment 8: accelerate task shifting**

It is hoped that time will be saved for medical practitioners to return to their core business while nurses and other health workers take on tasks that were previously performed only by medical professionals.

Package 3. Investing in isolated areas

- **Commitment 9: ensuring access to emergency care in less than 30 minutes by 2015**

The aim is to improve the situation of the 2 million people who live more than 30 minutes of access to urgent care, and train, equip and pay the corresponding physicians.

- **Commitment 10: allow hospital doctors and staff to support outpatient facilities**

This is aimed to meet the needs of the local population and create attractive installation conditions for doctors.

- **Commitment 11: adapt the local hospitals and empower Centre Hospitalier Régional (Regional Hospital Center)**

This measure aims to meet the needs of the population in restructuring the organisation and partnership between health facilities, at the regional and local level.

- **Commitment 12: strengthen health centers**

The advantage for medical doctors is that they get their salary from the health centre while patients benefit from team work and a coordinated care approach

The *nationwide Rural Clinical School Programme (AU)* was established as a workforce strategy to address the chronic shortage of rural doctors and to improve rural medical workforce recruitment and retention through a rurally based undergraduate clinical training experience. In 2000-2001, the Australian Commonwealth Department of Health and Ageing provided funding to Australian medical schools to develop a national network of 10 Rural Clinical Schools. The Rural Clinical Schools provide an opportunity for medical students to undertake their clinical training across a network of hospitals, general practice surgeries and community medical centres in rural/regional locations throughout Australia. The Rural Clinical School at the University of Queensland was established in 2002. The MB BS (Bachelor of Medicine, Bachelor of Surgery) at the School of Medicine provides a four-year programme in which students undertake clinical training in years three and four. Students may elect to train in one of three clinical divisions, one of them being the Rural Clinical Division. The Rural Clinical Division consists of four main teaching sites within South-west and Central Queensland.

Since 2008, Bulgaria is offering GPs a *financial compensation programme* through the National Health Insurance Fund (NHIF) to work in remote areas. This financial compensation was introduced because the health workforce is severely disproportionally divided over the 28 Bulgarian regions. GPs who want to receive the funding from the NHIF need to fulfil a number of criteria as set up by the NHIF. They need to work in small settlements outside the major cities, which until now have not been served or are characterised by long distances from the practice to other hospitals, access difficulties (alpine conditions, rough terrain, poor roads), dispersion of practice or clinic serving two or more cities, adverse conditions related to population served or adverse living conditions, or other specific terms that were established by the NHIF and Bulgarian Medical Association.

The *start-up grant for young doctors in Estonia (EE)* is aimed at motivating and supporting the start-up of young doctors, including family physicians and medical specialists, in specialities in which recruiting has proven difficult. The number of doctors is decreasing in Estonia. Moreover, Estonia is facing an uneven distribution of specialist services around the country. The start-up grants can be applied for within three months of taking up professional work. Requirements for the start-up grant are that physicians:

- Have graduated and completed a residency in anaesthesiology, emergency medicine, laboratory medicine, family medicine, radiology, internal medicine, or general surgery specialist (see Table 1);
- Have to consent to work five years in the chosen area of work after receiving the grant;
- Work at least 40 hours a week (note: there is no evidence of whether this has been effective).

The *resident scholarship programme (HU)* has been established since 2011. The aim is to retain medical doctors in Hungary. The international mobility of doctors has increased significantly since Hungary joined the European Union. One of the main triggers for moving is that the wages in the Hungarian healthcare sector cannot compete with the wages in the western part of the European Union. One of the challenges is therefore to motivate graduates to enter into Hungarian residency training programmes.

The resident scholarship programme offers tax-free scholarships for resident doctors. To receive the scholarship they have to agree that they will work for the Hungarian public healthcare system after specialisation training for the number of years that their scholarship lasts (5 years in most cases).

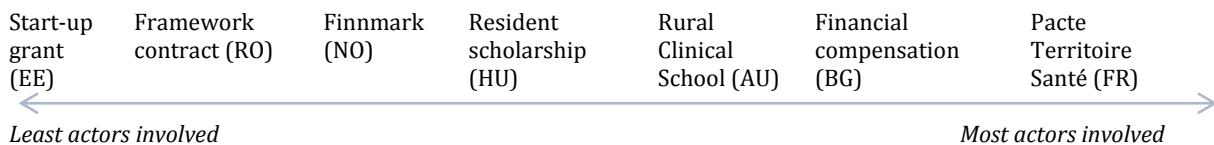
The scholarship also provides necessary financial security for establishing a family and beginning a career (EEKH, 2014). There are four different types of scholarships included under the Resident Scholarship programme targeting young medical doctors; a Scholarship regardless of the type of speciality they are training in (*Markusovszky Ösztöndíj scholarship*), resident hospital pharmacologists (*Than Károly Ösztöndíj scholarship*), paediatrician residents who are willing to work in underserved areas in primary care in long-term “unfilled” practices (*Méhes Károly Ösztöndíj scholarship*), and emergency medicine residents (*Gábor Aurél Ösztöndíj scholarship*).

The *primary care internship support project in Finnmark (NO)* was launched in 1998 with the explicit aim of recruiting medical interns for further work in Finnmark. Finnmark is a county in the extreme North-Eastern part of Norway. The recruitment of sufficient health workers in rural and remote areas has been a constant challenge in Finnmark. In the autumn of 1997, 19 (23%) primary care physician posts were vacant

and 12 (15%) others were occupied by physicians on long-term leave. Finnmark was granted funds by the Ministry of Health to address this crisis and as a result the intern support project was introduced. The programme consists of group tutorials for medical interns, in addition to the day-to-day clinical supervision by their local GPs, and encourages them to discuss the challenges of their roles and potential solutions. The aim is to provide adequate professional and social support for interns during their service in Finnmark and help them overcome their worries and concerns. This is regarded as a prerequisite for retaining them for further service after finishing their internship. The meetings also provided opportunities to overcome professional and social isolation by networking with peers from neighbouring municipalities.

In Romania, *financial incentives* were introduced for the first time in 1999 in the *Framework Contract*. The Framework Contract provides financial incentives to attract GPs to work in deprived areas. The Framework Contract regulates the delivery of all types of healthcare services in Romania that are funded (totally or partially) by the National Health Insurance Fund (NHIF). Romania faces difficulties in attracting GPs to rural areas and establishing (timely) access to primary care services for inhabitants of rural settings. In 2008, it was found that 16.1% of population in rural areas had no regular family doctor. The number of uncovered inhabitants varied heavily by regions, being worst in the South-East, South and West regions of the country. Depending on the conditions in which a primary care office is performing its activity, the funding can vary from 10% to up to 100%, depending on a point system. Points are determined based on criteria such as distance to the closest urban setting, living conditions in the doctors' office (heating, drinkable water), population density, populations' socio-economic level, patients' insurance levels, distance to emergency care, easiness to go to patients, distances in target area.

Actors - roles, responsibilities and cooperation



As stated before, the majority of the seven included cases are situated at policy level. This is reflected in the division of responsibilities between the actors involved. For the three cases in Bulgaria, Estonia and Romania that offer purely financial rewards for (young) doctors to settle in underserved areas, responsibility for executing the measures lies with national policy bodies. The *resident scholarship programme* in Hungary is executed at national policy level but was developed jointly by the Hungarian Government and the Hungarian Association of Resident Doctors. The two cases situated at organisational level cooperate closely with local actors, for example the *University of Queensland Rural Clinical School* works closely with Queensland Health, local GPs and specialists. Finally, the extensive French *Pacte territoire santé* was developed at national policy level, but is executed at regional level. However, it should be noted that a constant reciprocal exchange process is taking place between these two levels. Both during the development phase and the running of the measures, close cooperation takes place between institutions at both levels and medical associations, local associations and other stakeholders were, and are, constantly involved in these processes.

The *Pacte territoire santé (FR)* was developed by the Ministry of Health, but in close consultation with medical associations, local associations, local and regional territories representatives, etc. Although the *Pacte territoire santé* was launched in December

2012, the implementation is being done gradually and is still on-going. Some of the measures, such as the new financing schemes for the *Maisons de Santé Pluridisciplinaires*, need a lot of consultation before taking effect legally. The Pacte is initiated top-down from central Department of Health level and the implementation is conducted by the regional entities of the Ministry of Health (*Agences régionales de santé* - ARS). The ARS experience some difficulties in this, as financial and/or legal efforts are required from the central Department of Health level to implement certain measures, but these have not been provided up to now. This means that the introduction of some of the measures from the Pacte has been delayed. In the implementation of the measures, there is a lot of cooperation with the people who the measures concern, i.e. medical doctors, professional medical associations, local GPs, educational institutions and so on. Alongside the implementation, a package of communication has been used to make people aware of the programme. Brochures and a communication kit were developed, there is a specific page on the website of the Ministry of Health (http://www.sante.gouv.fr/le-pacte-territoire-sante-pour-lutter-contre-les-deserts-medicaux_12793.html), there were presentations about the measures at different professional exhibitions and there were press releases and statements by the Ministry of Health. Because of all this communication, the Pacte is now fairly well-known.

The *University of Queensland Rural Clinical School (AU)* works closely with Queensland Health, local GPs and specialists to offer unique, patient-centred learning experiences to students who undertake their clinical training in this area. It has purpose-designed Clinical Skills and Simulation Facilities at all its sites which are readily available to training partners, i.e. local doctors and health professionals, to undertake skill maintenance and professional development activities.

The *GPs financial compensation programme (BG)* is executed at national level but focuses on remote areas in Bulgaria as defined in accordance with the so-called 'Map of Health Care Needs', which was prepared several years ago. The map defines how many specialists are needed in particular settlements in each of the 28 Bulgarian regions. The map was prepared by the Bulgarian Ministry of Health, with input from their decentralised structures and probably with some input from municipalities. In 2011, it was approved by the Bulgarian Cabinet that Bulgaria should have at least 5.374 GPs to provide adequate primary health care to the population.

Start-up grants in Estonia are regulated in the Health Services Organization Act. The Ministry of Social Affairs is responsible for the execution of the programme, i.e. in allocating the grants and in checking whether they are being used lawfully. A physician who has received the beginners' allowance is required to inform the Ministry of Social Affairs if stopping employment or practice before five years have passed from the receipt of the allowance. Furthermore, the employer has the obligation to inform the Ministry of Social Affairs if the physician who has received the beginners' allowance terminated employment.

The *resident scholarship programme (HU)* was developed jointly by the Hungarian Government and the Hungarian Association of Resident Doctors. The programme is run and financed independently by the Hungarian Government. The procedures surrounding the programme (including application, contracting, payment, monitoring) are coordinated by the Office of Health Authorisation and Administrative Procedures (Egészségügyi Engedélyezési és Közigazgatási Hivatal, EEKH).

The *primary care internship support project in Finnmark (NO)* is organised at the municipal level, where primary care in Norway has been organised since 1984. Helse Finnmark [in English: Health Finnmark] has experienced recruitment and retention

problems over the years, and is one of the partners in Finnmark striving to solve these challenges. The body that has taken a lot of responsibility for the recruitment and stabilisation of GPs in Finnmark is the State Fylkeslege [in English: "County Medical Officer"]. In 1997, when the intern support project in Finnmark started, the then Chief County Medical Officer was able to obtain funding and the internship support project was launched. Currently, there are three intern groups in Finnmark, one in each part of the county. Each group is led by a different experienced GP who acts as a tutor for the group.

The *Framework Contract (RO)* regulates the delivery of all types of healthcare services in Romania that are funded (totally or partially) by the National Health Insurance Fund (in Romanian: Casa Nationala de Asigurari de Sanatate). The NIF is an autonomous public institution of national interest, with legal personality, whose main activity is to ensure consistent and coordinated operation of the health insurance system in Romania. The NHIF also publishes the norms of implementation of the Framework contract in which the financial incentives to attract GPs to underserved areas are mentioned.

Finances

The interventions taken to attract GPs to underserved areas almost all use financial incentives to achieve their goals. Depending on the nature and scope of the programmes, these costs can be considerable. For all seven cases, funding is predominantly provided by national authorities, most often the respective Departments of Health. Costs can vary for funding agencies according to the number of participants making use of the measures offered, which is also influencing the variable administrative costs involved. However, most often, a maximum expenditure ceiling has been fixed upfront in national budgets.

There is not one global budget or financing dedicated to the *Pacte territoire santé (FR)*. Most of the measures are financed by the Sécurité Sociale. Some of the measures in the Pacte that are totally new, like the PTMGs, are therefore required to find new ways of financing. Other measures could be financed by the different partners, such as the Ministry of Health, the regional health authorities [in French: Agences Régionales de Santé – ARS] and the Social Security System. As financial resources for some of the measures are currently not yet made available to the ARS, who are responsible for implementing the measures, their introduction has been delayed. Considerable financial means are involved in introducing this package of measures. For the first measure, students will be encouraged to do their internship in remote areas - more than 15 km from the place of training or residence - through the creation of a fixed transport allowance of € 130 per month. For measure 2 (fellowships), medical students receive a fellowship of €1200 a month while in medical school, provided that they undertake 165 patient consultations per month, and commit to work in an underserved area after they finish their education. The time for which they commit to work is similar to the time period for which they receive the fellowship. For measure 3 (*territorial general practitioner (PTMG) contracts*), GPs receive a minimum salary (gross monthly income of € 6,900), regardless of their number of patients and in addition they receive better social protection. This includes sickness leave and maternity leave, which is particularly important for female doctors and the number of young female doctors in France is increasing. The growth of MSP-structures (Maisons de Santé Pluridisciplinaire) throughout France is due to the efforts of professionals and elected officials. It requires new funding up to an average of € 50,000 per team (paid by Social Security). The intensive deployment of telemedicine mobilize substantial funds through the "digital hospital" programme, to which almost € 400 million is allocated over five years.

The *University of Queensland Rural Clinical School (AU)* is exclusively funded through the Australian Government's Rural Clinical Training Support Programme. The funding parameters as set out by this programme must be strictly adhered to in order to secure future funding. These parameters require that 25% of the medical students must come from a rural background, 25% of medical students must undertake a minimum of one year of their clinical training in a rural area, and universities must build training capacity and support for their rural academics/teachers.

Funding levels for each participating university in the Rural Clinical Training Support Programme are determined by the Minister with advice from the Department, based on a funding model. This model includes a base grant for each medical school of \$2.8 million per year, with additional funds allocated to each school based on student numbers and the level of remoteness of each school's training programme. Reporting and accountability requirements are outlined in the Funding Agreement with each university. These include six-monthly performance reports, six-monthly expenditure reports, audited financial statements at specified times during the project period and a final performance report at the end of the project period.

The *GPs financial compensation programme (BG)* is provided by the National Health Insurance Fund and ranges from approximately €60 to €600 per month for a GP practice in an area with adverse working conditions, i.e. a remote area. In the North-West region of Vidin, for example, doctors are offered 500 Bulgarian Lev (comparable to €255) to open a practice in one of the settlements with poor access to medical care. This financial compensation is roughly equal to a minimum salary in Bulgaria. However, GPs state that the money is not enough to be able to withstand. The main income of GPs is called "capitation", this is a monthly payment for each patient enrolled. When a doctor has fewer patients, as GPs that serve smaller villages have, the total amount of money is still not enough to sustain their practice.

The *start-up grant for young doctors in Estonia* is about €15.000. However, the beginner's allowance also includes income tax. The income tax withholding rate is 21%, but each individual medical specialist will receive €15.000. This means that the costs for the Government who provides the start-up allowance are higher than €15.000 per medical specialist. In 2012, the State Budget scheduled payments of €150.000 for the start-up grant programme, but it was stated that the amount of the start-up allowance depended on the number of applicants. Should there for example be 9 or 10 approved applications, the grant would be €15.000. However, should there be 15 approved applications; the individual grants would be €10.000.

The *resident scholarship programme (HU)* is financed by the Hungarian Government. The *Markusovszky Ösztöndíj* and the *Than Károly Ösztöndíj* scholarships are both 100.000 Hungarian forint (HUF) per month, approximately €324 per month. The payment only happens if the resident fully complies with the demands of his/her training programme. In 2014, the total budget for *Markusovszky Ösztöndíj* scholarship amounts to HUF 660 million, approximately €2.138.400, for the *Than Károly Ösztöndíj* scholarship the amount is HUF 24 million, approximately € 77.760. The *Méhes Károly Ösztöndíj* scholarship and the *Gábor Aurél Ösztöndíj* scholarship are both 200.000 Hungarian forint (HUF) per month, approximately €648. In 2014, the total budget for both scholarships amounts to HUF 36 million, approximately € 116.640.

The *primary care internship support project in Finnmark (NO)* was granted funds by the national Ministry of Health and Care Services/ Directorate of Health to address the health workforce crisis in the county. The Chief County Medical Officer of Finnmark at that time had made known his concern to the Ministry of Health that one third of the positions for GPs in Finnmark were not filled. This was when the MoH decided to supply Finnmark with the funds required to solve this recruitment crisis. The Ministry

of Health paid the salary of the group tutor and there was also money to refund the costs for the doctors that attended (e.g. travel costs etc.). Up to now, the Finnmark intern support project is being funded in this way. This funding is non-conditional. In the first years of the programme, the funding was around 1 million Norwegian Krone (approx. €119.190) annually. The funding is somewhat higher now, because there are more interns.

The *financial incentives in the Framework Contract (RO)* are funded based on a list of criteria. There are no results about exact amounts paid through the financial incentives, but it is clear that the amounts are decreasing. This is because until recently, GPs in Romania received 50% of the income from pay-for-service and 50% for the patients registered with their practice. So the remuneration of GPs consists of a mix of capitation fees and fees for services. Capitation fees are related to the number and age of registered people and can be higher depending on the location of the practice (urban, rural), the structure and profile of the population and hardship conditions. Hence, the financial incentives to attract more GPs to rural areas are directly related to the capitation fees; depending on the conditions in which a primary care office is performing its activity, the total number of points based on which it receives pay per capita can be increased by up to 100%. The Romanian National Society of Family Doctors (SNMF) informed us that a new version of the framework changes the ratio between pay per capita and pay-per-service system from 50% - 50% to respectively 20% - 80%. Considering the fact that the percentage of increase in funding for remote and isolated areas is directly related to the pay per capita, this means a significant decrease in the amount of funding for GPs in rural areas.

Facilitators and barriers

Facilitators

Essential to the *Pacte territoire santé (FR)* is that it is a "pact", which means that it is based on large consultations with all involved stakeholders, such as with medical associations, local associations, local and regional territories representatives. It is not mandatory, but based on a set of incentives from which the most appropriate measures for the region can be chosen. This open approach is well appreciated by all stakeholders and the adoption of the measures is steadily growing.

The reason that the *primary care internship support project in Finnmark (NO)* was successful is because of the severe need for doctors in Finnmark. Because of this high need, municipalities were so glad they had an intern in the first place that they took very good care of them and would happily give them two days off to attend the support meetings, if this increased the likelihood that the intern would apply for a job in Finnmark after finishing his/her internship. Another crucial success factor was the funding by the Ministry of Health. Our informant stated: 'we could not have done it without that'. The main barriers in the running of the support groups were related to geographical issues and the climate in Finnmark. It was important to plan things well in advance and with safe time margins, so as to make sure that everyone was able to attend the meetings.

Barriers

The cases included under this topic face diverse barriers. Even though the *GPs financial compensation programme (BG)* has been in operation since 2008, it is not very actively being used. One of the main barriers for use of the programme is that many doctors are dissatisfied by the amount of support provided. In Estonia, the amount of the *beginner's allowance* is not a problem, but it has been reported that physicians usually already have families by the time they graduate. This makes moving location complicated.

The *Finnmark intern support project (NO)* mainly faced difficulties which were related to the problem that the intervention is focusing on, namely the remoteness of the area. The main barriers in the running of the support groups were related to geographical issues and the climate in Finnmark. It was important to plan things well in advance and with safe time margins, so as to make sure that everyone was able to attend the meetings.

In France, some of the measures of the *Pacte territoire santé* are experiencing a delay in implementation by the regional health authorities because financial and/or legal efforts that need to be made by the central Department of Health have not yet been done.

Replicability

The cases included under this topic are fairly diverse, ranging from a whole package of measures (*Pacte territoire santé (FR)*) to purely financial incentives. Organisations should consider for themselves what the most promising measure would be. The *Finnmark support project (NO)* costs relatively little money and obtains good results, whereas the provision of financial rewards is costly, without having the certainty that it will have an effect. Some crucial factors that need to be taken into account are:

- Measures which are purely financial incentives by providing (young) doctors with financial benefits if they start working in an underserved area need to make sure that the amount of financial stimuli provided is sufficient.
- Medical students and/or young medical doctors need to be aware of existing measures and programmes. For example in Estonia, the introduction of a regulation such as the start-up grant for young doctors in Estonia (EE) needs a good media campaign and pre-introduction.
- It would be best to introduce the existence of certain measures to medical students during their study period, so that they will have sufficient time to decide which region they would like to work in after graduation.

Effects of the interventions on recruitment and retention

It is difficult to make a distinction between the effects of the interventions on recruitment and retention and more general effects. General effects such as a better coverage of health needs in rural and underserved areas by a better geographical distribution of doctors, will also have an effect on recruitment and retention. However, most of the effects that were evaluated are focused on the process level (more scholarships, more contracts,...) and less on outcomes (better geographical distribution of doctors, increased physician density in rural and underserved regions, higher proportions of GPs, ...).

Some of the included cases are looking at the effects that they have on recruitment and/or retention numbers, but do so in different ways. The implementation and working of the *Pacte territoire santé (FR)* is constantly monitored by the Ministry of Health at national and regional level. In Bulgaria, the National Health Insurance Fund monitors data concerning the number of GPs working in Bulgaria and can establish whether the *GPs financial compensation programme* stops or slows down the decline in number of GPs. The *University of Queensland Rural Clinical School (AU)* and the *intern support project in Finnmark (NO)* are measuring the recruitment and retention rates of former participants of their respective programmes. The University of Queensland has even established an alumni database for this which tracks career pathways and vocational choices, with follow-up data collections every 2 years. The results of both cases are encouraging; Rural Clinical School graduates are 2.5 times more likely to work in a rural area and significantly more interns from Finnmark took their first fully licensed physician job in an underserved part of Norway.

In Estonia, the *start-up grant for young doctors* has only been granted to 10 medical specialists since its start in 2012. Hence, results in terms of R&R cannot be established based on this small set. In Hungary, the *resident scholarship programme* is very popular, but as an average medical specialisation training programme lasts 5 years, it is still too early to examine the link between the scholarship and R&R outcomes.

The implementation and working of the *Pacte territoire santé (FR)* is constantly monitored by the Ministry of Health. A first thorough evaluation of the effect of the *Pacte* is expected at the beginning of 2015, but the first indicators are encouraging. For measures 2 and 3, the numbers of signed contracts is increasing. For measure 1 (internship in general medicine), 2500 GP tutors (*maître de stage*) have been accredited (4% of all GPs in 2012/13). This number increased further in 2013/14. 60% of all medical students will do an internship in general practice during their studies (compared to 42% in 2011).

The number of scholarships (Contract d'engagement de Service Public (CESP)) increased from 353 in 2012 (when launched) to 881 in 2014. The aim is to provide 1500 contracts in 2017. 180 territorial general practitioner (PTMG) contracts were offered from September 2013 and all were taken within four months. 303 PTMG contracts are expected by November 2015. In all 26 ARS regions, a reference person has been appointed to support young doctors to get installed. A new website will be launched in January/ February 2015 to guide young doctors through the *Pact Territoire Santé*. The number of 'maisons de santé pluridisciplinaires' grew from 174 in 2012 to more than 600 in 2014. The number of SAMU physicians (MCS) (doctors who provide first care on voluntary bases in emergency situations in regions where access to urgent care is more than 30 minutes away) grew from 150 in 2012 to 650 in 2014. Nine regions have been selected as pilots to develop telemedicine further (teleconsultation and tele monitoring).

In addition, at the national ministerial level, every two months there is a meeting between the Ministry of Health, agencies in charge of health, the Ministry of Universities and Research, and other partners. There are also regular meetings, approximately four times a year, with the people who are in charge of implementing the *Pacte* in the regions to exchange ideas, actions, problems, ways to improve the measures and so on.

The *University of Queensland Rural Clinical School (AU)* graduates first entered the medical workforce in 2003. In 2006 a longitudinal study was designed to track workforce participation patterns since graduation. The first stage of the study reported primarily on intern location choices. The second stage entailed maintaining a UQRCS alumni database and tracking career pathways and vocational choices with follow-up data collections every 2 years. This tracking database was established in 2006. In 2010, it was found that 40% of the graduates were working in a non-urban, rural and remote area. Eight per cent of all graduates had chosen 'rural medicine' as area of speciality. Next to these database data, a qualitative study was undertaken and it was found that the primary drivers of and influences on early career decisions were personal/family reasons, positive rural exposure in the RCS and specialty training requirements.

The University of Queensland Rural Clinical School continues to grow. Currently, the Rural Clinical School has an intake of up to 150 medical students in the clinical phase of the medical programme who live and work at one of the major academic sites for at least the duration of an academic year. Now in its second decade of operation, UQRCS is able to demonstrate a positive impact on the medical workforce in the regions in which it works (and elsewhere). Studies demonstrate that a student who has experienced the Rural Advantage via the Rural Clinical School is 2.5 times more likely to work in a rural area when compared with other University of Queensland medical graduates.

In Bulgaria, the National Health Insurance Fund published new data in January 2015 concerning the number of GPs working in Bulgaria. These data show that the number of GPs (who had a contract with the NHIF) is below the required minimum for the country and continues to decline. Since 2005, the number of GPs in Bulgaria has constantly been decreasing.

Year	N of GPs	N of GPs needed	N of GPs lacking	% GPs lacking
2005	5340	5374	34	0,6
2007	5001	5374	373	6,9
2011	4715	5374	659	12,3
2013	4565	5374	809	15,1
2014	4515	5374	859	16,0

Moreover, the distribution of GPs over Bulgaria is suboptimal. The shortage of GPs is felt most acutely in small settlements. Fewer patients mean less money for maintenance of medical practice. Especially practices with "adverse working conditions" (1088 in total) suffer from a lack of GPs. According to the NHIF, regions with acute GP shortages are Vidin, Kardzhali, Razgrad, Silistra, Smolyan and Yambol. In Kardzhali, for example, only 64 GPs are employed, whereas according to the National Health Map the minimum to ensure adequate access to treatment for Kardzhali is 123 GPs. Hence, there is a lack of 59 GPs, i.e. almost half the GPs needed are not available. Even though the NHIF provides these practices with "adverse working conditions" with additional funding through the *GPs financial compensation programme*, doctors state that the money is not enough to be able to withstand. One GP, working in Pernik, an area with "adverse working conditions" explains: "You can pay your rent, but then there are costs for heating, electricity, water, and the biggest item is transport costs."

The *start-up grant for young doctors in Estonia (EE)* has been given to a total of 10 medical specialists since its start in 2012. Results in terms of increased recruitment in underserved areas are not being monitored. Moreover, the numbers of the beginner's allowance are too low at this point to make a significant difference.

The *Resident scholarship programme (HU)* is very popular, but the link between recruitment/retention and the scholarship programme has not been examined yet. As an average medical specialisation training programme lasts for 5 years, and most of the participants are still receiving the grant, it is too early to draw conclusions. However, the number of doctors who requested a verification certificate for working abroad has slightly decreased since 2011, when the programme started (from 1200 in 2011 to 955 in 2013).

For each year that the programme was run there was a pre-determined budget for the scholarships, and in every year there were more applicants than places. The number of participants contracted per year varies from 600 in 2011 to 585 in 2013. The total number of participants up to 2014 was 1692. 95% of all participants are participating in the *Markusovszky Scholarship*. This is because the *Markusovszky* programme is a general programme that is available for all medical doctor residents, regardless of their type of specialisation training. Hence, there has been over-application for the

Markusovszky programme every year. The maximum number of available places is determined by the yearly budget and the numbers are announced for each programme when the application procedure starts.

The *primary care internship support project in Finnmark (NO)* was established in 1998. In the years that followed, from 1999 until 2006, data were collected from graduates who had conducted their primary care internship in Finnmark and an evaluation was conducted. However, since no baseline data were available, the results from Finnmark were compared with the results from interns in Nordland, the second most remote county in Norway. It was found that significantly more interns than could be expected from their origin took their first fully licensed physician job in the north of Norway. Given that this improvement coincided with the introduction of supported internships in the north, this fact was interpreted by the researchers as an indication that internship in the north, when accompanied by adequate professional and social support does promote recruitment. However, causality cannot be proven. More recent data that specifically focus on this intervention are not available. Interns are not being monitored anymore because of a lack of time on behalf of the people conducting the intern support groups.

In Romania, the number of rural GPs remains fairly stable in absolute terms, but is decreasing in relative terms:

Year	Total N of doctors	Total N of active GPs	Rural
2009	N/A	12.009	4.446 (41%)
2010	52.204	11.170	N/A
2011	52.541	11.211	4.699 (31,2%)
2012	53.681	11.151	4.651 (33,1%)
2013	51.993	11.179	N/A










Hence, the *financial incentives provided through the Framework Contract (RO)* appear to have little effect in attracting and/or retaining GPs. This is consistent with anecdotal evidence received by the Romanian National Society of Family Doctors (SNMF), the main professional association of family doctors in Romania. The SNMF informed us that the number of GPs continues to decrease and that the number of medical graduates entering family medicine residency is 'decreasing dramatically'. Young doctors prefer to emigrate.

Concluding remarks

If we set the interventions included under this topic – attracting and retaining GPs to underserved areas – against the R&R interventions included under the seven other case topics, it stands out that these are more often purely financial incentives. Under the other topics, financial incentives are always accompanied by other types of measures (e.g. a combination of financial incentives and education). Moreover, compared to the other cases, interventions under this topic are relatively often situated at policy level and involve high costs, even though the proven effectiveness of purely financial incentives is generally known to be low and this is confirmed by our findings.

4.3. Providing training, education and research opportunities for a life-long career

Table 6: interventions focused on providing training, education and research opportunities for a life-long career

Case	Country	Intervention type	Running time	Case report
3.1. Bridging courses	PL		2003 – no end	Appendix 3.1
3.2. Graduate Nurse Programme	AU	 	2008 – no end	Appendix 3.2
3.3. Research as a form of CPD	SE	 	Unknown	Appendix 3.3
3.4. Flying Start NHS Scotland	UK	 	2006 – no end	Appendix 3.4
3.5. Flying Start Queensland Health	AUS	 	2012 – no end	Appendix 3.5

Short description of interventions under this topic

In their aims and focus, the cases under this topic show a wide variation. The Swedish case has a focus on research opportunities, which is different from the other cases as the support that is offered aims at supporting development as a *professional and directly relevant skill*. The interaction between hospitals and different Swedish councils provides insights into how stakeholders use opportunities differently within the same institutional setting. The other interventions have a strong organisational factor, specifically focused on recent graduates. The transition from classroom to clinical practice is generally recognised as problematic, among others the support for newly graduates. Hence, these programmes are aimed at strengthening skills, confidence and values, as professionals starting their careers are still very open to taking up new knowledge and professional values.

The *bridging courses (PL)* were initially introduced to offer Polish nurses and midwives, who do not fulfil the requirements for permission to work in other EU countries, the possibility to obtain a Bachelor degree and hence become eligible to work in other EU countries. However, other important goals of the bridging courses are to motivate Polish nurses and midwives to further develop their professional qualifications, provide them with better career opportunities and increase the professional and social prestige of nursing and midwifery in Poland.

The *Graduate Nurse Programme (AU)* was initiated by the not-for-profit hospital Calvary Health Care ACT in Australia, with the aim of improving retention rates of graduate nurses and increasing recruitment of new graduates. It provides a programme with a number of workshops, orientation and rotation days, and study days to cover a number of clinical and non-clinical topics.

The *opportunity to perform research as a form of Continuing Professional Development (SE)* outlines the collaborations between hospitals and Swedish counties (the administrative level in Sweden responsible for healthcare delivery). Hospitals have the opportunity to offer positions in which healthcare staff, in particular physicians, are able to spend time on research and further professional development as an incentive to retain or recruit healthcare professionals. The arrangements between different hospitals and counties provide an insightful variation.

The *Flying Start NHS programme for Scotland* is developed by NHS Education for Scotland and delivers education and training for those who work in NHS Scotland. It

aims at professionals starting their career, early career development and support for newly qualified health practitioners. It has been high on the Scottish agenda with a view to decreasing both student and post-registration attrition rates. It recognised that an individual's first experience of working with NHS Scotland is likely to have a big influence on future career plans and hence recognised the need to provide support during initial employment within the NHS. This takes the form of a web-based educational resource to support the transition from student to qualified practitioner to make this first experience a positive one. The web-based programme is supported by mentors and line managers within new professionals' organisations.

The *Flying Start Queensland Health (AU)* builds on the Scottish programme. During consultation with allied health professional groups, it became clear that more support was needed for new starters. An investigation into existing new starter/orientation/induction programmes and related resources relevant to Allied Health was conducted and revealed Flying Start NHS Scotland as an option, as the programme stood out as a structured, inter-professional education package that provided support for both new starters and their supervisors or mentors.

Actors – roles, responsibilities and cooperation in the development and implementation

The *bridging courses (PL)* were the direct consequence of the negotiations between the Polish authorities and the European Commission in the Accession Treaty, prior to Poland joining the EU. Hence, the freedom of scope in developing the (curriculum) for the bridging courses was very limited for the Polish MoH, let alone for the individual universities who had to implement the courses.

The *Graduate Nurse Programme (AU)* results from an internal staff-satisfaction survey within the Calvary Health Care ACT hospital. The development of the programme included the use of focus groups, which identified issues including lack of orientation and induction days and dissatisfaction with the study day content. Feedback and reflection from the target group were included. Internally, the appointment of a Graduate Nurse Coordinator has been identified as of key importance in the development and implementation of the programme. The organisational programme is otherwise independent from any policy frameworks or institutional settings.

Contrary to the Graduate Nurse Programme, *the opportunity to perform research as a form of Continuing Professional Development (SE)* is institutionally embedded within the Swedish system. Swedish counties are responsible for healthcare in the region. The responsibility for (bio)medical research is divided between universities and the county councils, urging them to collaborate. This shared responsibility is further framed in the so-called ALF agreement which outlines the financing of clinical research by physicians, which in turn is done by the central government. Formal cooperation agreements are helpful for making this collaboration successful, as well as having a university nearby.

Flying Start NHS Scotland provides a centrally-developed tool for organisations. While staff attrition is an organisational issue, it has been identified as an issue that troubles most healthcare services. NHS Education for Scotland, in partnership with NHS Scotland and the Higher Education Institutions (HEIs), developed the Flying Start NHS programme but is not responsible for its implementation. In 2006, funding was provided to Scottish NHS Boards to support the implementation of Flying Start NHS, while NHS Education for Scotland provides guidance to individual Boards when requested. Following the development between stakeholders on policy level, the day-to-day implementation has been the responsibility of healthcare services themselves.

Flying Start Queensland Health followed a similar problem identification as in Scotland. Following recommendations from the 2007 Ministerial Taskforce on Clinical Education and Training, Queensland Health in 2009 undertook a training needs-analysis across the allied health disciplines to assist in determining current and emerging gaps in clinical education and training. Support for new starters, including new graduates was identified as a need across most disciplines. Once Queensland Health had decided that the Flying Start programme would fulfil its needs, the Allied Health Professions' Office of Queensland contacted the education unit of NHS Scotland, NHS Education for Scotland. The initial reaction of NHS Education for Scotland to transferring the Flying Start programme to Queensland was positive and a plan was made to investigate the opportunity further. There were issues with the licensing agreement, but adapting the Scottish programme to the Queensland context proved to be straightforward.

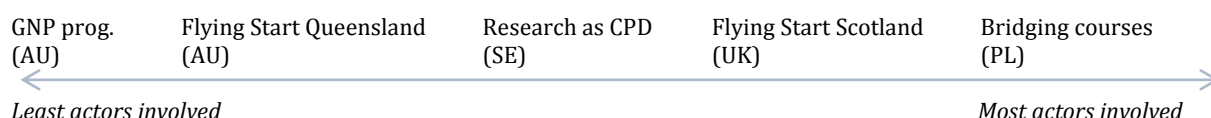
The Cunningham Centre is a Registered Training Organisation (RTO) for Queensland Health, and provides state-wide training and education and provision of post-graduate clinical upskilling. It has played a central role in realising the Flying Start Programme for Queensland.

Up to the official launch of Flying Start Queensland Health, the Cunningham Centre staff had been working with lead contacts in each of the 16 local hospitals and health services throughout the state, to work out a strategy of promotion and rollout in each area. During the implementation phase, these contacts were key points for disseminating information and collecting feedback. The key champions at local level were either directors of allied health or team leaders, i.e. they were usually in a senior or management position.

Just before the implementation of Flying Start Queensland Health, a professional support policy had been released within Queensland. This meant that for the first time, a standardised approach for allied health professionals to receive professional supervision or mentoring was available. This was an enabling factor in the implementation of Flying Start Queensland Health, as people were in the process of establishing mentoring arrangements and needed resources to use in these arrangements.

The development and implementation of the different cases within this topic have various backgrounds. The bridging courses (PL) are strongly determined by European regulations, whereas the Graduate Nurse Programme (AU) is an organisational and independent programme. The Swedish framework, on the other hand, emerges from a policy framework, with organisations responsible for optimising the opportunities available to them. This implies dependencies on interest and capacity for creating organisational programmes, and the ability to use inter-organisational relations to further realise them. Flying Start NHS Scotland (UK) and Flying Start Queensland (AU) are slightly different, as different organisations started to collaborate based on a shared problem identification and definition. Like in Sweden, organisations are responsible for the implementation within an enabling legal and policy framework.

Actors – roles, responsibilities and cooperation in the day-to-day running



Many actors at various levels are involved in the running of the *bridging courses (PL)*. Since 2008, the European Social Fund has co-financed the 'bridging courses'. The Polish Ministry of Health – Department of Nurses and Midwives is responsible for the implementation and realisation of this ESF-project. The contractors are the Polish universities, who are selected via open tender procedures to carry out the bridging

courses. In 2014, bridging courses were being offered by 71 universities and accredited by the Ministry of Health to do so. The universities, in their turn, are responsible for the recruitment and selection of participants and the gathering of required documentation. Hence, many formal cooperation agreements are involved in the bridging courses (between ESF and Polish MoH, between Polish MoH and universities and between universities and course participants).

The *Graduate Nurse Programme (AU)* is an organisational programme, with responsibilities centred in one role: the Graduate Nurse Coordinator (GNC) and later the Graduate Coordinator. Together with a Learning & Development Project Manager the GNC undertook an extensive literature review and analysis of other local and national GNPs. The intent was to identify key best practice aspects of GNP that could be incorporated into the new programme. The Graduate Coordinator is the current go-to person.

The day-to-day running of *providing opportunities to perform research as a form of Continuing Professional Development (SE)* is covered through employment agreements between hospitals and universities in several counties, such as Upsalla, Skane, and, Stockholm country, and Orebro. Sometimes hospitals or universities use this opportunity as a specific recruitment tool, but strangely enough not in Stockholm County's collaboration with the prestigious Karolinska University Hospital – perhaps its reputation does not require any additional recognition and it's used implicitly.

The *Flying Start NHS Scotland* programme's day-to-day running is an organisational responsibility. Consequently, organisations use the health system's programme differently. In general, those participating in the Flying Start NHS programme are appointed a mentor, whose role is to offer a light-touch approach to guide new entrants through the programme and lead them to completion. Participants will also work with peers and multi-disciplinary team colleagues. In practice this works as follows: newly qualified staff can register by visiting the website <http://www.flyingstart.scot.nhs.uk>. They must enter their details there following the launch. They should also consult their line manager/mentor to arrange for appropriate time/support to complete the programme. In addition, they need to confirm with their line manager who their named mentor will be, meet with their mentor as soon as possible to agree how they will work together, locate computers and other educational resources that can be accessed on a regular basis and access protected learning time in their work schedule wherever possible. Line managers therefore play an essential role in making valuable participation in the programme possible.

Apart from the website itself, the *Queensland Flying Start Programme (AU)* is not considered to need any additional new infrastructures. Some organisations increased the number of computer stations available for allied health staff, though this fell outside the scope of the Flying Start project. The Cunningham Centre undertook a significant amount of promotion of the programme during the year 2012-2013. However, ongoing promotion of Flying Start has since then been at the discretion of individual Hospital and Health Services and the activity has varied widely between regions.

Day-to-day responsibilities are on an organisational level for all involved cases, however there is a variation in the exact position. The *Graduate Nurse Programme (AU)* creates new roles in order to achieve the goals of its programme, whereas the *Flying Start Programmes* seems to rely on the time and capacity within existing roles. This might be less resource intensive, but could be a barrier in the realisation of the programmes.

Finances

The fee for the *bridging course (PL)* is about 1900 Polish Zloty (€441,27) per semester. Because of the high costs involved for nurses, the European Social Fund (Priority II: Measure 2.3 Sub-Measure 2.3.2 of the Human Capital Operational Programme 2007-2013) has been co-financing the bridging courses since 2008. Hence, nurses and midwives either cover the costs of this study on a private basis or they had the opportunity (at least over the last years) to follow the course free of charge because fees were covered by the ESF. The total budget for the ESF bridging course-project is approximately 193 million Polish Zloty (€45.649.132).

The *Graduate Nurse Programme's* financing was triggered by a hospital-wide staff satisfaction survey showing a need to expand Learning and Development (L&D) across Calvary Health Care ACT. In addition, a Learning & Development project was funded which included the redevelopment of the existing Graduate Nurse Programme. As part of the L&D project, a Graduate Nurse Coordinator (GNC) was employed in January 2008 to redevelop the GNP. In 2009, funding for an on-going Graduate Coordinator was secured. Additionally in 2009, a Graduate Facilitator position was trialled to overcome some of the assessment and feedback issues identified by the 2008 graduate nurses.

In Sweden, through the ALF framework agreement between the State (which runs university education) and the county councils (which run the hospitals) in *financing the clinical research of physicians*. The ALF funds are the government's way of remunerating the university hospitals for training doctors and for clinical research. This means that most clinical research is paid for by the state, even in the council-run hospitals. So for example in Stockholm County, Stockholm County Council is paying for the time that the Karolinska University Hospital is providing to healthcare staff to conduct research. In addition to financing through the ALF-agreement, many researchers receive grants through internal and external funds that provide money to allow them to "pay themselves" time for research.

Flying Start NHS is financed by the Scottish Government. In 2005, the Scottish Executive Health Department commissioned National Health Service (NHS) Education Scotland to develop the programme and in 2006 short-term funding was provided to Scottish NHS Boards to support them in implementing Flying Start NHS. In 2010 the intellectual property rights of the programme were protected, which resulted in the successful branding of Flying Start NHS®. The purchase of a licensing agreement to use the Flying Start programme by NHS England (in 2010) and Queensland Health (in 2011) yielded considerable benefits for NHS Education for Scotland, although all parties involved are reluctant to make the amounts publicly available.

Where the licensing of the *Flying Start Programme* generated additional income for the Scottish NHS, it required additional expenditures for the *Queensland Flying Start programme*. To be allowed to use the programme, Queensland Health paid a license fee to NHS Education for Scotland for the first three years of licensing. Subsequently, each two-year extension involved an additional license fee.

The main other costs that Queensland Health needed to make relate to the contract with the website hosting and a support contractor. This involved an initial set-up fee and each two-year extension period incurred an additional fee. The other costs involved concern Human Resources. These costs were situated mainly at the start-up of the programme, as later on the Cunningham Centre devolved some of the responsibilities for promoting the programme to the individual local levels. Potential savings could have been made by purchasing the programme, as R&D in this area was no longer required.

Facilitators and barriers

Facilitating factors in the running of the *bridging courses (PL)* were found at policy level – in the financing through the ESF, which took away many financial constraints for nurses – and at organisational level in the increasing professional experience of nurses and their motivation to continue studying. For universities, there were quite a number of barriers involved when the bridging courses were run for the first time. These mainly related to administrative and regulative barriers, which were overcome by development of national regulations, appropriate standards and curricula.

Facilitators related to *Calvary Health Care ACT's Nursing Programme (AU)* are a sense of necessity – in this case emerging from a staff satisfaction survey, a plan on how to address issues including an action plan, and the resources to hire the skills and a contact point for implementation. Barriers were not specifically mentioned.

In *Sweden*, there is room for improvement in realising the optimal collaboration between practice and research: in general, a person's career development is determined by the organisation in which he/she is employed. So even though a physician may work 70% of his time at the University Hospital and 30% of his time at the University, if he is employed by the University Hospital than his career structure will be formed by the 'rules' of the University Hospital, as this employer is responsible for it. In practice, this means that for young doctors, there are advantages into only doing clinical work instead of combining this with research. This is because, if you want to make a career in the hospital, you are 'judged' by the amount of clinical work you perform. Doing research has an effect on your salary as salaries are dependent upon clinical knowledge and skills. If you can rise in rank (and get paid more) by doing five-year clinical work, then why would you do research?

A survey on the *Scottish Flying Start Programme* found that difficulties in completing the programme were experienced due to competing pressures within work time, the technicalities of the system, and the need for further support. While respondents reported that they theoretically had protected time to enable them to complete Flying Start NHS, four out of five were not always able to take it. Themes emerging from the Australian Programme evaluation included insufficient time to use the resource, absence of supervision in the workplace and the non-specific nature of content.

In terms of conducting research as a specialist, it might be important to offer the opportunity to do research, even if it is not of interest to everyone or if it is more attractive for different stages in one's career. It has been mentioned that it is not attractive to junior specialists, but that is understandable – they just finished their education and moved into practice. It is likely that having the opportunity to conduct research becomes more interesting after several years of practice (it might also result in higher quality research), but in the light of recruitment this could be promoted as a benefit that might not be of interest *now*, but could be for the future.

The *Flying Start Programmes* met a challenge that is an issue often identified in realising Continuous Professional Development: the availability of time and prioritising for health professionals. It is also a barrier that results from the lack of availability of staff.

Replicability

Conditions for replicability have not been identified by the *Calvary Health Care ACT*. The availability of resources to provide for the required staff costs is necessary, as well as a sense of need and support within the organisation. Insights into staff satisfaction within the organisation might be instrumental in this process.

In Sweden, one of the most important aspects for hospitals that want to offer their staff the possibility to conduct research is to have a cooperation agreement with nearby universities. Formal cooperation agreements facilitate the exchange of knowledge and can be beneficial for both institutions.

The focus on the Scottish *Flying Start Programme* in this study was on the aspect of replicability. The case showed that the language and content of the course made it easy to adapt the format to the requirements in Queensland, however the experience with licensing in both institutions was cause for delay and required effort in ironing out. Language and culture within the Scottish NHS might differ from other health systems that seek to purchase the programme. It was the right of NHS Scotland to trademark the programme and gain income over it in order to cover developing costs. However, if replicability is the only aspect to look at, the licensing is a barrier and administrative burden for duplication.

In addition, the following experiences should be considered when purchasing and duplicating the system:

- Economy of scale: Within the Scottish NHS there are about 100.000 users of the site, because of the sheer number of allied health professionals and nurses in that area - in Queensland there are many fewer users. Moreover, Queensland has got a lower population than Scotland. This means that the economy of scale for both programmes isn't comparable.
- It was relatively straightforward to adjust Flying Start NHS Scotland to the local Queensland context. NHS Scotland provided the content and the Cunningham Centre had the opportunity to use a reference group to contextualise that content to its local Queensland environment.

As the *Graduate Nurse Programme (AU)* is an organisational programme, its institutional and policy context are an irrelevant factor for duplication, meaning that each health service or hospital could create the right conditions for duplication.

Although the institutional relation between counties and hospitals is important in Sweden for shaping the relation between both actors, it is not a necessity: irrespective of the policy system, employers can make agreements with (university) hospitals for collaboration and exchange. For many universities and university hospitals across Europe this will already be the case, and they might not consider this a factor in recruitment processes as their reputation doesn't require them to do so. However, they could use it in their 'hospital marketing' activities. Smaller hospitals probably need to make a bigger effort about their collaboration with educational actors, and be a bit 'louder' about it.

The *Flying Start Programmes* can be duplicated, although requiring local adoption and testing. But even considering administrative challenges, the Australian Cunningham Centre still considers the actual costs of the licensing agreement are relatively cheap compared to the costs of employing people to develop (the content) of such a resource themselves. It saves time and does not require hiring expertise. For other countries language and culture might be factors preventing duplication.

Effects of the interventions

Effects on recruitment and retention

Up to June 2014, a total of 30.577 nurses and midwives graduated from the *bridging courses (PL)* and obtained a Bachelor degree. No effects in terms of recruitment and/or retention could be established.

Important measures of the success of the new graduate nurse programme within *Calvary Health Care ACT (AU)* are recruitment and retention rates. Retention rates have been compared between the old programme and the new programme. There has been a significant improvement in retention rates of graduate nurses from 64% in 2007 (old programme) to 88% in 2008 (new programme). Hence, these retention rates apply to the nurses who participated in the programme, not the retention rates for the total organisation.

None of the *Swedish universities or hospitals* involved was able to produce numbers of the effects of being able to offer healthcare staff the opportunity to conduct research on recruitment and retention numbers. It should be noted that this is a fairly difficult thing to do, considering the many confounding factors and especially the fact that there is no clear 'before' and 'after' with this kind of intervention.

There is on-going evaluation of the *Flying Start programme* and NHS Education for Scotland reports registration figures to the Scottish Government. However, the effects of the Flying Start programme on R&R of newly qualified staff within the NHS are currently not fully measured. In 2010, a two-year evaluation of the programme by Banks et al. (2010) was finished which focussed on the impact and effectiveness of Flying Start NHS in supporting the recruitment, confidence and skills development of newly qualified nurses, midwives and allied health professionals within NHS Scotland. As part of the evaluation Banks et al. carried out a scoping exercise to identify available baseline data from associated bodies concerning current recruitment and retention of newly qualified staff within the NHS. The aim was to examine the impact of Flying Start NHS by tracking changes in recruitment and retention by year following implementation of Flying Start. Despite considerable efforts to identify databases that would enable a statistical analysis of recruitment and retention patterns over the period since the introduction of Flying Start NHS, data of adequate quality were not available. The research team also conducted interviews and asked participants on their views concerning Flying Start's influence on recruitment and retention. A large majority of participants indicated that there was no evidence that Flying Start had had an impact on recruitment. Nonetheless, the programme had significant value. Final year students stressed the importance of feeling valued and indicated that their 'ideal' employer would have a reputation for supporting new graduates and that the provision of support to undertake Flying Start would be one way of gauging potential employers' commitment to supporting their future career development.

The Cunningham Centre, the leading actor in the *Flying Start Queensland (AU)* programme, never used retention as a key measure. Even though it is an important measure, the number of confounding variables in establishing whether Flying Start Queensland Health has contributed to retention is too high. Moreover, the industrial changes and the changes to funding arrangements that took place in Queensland over the last years have probably been the greatest influence on staff remaining in or leaving their positions. So it would be hard to detect the influence of Flying Start in the context of those movements.

Flying Start Queensland Health (AU) has experienced a progressive uptake of registered users in the first twelve months that the programme was run. During the

first six months of the programme, supervisor/mentor registered users outnumbered new starter registered users by a proportion of approximately 2:1. After one year, this proportion was approximately 3:2, representing a trend toward increased uptake by new starters. This was consistent with the focus of promoting and raising awareness among supervisors/mentors that occurred during the implementation period.

Registrations up to 30 June 2013 totalled 1173 users, categorised as 500 new starters (42.6%) and 673 supervisors/mentors/managers (57.4%).

Of the 500 new starters that registered in the 2012-2013 year only 39 (8%) returned to the site in the 2013-14 year while there were 264 new starters registered for the first time. This indicates that while Flying Start continues to attract new starters to the site, the typical period of use is less than 12 months. Over 2013-2014, Flying Start was taken up by 250 new starters and 120 supervisors and mentors. During the 2013-14 year a total of 453 new and returning users accessed the site. This is considerably lower than the 1173 users during the previous 12 months of operation. This decrease was anticipated though, as there had been a significant amount of resource promotion undertaken by the Cunningham Centre in the 2012-13 year.

Evaluation of the Flying Start Queensland Health programme. While the ease of use of the Flying Start Queensland Health website was rated highly (5.2/7), the perceived usefulness rated more moderately (3.5/7). The most prevalent themes in user comments regarding the most useful aspects of Flying Start Queensland Health were access to resources, ease of use and support for supervision practices. The most prevalent themes in user comments regarding the least useful aspects of Flying Start Queensland Health were insufficient time to use the resource, absence of supervision in the workplace and non-specific nature of the content.

Proxy measures/other effects

Survey research showed that for 95.5% of the graduates of the bridging courses (PL) the main advantage is the increase in professional qualifications that they obtained. 85.4% of the graduates had increased motivation for career development and further development of his/her professional qualifications. However, the possibilities that the bridging courses brought in terms of social- and career advancement were only moderate. Approximately 40% of the graduates felt that graduating from the bridging course had contributed to these aims.

Calvary Health Care ACT (AU) conducted an evaluation of the new GNP. In 2009, following the completion of the programme all GNs who completed the 2008 GNP were invited to participate in focus groups. GNs reported that the best aspects of the GNP were being supported, encouraged and accepted as a team member.

In November 2009 an email inviting participation was sent to newly qualified practitioners registered to undertake *Flying Start NHS Scotland*. When asked if Flying Start NHS had helped them to understand their future career options, just over one in 10 newly qualified practitioners (n = 65, 11.9%) indicated that it had; 173 newly qualified practitioners (31.6%) reported that it had not helped. Findings from the survey also indicated that most newly qualified professionals found participation in the scheme to be a positive experience, particularly in relation to clinical skills development and confidence. However, the evaluation also found that difficulties in completing the programme were experienced due to competing pressures within work time, the technicalities of the system, and the need for further support. While respondents reported that they theoretically had protected time to enable them to complete Flying Start NHS, four out of five were not always able to take it.

In short: evaluation programmes run into a high number of challenges, but there are some opportunities as well:












- Often there are too many variables involved in order to determine a causal relationship between the programmes and recruitment or retention of professionals;
- In the case of CPD, recruitment and retention are not the key outcome measures;
- Using web applications makes it easier to measure attrition rates in courses, and provides a direct opportunity to approach individual users for evaluating services

Concluding remarks

In comparison to the seven other case topics, relatively little actors are involved in interventions providing training, education and research opportunities for a life-long career. Moreover, the interventions can have effect in a relatively short time (after all, just offering the possibility for training/research can already have an effect), but it is difficult to say how long the effects last. Finally, an often recurring barrier for these sort of interventions, which none of the other interventions seem to suffer from, is the fact that too little time is designated to professionals to participate in the interventions. This hampers their potential success.

4.4. Attracting nurses through the extension of practice and development of advanced roles

Table 7: interventions focused on attracting nurses through the extension of practice and development of advanced roles

Case	Country	Intervention type	Running time	Case report
4.1. Huhtasuo Haltuun-project	FI	 	2012 – no end	Appendix 4.1
4.2. Extension of nurses' roles and functions	AU	  	2000s – no end	Appendix 4.2
4.3. Subsidized education	CZ	 	2009 – no end	Appendix 4.3
4.4. Advanced Nursing Practice	FR	 	2009 – no end	Appendix 4.4
4.5 Nurse specialist function	NL	 	2009 – no end	Appendix 4.5

Short description of interventions under this topic

The five cases included under this topic are fairly diverse. All encompass either the extension of nurses' roles and qualifications and/or task substitution, but they are situated at different levels, and aim to do so in different ways. The factor that all of them have in common is further education of nurses, often combined with other elements such as changing regulations or personal and professional support to expand nurses' roles and practices.

The *Huhtasuo Haltuun- project* [in English: Huhtasuo Take-over- project] in Finland started in 2012. Because of the difficulties the Huhtasuo Health Centre had in attracting GPs, it decided to use the money that was available to hire 2 GPs (but for which it was unable to fill up vacancies) to hire 4 additional nurses instead. It also provided nurses with additional education and changes were made in the way patients were cared for (i.e. more often seen exclusively by nurses). Hence, the centre became nurse-oriented; most patients, especially chronic patients, have all or most of their contacts with nurses instead of doctors.

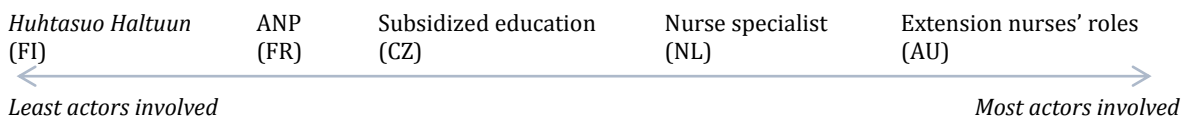
During the 2000s, based on a predicted nursing shortage, many Australian states developed interventions related to *extending nurses' roles, tasks and functions* to recruit and retain more professionals for the nursing workforce. This included greater access to professional development for nurses, changes in work practices and task substitution.

In 2009, as a reaction to nursing shortage in different fields, the Czech government decided to *subsidize a number of education courses for RNs* to become nurse specialists and in this way retain them in nursing.

In response to a projected decline in number of doctors and the desire to improve the career of nurses, France in recent years has been trialling *task substitution and advanced nursing roles*. Moreover, in 2009 the first MSc degree for nurses was introduced.

In the Netherlands, on 27 January 2009, the title '*nurse specialist*' was officially recognised by the Dutch Minister of Health, Welfare and Sport and it has been legally protected since then. Nurse specialists work at the interface between medical and nursing care, and treat defined groups of patients with whom they establish an individual treatment relationship. Since 2012, they are allowed to perform a number of 'reserved procedures', including the prescribing of medicines, initially for an experimental period of five years.

Actors – roles, responsibilities and cooperation



In all five cases that were included under this topic, there is a constant reciprocal interplay between the organisational and (national or regional) policy level in the introduction and running of the measures to attract nurses through the extension of practice and development of advanced roles. However, the influence of the organisational level on the policy level, if any, is limited and always follows *after* decisions made on policy level which influence individual healthcare professionals and institutions and/or educational institutions

The *Huhtasuo health centre* in Finland had been suffering from a shortage of doctors and (to a lesser degree) nurses for over a decade already. While staff of the health centre had pleaded for years to hire more nurses to fill the 'doctor gaps', the municipality of Jyväskylä wouldn't allow this. In 2012, the situation became so critical that the choice was either to shut down the health centre or continue running by working in a new system. Only then did the municipality agree that the money from two unfilled GP vacancies could be used to hire four additional nurses and the '*Huhtasuo Haltuun- project* started. Hence, it took the health centre a long time to convince political decision makers of the merits of this idea. This is because in Finland, the 'cultural' idea that doctors should provide all care is very strong. Because of some developments in Jyväskylä taking place at the same time, the centre was also able to hire other additional staff (in addition to the four new RNs, a social worker (1/2), substance abuse nurse (2/3) and half' a physiotherapist were added and the working times of a depression nurse increased). The new 'nurse oriented' way of working was independently developed by the staff of the Health Centre. There was a guiding group/executive team involved, but they were only informed about the project and did not provide input.

In Australia, *the extension of nurses' roles and functions* mainly resulted from decisions taken at state policy level in response to the predicted shortage of nurses. The initiatives that were taken always involved a reciprocal interplay between policy and organisational level. In New South Wales, for example the Department of Health developed protocols that had to be implemented by individual institutions and organisations to take effect. At the same time, individual public hospitals also redesigned how nurses provide care, within the realms of what the law would allow. The Department of Health subsequently publicised a number of these locally developed initiatives through the Models of Care Roadshow. This Roadshow was funded and organised by the NSW Nursing and Midwifery Office, an agency of the NSW Ministry for Health, to showcase existing examples of innovation and engage the profession in debates around the way care is practised and current and future roles. Hence, the NSW Department of Health not only took responsibility for implementing interventions, but was also active in disseminating the knowledge that was acquired at organisational level.

In the Czech Republic, the Ministry of Health holds responsibility for the *subsidised programme for healthcare professionals' education*. In 2008, it conducted a study evaluating the need and the priority amongst all of the specialist areas. Based on this evaluation, the first round of the subsidised educational courses for nurses ran in 2009. The subsidy for the specialized education is the responsibility of the Ministry of Health. However, a number of actors are involved in the day-to-day running of the programme. Employers (usually health care facilities) apply to the MoH for the extra financial resources to train more specialist nurses. There is an annual negotiation at the MoH about which professions, how many places and in which specialist fields will be subsidised. This is compared with the received applications from the employers and subsequently the numbers are adjusted to satisfy the current need. Hence, employers, the organisational level, have (limited) influence on the number and sort of course places that the MoH will make available. After the requested number of places is approved by the MoH, employers have to announce the opportunities to their employees and they can sign up. External administrators subsequently take over the daily administrative tasks.

In France, the Berland report on the co-operation of health professionals spurred the French state and individual healthcare and educational institutions into action. France started trialling with *advanced nursing roles* via a number of pilot projects. Based on the positive assessment of these pilot projects by the ONDPS (French National Observatory on the Demography of Health Professions) and HAS (French High Authority in Health), in 2009 article 51 was included in the Law "Hôpital, patients, santé et territoires". Hence, via the pilot projects that were conducted in the aftermath of the Berland report, it was shown on organisational level that task substitution can be a safe and promising way to solve existing staff difficulties in healthcare. Based on these positive results brought forward by 'the work floor', the Ministry of Health decided to include article 51 in the Law "Hôpital, patients, santé et territoires" and enabled the formal arrangement of task substitution. Moreover, the first Master degree for nurses was introduced in October 2009 by the University of Aix-Marseille and the *Ecole des hautes études en santé publique*. Hence, the implementation process has been a stepwise process in which various actors were involved, including the MoH, Regional Health Authorities (ARS) and educational and healthcare institutions (mainly through the pilot projects).

The legal recognition of the *function of nurse specialist in the Netherlands* was the end point of a process that started in the course of the 1990s. During those years, several reports and advices to the Ministry of Health appeared which pleaded for the

introduction of more task substitution in healthcare in view of the expected shortages. Professional organisations also lobbied for this. The Dutch Ministry of Health developed a positive attitude towards task substitution and in 2007, the MoH approved and financed the project which aimed to realise a number of essential preconditions for positioning the nurse specialist within the nursing professional career structure. Hence, based on independent advises and lobbying by the professional organisations, the Ministry of Health showed a strong political commitment to introduce the function of nurse specialist and paved the way for the legal introduction of this function.

When we look at the five cases, we see that the policy level always plays an important part when it comes to interventions aimed at extending nurses' practice. In the Czech and Australian cases, this influence mostly becomes visible through top-down imposed measures, although in the Australian case there is also some reciprocal influence visible. In Finland and the Netherlands, we see that it took a long time to convince the policy level to agree to the extension of nurses' practice, severely delaying its introduction. In France, we find the most reflexive process between policy and organisational level; the Department of Health allowed pilot projects to run, which were able to show positive results, which led to the introduction of legislative changes.

Finances

It proved extremely difficult to retrieve information on the amount of financial resources that is needed to implement and run the various measures that have been taken to expand nurses' roles and/or tasks. For the cases in Australia and France, no information could be retrieved. This may be due to the fact that measures were mainly developed and introduced at policy level, whereas the actual elaboration and running needs to be picked up at regional policy or organisational level. In Finland, there was barely any additional funding available for the *Huhtasuo Haltuun project* and it was introduced mainly within existing financial resources. The *subsidiary education courses for RNs (CZ)* and the *education for nurse specialists (NL)*, on the other hand, are highly subsidised and require substantial financial resources to be implemented.

For the *Huhtasuo Haltuun project (FI)*, there was no additional money available to support the project. Hence, the staff developed and conducted this project alongside their regular hours at the health centre. The four additional nurses that were hired were paid with the money that was 'saved' by the two unfilled GP vacancies. However, the employer did pay for the prescribing courses that the nurses followed (€5.000 plus reimbursement of 20 school days). For the additional staff that was hired, other funding sources presented themselves by chance.

The *subsidiary education courses (CZ)* for RNs to become nurse specialists are part of a general 'subsidiary programme' that is available for all healthcare professionals in the Czech Republic. In 2014 there were 600 places available for all non-medical health care professionals with a total budget of about €2.200.000. Three hundred of these places were allocated for nurses. The programme is dependent on the amount of finances released from the state budget every year. In 2014, the budget was larger than in 2013. After the MoH has approved the number of available places, employers have to announce the opportunities to their employees and they can sign up. If the nurse applicant fulfils all requirements, the subsidy is paid to the nurse's employer. Employers can use the subsidy they receive per individual nurse for covering the following costs: the cost of the specialist course (teachers, rooms, equipment, administration), the wages of the participating nurses and their travel costs and food, wages for extra personnel, if the employer needs to hire more nurses, because some are in school.

In the Netherlands, nurse specialists are educated in the Master programme of Advanced Nursing Practice (MANP). Because of the social importance of this education, it is jointly financed by grants from the Ministry of Education (pays in-school fees,

€7,650 per training place) and the Ministry of Health (compensates the salary costs for the replacement of a nurse who follows the MANP, €45,000 for entire study period one student). Therefore, the statutory tuition fee for nurses to follow the MANP is relatively limited (€ 1.906 for the study year 2014-2015). Nurse specialist registration and re-registration (>5 years) costs are €150 excluding VAT (€181,50 including VAT). Hence, this produces considerable costs for the Ministries of Education and Health, while keeping the costs for nurses low.

Facilitators and barriers

As said before, the five cases included under this topic are fairly diverse. However, one important overarching facilitating factor seems to be the need for political commitment. In Finland, the *Huhtasuo Haltuun- project* could only take place after the municipality was convinced of its added value. This process took years and severely delayed the introduction of the project. Likewise, in the Netherlands, for the introduction of the function of *nurse specialist*, political support needed to be obtained so that a change in the law to introduce this new function could be made. In the Czech Republic, it was stated by our informants that the fact that the *subsidized specialist education* for nurses is described in the Czech law, is important for the success of the programme as this ensures that it becomes a mandatory item of the state budget.

On the work floor, the individual success stories of *nurse specialists (NL)* acted as facilitating factor in the rollout of the function. Experienced nurses with senior positions, and a good cooperative relationship with doctors, were usually the first to follow the MANP and become nurse specialists, and their successes inspired other RNs in the ward or in the institution to pursue this goal too. The aspect of nurses' experience was also found as an important facilitating factor in the success of the nurse-oriented *HuHa project (FI)*. To make such a nurse-oriented project work, it is important that nurses are experienced and well-educated. Other facilitating factors were the united understanding and sharing of the vision of the project, the good working atmosphere in the organisation and the fact that the project was developed bottom-up; this decreased resistance to the project.

Important barriers for these interventions lay in their implementation. As explained before, for example in Finland and the Netherlands, the policy level had to be convinced about the respective measures and these processes took years to complete. Often, the initial resistance to these sorts of measures is related to 'cultural ideas' about what constitutes a doctor and what constitutes a nurse; the traditional cure-care divide is widespread, despite of the changes which have occurred in nurses' and doctors' knowledge and practice over the last decades.

The main barriers in the running of the included measures relate to the time they require and the administrative burden. For example the subsidized *specialist education programme for nurses (CZ)* is suffering from an unnecessarily high administrative workload; the amount of related documents that need to be circulated between the MoH, the administrator and the recipient could be decreased. Moreover, modern technologies, software and programmes could be used for the remaining agenda. In France, the same problem has been reported with regards to the implementation of *Article 51 of the 2009 Law "Hôpital, patients, santé et territoires"*. The writing of a 'protocole de coopération' is a complex and time-consuming process. After the writing of the protocol, it is examined at regional and subsequently national level, after which the authors receive feedback and need to re-write the protocol. This process can take months or years to be completed. Therefore, many of the protocols are in early stages of writing and very few of them are actually being implemented in practice. Moreover, once the protocol has been approved, the nurse will perform additional tasks but she/he will not be paid more money. This also acts as a disincentive.

A general characteristic of the labour market situation in France which acts as an impediment to the further development of task substitution is the fact that some nurses work on a self-employed basis in which they are paid by fee-for-service (14.6% of all nurses in 2009). Fee-for-service, and more generally the system for financing self-employed practice, does not facilitate the movement towards greater co-operation between doctors and nurses in the primary care sector.

For the *nurse specialist (NL)*, uncertainty about (the consequences of) political decisions and changes in the financial (reimbursement) system in healthcare act as a barrier to the further roll-out of the function of nurse specialists. The uncertainty that is created by these changes leads healthcare institutions and/or individual physicians to take a cautious approach with respect to introducing (more) nurse specialists on the ward.

Replicability

Because of the diversity in cases included under this topic, the different levels at which they are situated and the considerable influence of legal frameworks on these kind of initiatives, it is difficult to establish general criteria for replication. However, one of the most important things that countries or organisations that want to introduce task substitutions and/or extend nurses' roles need to do, appears to be to create political goodwill for the proposed changes and gather a substantial amount of support, both among nursing stakeholders and medical stakeholders. Task reallocations are a sensitive topic in healthcare and need a broad coalition of support if they are to be successful. Moreover, processes need to be made as easy as possible and administrative burdens should be kept at a minimum, as many healthcare professionals are already working under an administrative burden. Finally, financial resources are needed to implement the changes in organisations, provide nurses with additional educational qualifications, and so on.

Effects of the interventions

The effects of changes in (legal) regulations for task substitution and/or advanced practice, and the obtainment of further educational qualifications are generally permanent. However, it should be noted that these type of measures need time to ground, just as the effects they have may take some time to show. Because of this, among other reasons, it is difficult to establish a direct link between the extension of nurses' practice and roles, and recruitment and retention rates. This is probably why, if we look at the five included cases, monitoring or evaluation of the measures barely seems to take place.

The Huhtasuo Health Centre has tried to measure the results of the *Huhtasuo Haltuun-project (FI)* in several ways, including asking patients and staff for feedback and measuring a whole range of process and patient outcomes. Results show that patients are satisfied with the new nurse-oriented way of service provision. The overall perception is that services have improved. Also, satisfaction with the care received by nurses improved. Staff at the health centre is also very positive about the results of the project. For example, nurses' skills and capabilities are now fully being utilised and they are in a better position to influence the course of daily work, which contributes to job satisfaction. There are many more patient contacts, mainly caused by the high increase in patient contacts with nurses (especially phone calls). Because of this, chronic diseases can be detected at an earlier stage, leading to better health outcomes. For example, diabetic patients showed remarkable progress in lowering their blood sugar level. Moreover, based on the Assessment of Chronic Illness Care (ACIC) evaluation, it becomes clear that the Huhtasuo Health Centre has made much progress in chronic care provision.

For Australia, we only identified some results for the state of *New South Wales*, where nurses have been provided greater access to professional development, by changes in work practices and by freeing up registered nurses for more complex tasks. The New South Wales Department of Health has reduced the nurse resignation rate and recruited more nurses. The annual rate of resignations fell from 16 per cent in 2001-02 to 14 per cent in 2005-06. The number of nurse vacancies fell by 13 per cent between 2001-02 and 2005-06. Between 2001-02 and 2005-06 the average number of permanent nurses employed increased by four per cent. Yet the Department itself recognises that it is too early to judge whether the measures taken will ensure that the nursing workforce in public hospitals will be adequate in the future.

In the Czech Republic, since 2009, between 485 and 694 places have been approved on an annual basis for the *subsidised education courses for RNs to become nurse specialists*. There are no follow-up data available about the recipients of the subsidies, so it is not clear how many of them actually stay in the nursing profession.

In France, the uptake of Article 51 of the 2009 Law "Hôpital, patients, santé et territoires", i.e. the writing of protocols so that tasks can be substituted from one healthcare professional to another, has been lower than expected. Even though there are no data available about this, it is clear that because of the complexity of the process many of the protocols are in early stages of writing and very few of them are actually being implemented in practice. The "*Clinical Nursing Science*" Master programme at the *Ecole des hautes études en santé publique* is popular with new graduates. However, for the EHESP, it is difficult to establish whether graduates of their programme start working at ANP level or at RN level, because only four cohorts have graduated since the introduction of the Master programme. It is clear though that few students at the end of their study are writing 'Article 51' protocols. Hence, it is unlikely that they will be working at ANP level.

In the Netherlands, the number of *nurse specialists* has constantly grown since the function was first introduced. Currently, there are 2519 registered nurse specialists. However, this is still a far cry from the 5% of the total nursing profession in the Netherlands that was advised in 2006. Moreover, it is impossible to say anything about whether the introduction of the function of nurse specialist has affected recruitment and retention numbers. While the belief within the nursing profession is that a substantial part of the current nurse specialists would have left the nursing profession were it not for this function, there are no hard numbers available to underpin this.





A final remark concerning the effects that measures focusing on extending nurses' roles and practice may have is that once 'new' roles and tasks become embedded and are considered to belong to the 'standard repertoire' of a nurse or nurse specialist, they may lose their attractive and retaining qualities.

Concluding remarks

Compared to the other seven case topics, measures focusing on advanced practice (roles) for RNs are relatively often dealing with legal barriers as the scope of practice for health professionals and/or the introduction of new roles in healthcare are enshrined in law, and legislative changes are often highly politicised and take a lot of time. Hence, of all case topics included, the interventions that concentrate on advanced practice (roles) for nurses take most time to introduce. Moreover, their impact lag is relatively long, as legal changes are just a first step in the process. RNs then need to acquire the necessary competencies, special training may need to be developed, subsequently, the advanced practice/new roles need to be introduced and ground in practice, and so on.

4.5. Providing good working environments through professional autonomy and worker participation

Table 8: interventions focused on providing good working environments through professional autonomy and worker participation

Case	Country	Intervention type	Running time	Case report
5.1. Buurtzorg	NL		2006 – no end	Appendix 5.1
5.2. Self-managing teams	BE		2014 – no end	Appendix 5.2
5.3. We Care Teams	BE		2013 – no end	Appendix 5.3
5.4. Grannvard Sverige	SE		2011 – no end	Appendix 5.4

Short description of interventions under this topic

We included four interventions that focus on creating good working environments by providing employees with professional autonomy and a high degree of participation in the organisation. The 'source' intervention is *Buurtzorg the Netherlands*, the three other interventions replicated – to a greater or lesser extent – the original Dutch intervention.

Since its establishment in 2006, Buurtzorg has provided home care via professionally autonomous home care teams, including both (community) nurses and community caregivers. Buurtzorg's trademark way of working is characterised by the high level of professional autonomy and responsibility that its home care teams have and the limited overhead of the organisation. While not originally introduced as a recruitment and retention intervention, proxy measures show that Buurtzorg is highly successful in this regard. Because of this, and the fact that many countries are struggling with how to best organise the ever increasing demand for home care, the Buurtzorg way of working has been replicated in several other European (and non-European) countries, including Belgium and Sweden.

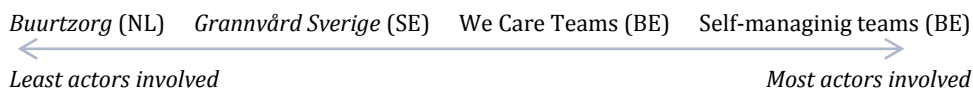
In 2011, Buurtzorg was replicated in Sweden via the establishment of the new home care organisation *Grannvård Sverige*, an official sister organisation of Buurtzorg the Netherlands. It operates on a much smaller scale, but according to the same autonomous self-steering way of team working. Although this way of working and the resulting care provision are successful, difficulties in translating the Dutch concept to the Swedish context are encountered with regards to sustainability.

In Belgium, two existing home care organisations, the *Wit-Gele Kruis Oost-Vlaanderen* and the *Wit-Gele Kruis Vlaams-Brabant*, both incorporated the autonomous self-managing Buurtzorg way of working, but to varying degrees. The WGK Oost-Vlaanderen is currently in the first stages of its phased implementation strategy for the introduction of self-managing teams within the organisation (which runs from 2013 until the end of 2015). It developed this new way of working in close cooperation with Buurtzorg the Netherlands and tries to resemble the Dutch example as close as possible, albeit taking into consideration the limitations that an existing organization raises.

The *WGK Vlaams-Brabant* also changed its 'old' way of working and thereby took Buurtzorg the Netherlands as its source of inspiration. In February 2013, it introduced the new way of working all at once in the organisation. However, while the new so-called '*We Care Teams*' are clearly inspired by Buurtzorg the Netherlands, the WGK Vlaams-Brabant tailored and adjusted the Buurtzorg way of working significantly to its

own environment. Hence, it deviates from Buurtzorg the Netherlands on certain crucial points and does not resemble it to the extent that the Wit-Gele Kruis Oost-Vlaanderen and especially Grannvård Sverige do.

Actors – roles, responsibilities and cooperation



Development and implementation

When introducing the self-managing way of working in home care, either by establishing a new organisation or introducing it within an existing organisation, the legal and financial policy framework in which organisations find themselves exert significant influence on the extent to which this way of working can be introduced and on its potential success. The self-managing way of working in home care was originally developed for the Dutch context. When *Grannvard Sverige (SE)* was introduced, and the *WGK Oost-Vlaanderen* and *Vlaams-Brabant (BE)* also wanted to introduce the 'Buurtzorg way of working', they were faced with different policy and financial contexts. This resulted in a trade-off between sticking to the original concept and adapting it to the specific requirements of the legal and financial context.

Buurtzorg (NL) was introduced in 2006 by Jos de Blok because of dissatisfaction with the existing way home care was provided. Being a home care nurse himself, with management experience and a background in business administration, he had long envisioned a new care model in which nurses would provide community care in self-directed teams, supported by new technology and minimal administrative oversight. With this background knowledge, Mr De Blok started the first Buurtzorg team from his home. In the years that followed, Buurtzorg rapidly expanded. Despite the increase in scale, the way of working remained the same.

The development and introduction process of the self-managing way of working in home care in Sweden and Belgium, inspired to a greater or lesser extent by the Dutch Buurtzorg example, were shaped by the specific context demands and the experience and knowledge of the actors that were involved in the introduction process.

The idea of establishing a Swedish copy of the originally Dutch concept *Buurtzorg*, originated simultaneously in Sweden and the Netherlands. Jos de Blok met the Swedish researcher Stig Tegle in 2010. Mr Tegle had conducted a study on care for the elderly across eight European countries. Via this study, he learned about Buurtzorg the Netherlands. When he and Jos de Blok met, they both concluded that Sweden and the Netherlands were facing similar problems in elderly care, and the Buurtzorg concept could be a solution for Sweden's problems as well. Hence, Jos de Blok was involved in the start of *Grannvard Sverige* right from the beginning.

When Jos de Blok decided he would like to introduce the Dutch Buurtzorg concept in Sweden as well, the originally Swedish nurse Mona Lindström worked for Buurtzorg the Netherlands. Together with Jos de Blok she repeatedly travelled to Sweden to meet people and explain the differences between the 'usual' way of working (which is similar in Sweden and the Netherlands) and the Buurtzorg way of working. After a couple of months, it was decided that Ms Lindström would start the Swedish Buurtzorg. In November 2011, Ms Lindström began with the paperwork that was required from the municipality. The great advantage was that Ms Lindstrom was familiar with the Buurtzorg way of working, as she had worked for Buurtzorg the Netherlands, and with the Swedish context in which the new organisation had to be embedded. Moreover, she could count on the help of both Buurtzorg the Netherlands, in terms of advice and financial resources, and Mr Tegle.

The situation for the two Belgian home care organisations that introduced the self-managing way of working was different right from the beginning, as they had to implement the new way of working within an existing organisation, in contradistinction to the new organisations *Buurtzorg (NL)* and *Grannvard Sverige (SE)*.

The *WGK Oost-Vlaanderen (BE)* has taken *Buurtzorg* as an example, but explicitly not as blueprint, because the Belgian context differs considerably from the Dutch context in terms of financing of home care, different labour laws and so on. During the development process, the *WGK Oost-Vlaanderen* talked to *Buurtzorg (NL)* for several years, gathered inspiration, conducted work visits to the headquarters of *Buurtzorg* met with a *Buurtzorg* team coach and it met Ben Wenting of the Institute for Cooperation Issues. The goal for *WGK Oost-Vlaanderen* was to make use of the methodology, philosophy and experience that *Buurtzorg* the Netherlands had already gained in working with self-managing teams. Moreover, it was also helpful to have *Buurtzorg* as an example to convince the government board of the *WGK Oost-Vlaanderen* of the added value of self-managing teams. While *Buurtzorg* the Netherlands was a big help for the *WGK Oost-Vlaanderen*, preparation also included literature research and visits to other organizations that introduced the self-managing way of working. Furthermore, the directors at the *WGK Oost-Vlaanderen* followed specific courses, such as unifying leadership, value-oriented negotiating and dealing with change. In addition, Tom van Acker, a senior consultant in innovative work organization of Flanders Synergy and expert in labour innovation, provided the *WGK Oost-Vlaanderen* with help in developing and introducing the self-managing teams.

The *WGK Vlaams-Brabant (BE)* took *Buurtzorg (NL)* as its inspirational point of departure, but was never in direct contact with *Buurtzorg*. The *WGK Vlaams-Brabant* started the trajectory of introducing the self-managing way of working in its organisation by contacting Flanders Synergy, a competence pool innovate work organisation founded by the Flemish Government, to support its self-managing teams project. Since 2012, Ms Veerle Put, manager of Input HR Consulting, has professionally supported the *WGK Vlaams-Brabant* with the implementation of the self-managing teams.

Organisational framework / Day to day running

Buurtzorg (NL) distinguishes itself from 'traditional' home care organisations through its flat network organisation, limited overheads and the high degree of professional autonomy and responsibility that its home care teams have. In 2013, *Buurtzorg's* overheads comprised 30 persons, including the back office (financial administration, client administration, personnel administration and automation via the *Buurtzorgweb*), 15 coaches and two directors. Financing, contracting, boundary conditions etc. are organised centrally and are removed as much as possible from the primary care process. When necessary, *Buurtzorg* consults and hires external experts in the area of human resources or cooperation agreements.

Buurtzorg teams work autonomously and divide tasks among themselves. They are responsible for housing, planning, work schedules, holiday planning, administration, hiring new colleagues, calculate the team results, and so on. Every *Buurtzorg* team has a Region Coach. These coaches have no leadership function and do not have hierarchical or performance responsibilities but try to stimulate the self-efficacy of a team. Since January 2008 all *Buurtzorg* teams are connected with the IT-system *Buurtzorgweb*. *Buurtzorgweb* is developed by the company *Ecare*, which adapted *Buurtzorgweb* to fit the *Buurtzorg* way of working.

Grannvård Sverige (SE), as official sister organisation from *Buurtzorg (NL)*, aims to approach the organisational framework of *Buurtzorg* as closely as possible. While this is an agreement between the two organisations, nothing has been officially and formally written down about this. *Grannvård Sverige* teams operate in the same way as *Buurtzorg* teams. They are small autonomous self-steering teams, consisting of

nurses and assistant nurses. Buurtzorg and Grannvard are currently working on which elements of the Buurtzorgweb (the internal IT-system) can be used in Sweden and which parts need to be country-specific.

The two existing Belgian home care organisations have more significant overheads than *Buurtzorg (NL)* and *Grannvard Sverige (SE)*, which could introduce the self-managing way of working from scratch and build the organisation around this. However, in the professionally autonomous team way of working for home care teams, the *WGK Oost-Vlaanderen (BE)* is sticking as closely as possible to the Buurtzorg example. The function of head nurse disappears and each care team will have a 'team coach', similar to the Region Coaches that Buurtzorg teams have. Likewise, tasks such as administrative tasks, going through intranet information, preparing staff planning, and so on, will be taken up by one of the team members.

In contradiction to the three other organisations, *WGK Vlaams-Brabant (BE)* has explicitly decided to remain working with head nurses. The reason for this is that the *WGK Vlaams-Brabant* believes that you can't expect people to be totally autonomous all at once and start working in a different way all by themselves. Head nurses are also responsible for the global work planning and the screening of new employees. In accordance with the Buurtzorg way of working, 'We Care teams' decide autonomously how they organise their patient care and they divide tasks among themselves. None of the two Belgian home care organisations is currently working with the Buurtzorgweb IT-system nor are there plans to do so in the future.

Finances

To introduce the self-managing way of working, substantial additional financing is required. The precise amount of this financing is dependent, among others, on whether autonomous working is introduced in a new organisation or within an existing organisation.

Buurtzorg (NL) has never received any funding from third parties. It started with one small team and grew gradually. Now, the start-up costs for a new Buurtzorg team are approximately €25.000. These costs are financed out of the exploitation and fetched by already existing Buurtzorg teams. *Grannvard Sverige (SE)*, Buurtzorg's official sister organisation, received the financial means to cover start-up costs by Buurtzorg. For the existing organisations *WGK Vlaams-Brabant* and *Oost-Vlaanderen (BE)*, the funding to introduce the new way of working was provided by third parties. Both organisations received funding from the European Social Fund and Flemish Co-financing Fund (VCF) of €100.000. However, the *WGK Oost-Vlaanderen* indicates that this is not even close to the costs that an organisation the size of *WGK Oost-Vlaanderen* has got to expend to introduce a fundamentally new way of working. Hence, both organisations invested considerable financial means from their own budget in introducing the autonomous way of working.

Depending on the extent to which the autonomous way of working is carried through, fixed overhead costs are fairly low as one of the key principles of professionally autonomous working is that teams take responsibility for many tasks themselves. Hence, administrative costs within an organisation may decrease. However, *Buurtzorg (NL)* and *Grannvard Sverige (SE)*, which were developed from scratch, have considerably lower overhead costs than the existing organisations that introduced the self-managing way of working. Direct variable costs differ depending on the number of self-managing teams and the number of clients in an organisation.

When it comes to the financial results and financial capacity of home care organisations that work via the self-managing way of working, an important role is played by the legal and financial reimbursement systems in place and the healthcare insurers. While the financial results of *Buurtzorg (NL)* have generally been good

through the years, with considerable net profits of up to 13,6 million Euro, in 2013 a net loss of €600.000 was reported. This was due to a modified policy of some Dutch health insurers who do not reimburse Buurtzorg's 'overproduction'. In the Netherlands, production agreements are made between health insurers and care providers. In principal, health insurers pay for the direct and indirect costs (e.g. travel time between clients) of home care provision. But if the care provider produces more care than agreed upon, then this 'overproduction' is the care provider's own risk and comes on the provider's own account.

In Sweden, *Grannvard Sverige* has struggled financially ever since its inception. It aims to break-even, but has not succeeded in this. The reason for this is that in Sweden, home care is financed by the municipalities and each municipality decides itself how much they pay home care organisations per hour for the work they do. Unlike in the Netherlands, indirect costs (such as travel time and administration time) are not covered, only the time directly spent with the client is covered. Hence, the tariffs that are paid by the municipalities are often too low to cover both direct and indirect costs. For *Grannvard Sverige*, this means that approximately 65% to 70% of its productivity is covered by the payments of the municipalities. While municipality's own homecare providers also regularly make losses, they are reallocated money from the municipality's general budget to make up the shortfall. This is not the case for Grannvård Sverige and up to now, Buurtzorg the Netherlands has paid for the losses of Grannvard.

It is too early to report on the financial effects that introducing a self-managing way of working has had for the existing home care organisations in Belgium.

Facilitators and barriers

The fact that the homecare organisations in Sweden and Belgium took *Buurtzorg (NL)* as their example, acted both as a facilitating factor and as a barrier. For *Grannvard Sverige (SE)*, the fact that Ms. Lindström had worked for Buurtzorg (NL) and had experience with working in autonomous self-steering teams, made it easier for her to introduce this way of working in Sweden and explain it to other nurses and nurse assistants who had never worked in this way before. For the home care organisations in Belgium that introduced the self-managing way of working within their existing organisation, it was helpful to learn from the methodology, philosophy and experience of Buurtzorg the Netherlands, and to use Buurtzorg's success to convince the government board of the *WGK Oost-Vlaanderen* of the added value of self-managing teams. On the basis of the results of Buurtzorg, it could be proven that it works.

At the same time, it proved difficult to stick to the original Dutch example in the legal and financial contexts of Sweden and Belgium respectively. For example in Sweden, municipalities have considerable power. As a home care organisation, *Grannvård Sverige* is required to work with the IT-system (for logging client details and billing times) that the municipality in which it operates requires. Hence at this moment, it cannot use 'Buurtzorgweb', which is extremely well tailored to the needs of autonomously working home care nurses. As said before, the financial system in Sweden, in which only direct client time is reimbursed and not indirect costs, also creates a difficult situation for *Grannvard Sverige*. Other smaller barriers were reported in the working of the teams, for example the *WGK Oost-Vlaanderen (BE)* found that it is difficult for teams to reach decisions jointly. Hence, additional training was needed to accomplish this.

Replicability

Over the last years, *Buurtzorg (NL)* has been replicated, to a greater or lesser extent, in other home care organisations in Sweden (*Grannvard Sverige*) and Belgium (*Wit-Gele Kruis Oost-Vlaanderen* and *Wit-Gele Kruis Vlaams-Brabant*), but also in Minnesota, USA and Japan. Based on these experiences, a couple of lessons can be drawn for other organisations that are thinking about introducing the Buurtzorg

autonomous self-managing way of working in home care. Most of these lessons apply both to organisations that start from scratch and existing organisations that want to change their 'traditional' way of working. The crucial factors that need to be taken into account are:

- Legal system around home care: labour laws, freedom of settlement or not, etc. In Sweden for example the form of free choice (LoV) leaves it up to each municipality as to whether private provision of care is allowed, as well as what level of care they are authorised to provide. For example, in Bålsta, one of the municipalities in which *Grannvård Sverige (SE)* is active, nurses are not allowed to provide higher levels of medical homecare even though they have the qualifications to do so. In the Netherlands, Dutch municipalities are not allowed to restrict nurses' practice as this is part of national law.
- Financing system around home care: who is providing the reimbursement? What costs are being reimbursed (e.g. direct costs, indirect costs)? As the Buurtzorg way of working brings with it a lot of indirect costs, countries or organisations that are also thinking about introducing this way of working should make sure that these indirect costs can be covered as well. If not, organisations may not be able to survive financially.
- Knowledgeable people: for introducing the self-managing way of working, people are needed who have knowledge of the Buurtzorg way of working and people who have knowledge of the context and the system in which it needs to be introduced.
- Similar IT-system: by introducing a self-managing way of working, the way information is being shared and administration arranged takes place in a different way than usual within an organisation. Buurtzorg is currently looking how it can adapt its own IT-system Buurtzorgweb to fit other countries' needs. Other organisation can then buy a license to use the system.
- Considerable financial resources: whether organisations start from scratch or introduce the self-managing way of working in an existing organisation, considerable financial resources are needed, either for start-up or for organising and implementing the required changes etc.
- Cultural differences: the Dutch culture has a more open feedback culture than many other countries. This influences how self-managing teams operate.
- Support of an external adviser with expertise in work organisation and change processes can be very useful, especially for existing organisations.
- Introduction from top to bottom of an organisation: the concept needs to be understood and supported by the top of organisations as well. When a manager does not get it and only parts of the concept are being introduced, and compromises are being made, organisations will never obtain the advantages of this way of working.

According to *Buurtzorg (NL)*, each country has to find its own way in how to arrange the autonomous self-managing way of working in home care. If Buurtzorg is asked for help, it provides advice. Buurtzorg supports the local people through GPs, nurses, coaches, the IT-support and often the Director Jos de Blok is involved as well. Because Buurtzorg is involved in this process in multiple countries, it gains experience and knowledge on how you can use the concept in different contexts: "You learn to devise something that fits the history and the culture of that country". What Buurtzorg the Netherlands ideally would like to do is introduce their way of working to another country, show how it works, and then find a partner in the respective country to develop the further growth of the concept.

Effects

For none of the organisations that introduced the self-managing way of working, was staff recruitment and/or retention among the primary aims. However, especially *Buurtzorg (NL)* has proven to be a very attractive place to work for homecare nurses who are fed up with the 'usual' way of providing home care. Except for *Buurtzorg*, the introduction of autonomous working took place too recently to be able to draw any firm conclusions about the effects on recruitment and retention.

Buurtzorg has grown ever since its establishment in 2006. Currently, there are around 700 *Buurtzorg* teams active all across the Netherlands. Turnover resistance in 2013 was scored 9,3 (out of 10) by *Buurtzorg* employees, making it an effective retention intervention. Another important proxy measure for staff retention is sickness absence levels. The average percentage of sickness absence for *Buurtzorg* is slightly lower than two per cent, whereas the average percentage in the home care branch in the Netherlands is 6,5 percent. Considering the fact that *Buurtzorg* has existed since 2006, the effects of recruiting and retaining staff seem to be long-term.

For the other three organisations that are (in the process of) working via self-managing teams, it is too early to draw firm conclusions about its effectiveness on retaining and recruiting staff. Yet all organisations are monitoring the effects of the introduction of the self-managing way of working. The *WGK Vlaams-Brabant (BE)* is specifically looking at staff satisfaction levels and turnover rates, i.e. the ratio in percentage of the number of employees with an indefinite contract who left the organisation in the running 12 months in relation to the total number of employees with an indefinite contract in the running 12 months. The *WGK Oost-Vlaanderen (BE)* will also closely monitor the effects of the introduction of self-managing teams on staff recruitment and retention, specifically whether the new way of working appeals to young people. This is important for the organisation, as it currently has a relatively experienced workforce with an average age of 41 years.





A final striking point is that three of the four organisations, the ones who introduced the autonomous way of working to the greatest extent, received prizes and awards for introducing self-managing home care teams. *Buurtzorg (NL)* won the Effortory award for 'Best Employer' in the Netherlands (with more than 1000 employees) in 2011, 2012 and 2014 and was runner-up in 2013. This title is awarded on the basis of independent employee surveys among at least 300 employees in each organisation. In the category 'Best Employer in Healthcare' *Buurtzorg* has ended on the first place for four years in a row; in 2011, 2012, 2013 and 2014. In September 2014, the *WGK Oost-Vlaanderen (BE)* received the 'Award for Care Organisation 2014' from the European care think tank PRoF for the trajectory it started in introducing the innovative way of working via self-managing teams. And *Grannvård Sverige (SE)* ranked first in a survey that studied how satisfied home care clients are in the Uppsala region in November 2014.

Concluding remarks

The topic on providing good working environments through professional autonomy and worker participation differs significantly from the seven other topics. In this case, the successful way of working of one organisation, has been replicated by other organisations in Sweden and Belgium. This is also the one topic in which R&R was not the primary aim of the organisations, but especially the 'inspiration organisation' *Buurtzorg (NL)* obtains very good results in this area. The role of personal champions in this topic is relatively high compared to the seven other topics; in all four organisations persons are needed who believe in this way of working and want to work hard for it.

4.6. Making the hospital workplace more attractive by improving family-friendly practices

Table 9: cases focused on making the hospital workplace more attractive by improving family-friendly practices

Case	Country	Intervention type	Running time	Case report
6.1. Kindergarten	CZ		2012 – no end	2012 – no end
6.2. Kindergarten	CZ		1950 – no end	1950 – no end
6.3. Dr DOC programme	AU		2000 – no end	2000 – no end
6.4. Health and wellbeing programme	UK		2009 – no end	2009 – no end

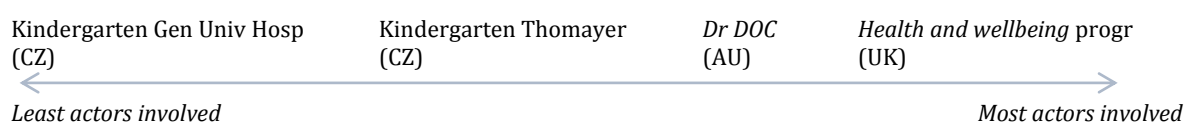
Short description of interventions under this topic

We included four cases under this topic, all situated at organisational level, but with a different focus. In the Czech Republic, the *Kindergartens of the General University Hospital Prague and the Thomayer Hospital Prague* were visited. Because there is a shortage of Kindergarten places in the Czech Republic, both hospitals introduced the Kindergarten to support staff to return to work and attract new staff by being able to offer them a place in a Kindergarten for their children. In both hospitals, nurses are the prioritised group and their children get prioritised access to the Kindergarten.

The *Dr DOC programme (AU)* is a rural workforce health and well-being programme offering both social and emotional support strategies, as well as practical cases, to rural GPs. Examples include an emergency support line and health check-ups. The programme was instigated in 2000 by the Rural Doctors Workforce Agency in South Australia and aims to improve rural GPs' health and well-being. The programme tries to look at the issues of doctor's health and wellbeing and how important that is in retaining doctors.

The *Nottingham University Hospitals NHS Trust (NUH) Health and Wellbeing programme (UK)* for hospital staff was introduced in 2009, although it is a continuation and expansion of an earlier 'Q Active project' that was implemented at NUH in 2005. The programme was introduced for several reasons, including the publication of the Choosing Health White Paper in the UK and the fact that NUH had high sickness levels. The *Health and Wellbeing programme* has multiple aims, including improving the physical and emotional wellbeing of staff and improving staff satisfaction, recruitment and retention. It offers a wide variety of activities, from weekly fitness classes to quarterly health checks to coping with stress-workshops.

Actors – roles, responsibilities and cooperation



Development and implementation

The establishment of the *Kindergarten at the General University Hospital Prague (CZ)* resulted from two different developments. First, there was a request from hospital staff for such a service. While the hospital board was supportive of this idea, and established via an intern study that there really was a potential for it, it had troubles in finding a way to bear the costs of this. Secondly, just after the hospital had once more started discussing the possibilities of establishing a Kindergarten, an Operational Programme Prague – Adaptability (OPPA) call came out with a definition that fitted the needs of the hospital, namely establishing a Kindergarten. When these two things came together, the current Director of the Kindergarten, together with some other people from the Hospital, wrote a plan, received the grant and was able to establish the Kindergarten.

The *Kindergarten at the Thomayer Hospital Prague (CZ)* also received funding from the OPPA fund to support its Kindergarten. However, because the Kindergarten was established in 1950, no information on the early stages of the Kindergarten could be retrieved.

The *Dr DOC programme (AU)* resulted from an idea of Dr Roger Sexton. He was at the time a practising GP in a rural town in South Australia who had an interest in doctors' health and saw the problems they were facing. He approached the Rural Doctors Workforce Agency South Australia because he wanted to try and develop a programme for rural areas. He was then invited to put forward some ideas and worked as a consultant for the programme. Together with Dr Sexton, the RDWA was able to fund the development of his ideas. That is how the core elements of the Dr DOC programme were developed. The RDWA could supply basic funding, but was also able to apply for extra funding to support the ideas.

The *NUH Health & Wellbeing programme (UK)* initially began in 2005 as the 'Q Active' project and was funded externally. This three year project focused exclusively on physical health until funding stopped in 2008. As the project proved to produce positive effects, Nottingham University Hospitals NHS Trust decided to continue funding the programme itself directly. The subsequent main milestones in the implementation of the 'new' Health & Wellbeing programme were:

- development of the health and wellbeing strategy (January 2010)
- recruitment of the health and wellbeing coordinator (May 2010)
- launch of the health and wellbeing strategy via inaugural health and wellbeing week (June 2010)

A health and wellbeing steering group was set up to oversee the implementation of the health and wellbeing strategy and action plans.

Organisational framework/Day to day running

The *Kindergartens in the Czech Republic* are run by the Directors of the Kindergarten and a limited number of staff, predominantly teachers and administrative and housekeeping staff. Apart from their reliability on external partners and the Hospitals for financial support, they seem to operate on a fairly independent basis.

The *Dr DOC programme (AU)* and the *NUH Health & Wellbeing programme (UK)* on the other hand are much more embedded in respectively the Rural Doctors Workforce Agency South Australia and Nottingham University Hospitals Trust. In particular the NUH Health & Wellbeing programme is subject to an extensive organisational framework in which responsibilities are clearly divided. The main actors in the programme are the Health & Wellbeing coordinator and assistant – who are responsible for the day to day implementation and delivery of the programme – instructors who run fitness classes, gym instructors and 3 therapists who provide

complementary and beauty therapies. A health and wellbeing steering group was set up to oversee the implementation of the health and wellbeing strategy and provide directions for the operational group. The health and wellbeing operational group oversees the day-to-day implementation of activities. Some of the Health and Wellbeing programme activity is delivered in partnership with a number of other departments in the Trust, most notably Occupational Health nurses, Physiotherapy, Clinical Psychology and Dietetics. Other partnerships include external partners.

The *Dr DOC programme (AU)* also cooperates closely with an external partner, namely the Doctors' Health SA association, which looks after the health of rural and urban doctors, specialists and medical students. The RDWA is one of the prime board members of Doctors' Health SA and funds this programme. In 2014, the RDWA and Doctors' Health SA made a formal agreement to make sure that they aren't both doing the separate programmes in the same area.

Finances

All four cases receive funding from multiple sources. For the two *Kindergartens* of the Prague hospitals (CZ), significant upfront fixed costs are involved, for example concerning the buildings, equipment, and so on. Operational costs are fairly stable, considering that the *Kindergartens* have a set capacity which is usually fully used. For the Health & Wellbeing programmes in Australia and the UK, upfront costs are limited, but operational costs of the programmes can vary significantly based on the activities that are undertaken.

The *Kindergartens* in the Czech Republic both receive financial support from the respective Hospitals and parents pay a fee for their children to attend. Additionally, both *Kindergartens* received considerable funding from the Operational Programme Prague – Adaptability (OPPA) fund (covering approximately 70% of the costs for both *Kindergartens*). However, OPPA funding is always provided for a limited period of time and at this moment, none of the *Kindergartens* receives money from this fund. The way they dealt with the resulting financial gap after the OPPA funding stopped differs between the *Kindergartens*. In case of the *Thomayer Hospital Prague*, the Hospital took on the operational costs that used to be funded by the OPPA and the *Kindergarten* could continue as before. The *General University Hospital Prague*, on the other hand, saw itself forced to increase the fees that parents have to pay (these more than doubled), which has resulted in a decreasing number of applications for the *Kindergarten*.

The two health and wellbeing programmes, the *Dr DOC programme (AU)* and the *NUH Health & Wellbeing programme (UK)*, both receive some 'structural' funding and search for additional funding for specific activities or parts of the programme. The *Dr DOC programme* is funded by the Australian Government and the State Government of South Australia. The RDWA receives funding to provide recruitment and retention support and the *Dr DOC programme* is still seen as a retention programme. In addition, the RDWA has been able to acquire extra funding for specific parts of the *Dr DOC programme*, such as the visiting health check-ups.

The *NUH Health & Wellbeing programme (UK)* is embedded into the organisation through continued funding of the post of the Health & Wellbeing Coordinator, who is employed on a permanent basis. However, there is no structural operating budget. There is a small budget for the project, which is provided through the cash back from the Cycle2Work scheme provider. Additional funding for specific activities is sought through the Hospital Charity staff lottery. The lottery has been very supportive and generous to activities of the Health & Wellbeing programme, such as the health & wellbeing week. Fitness classes, the gym and the wellbeing therapies are self-funded through the fees that staff pays to take part.

Because there are limited upfront costs for both health and wellbeing programmes, organisations can relatively easily consider different models of funding to cover operational costs. For example, the retreats that the *Dr DOC programme (AU)* used to organise for doctors were provided free of charge, because the RDWA had obtained specific funding for this, but may also be offered in a model of co-payment between a providing organisation and attending doctors.

Facilitators and barriers

Facilitators

All organisations mention the importance of having the right people in the right place to make an intervention into a success, as well as the importance of cooperation throughout. Both *Kindergartens in the Czech Republic* point out the importance of having a good team to make the Kindergartens work well, the importance of having the right experienced people in the right place, and of writing a sound plan for the OPPA fund to obtain funding. Another positive factor for the *Kindergarten of the General University Hospital Prague* is its location in the middle of the city centre.

One of the key things that made the *Dr DOC programme (AU)* work in the early stages was that there was an individual champion, Dr Roger Sexton, and an organisation champion, the Rural Doctors Workforce Agency. This was a strong partnership that was of crucial importance. Another thing that made the Dr DOC programme work was that it was well communicated to the rural areas and people were aware of the programme.

The main reason for the success of the *NUH Health and Wellbeing programme (UK)* has been partnership working. The key partnership is between human resources and occupational health at NUH. This was developed at the outset of the programme and is being continued throughout.

Barriers

While the *Kindergarten of Thomayer Hospital* does not report any big problems, except for 'everyday problems' relating to maintenance of the place, or personal or interpersonal issues, the *Kindergarten of the General University Hospital Prague* is struggling with one main issue, namely financing. The Kindergarten was never free of charge for parents, but this was gradually accepted. However, the inevitable increase in fee amount after the OPPA funding stopped in November 2014 has had a negative impact on the number of clients of the Kindergarten and the number of clients that applied to start in December (see also above). This is creating problems in terms of sustainability.

For the *Dr DOC programme (AU)*, the costs of certain parts of the programme, combined with practical difficulties, meant that certain activities had to be stopped. The main problems were encountered in the area of the health check-ups. It was, for example, economically and practically unfeasible to continue making visiting health check-ups to GPs in rural areas, because this took a lot of time and money. However, no other main problems have been reported.

The main challenge for the *NUH Health and Wellbeing programme (UK)* is making the programme accessible to all staff, particularly those who work shifts and find it more difficult to access the onsite services. In addition, funding the activities is an area of constant attention.

Replicability

A clear divide must be made in terms of replicability between the *Kindergartens* in the Czech Republic and the *Dr DOC programme (AU)* and *NUH Health and Wellbeing programme (UK)*, which are both staff support programmes. The divide is mainly related to the costs involved and the effects that the cases sought. The Kindergartens

are expensive to run and are only an option for fairly large organisations. The effects of (not) having a Kindergarten are immediate and short term, also considering the fact that employees only need this service when their children are of a particular age. The health and well-being programmes for staff, on the other hand, can be introduced in organisations of any size, although economy of scale should be taken into account. Organisations can for example develop their own programme or 'outsource' parts of the programme, depending on their size. The upfront costs are fairly limited and the effects can be long lasting. Moreover, measures taken under these programmes can be continued even after the programme itself has ceased to exist.

Hence, conditions for replicability for the *Kindergartens* are:

- Securing sufficient financial resources
- If a grant application needs to be written, it pays to let this be done by a knowledgeable person in the organisation who has experience with this or, if available, a special unit within the organisation. This increases the success rate of the application.

For organisations that are also thinking about establishing a health and wellbeing programme, crucial factors that need to be taken into account are:

- The programme requires additional funding. Should the organisation not be able to cover this itself, external funding needs to be searched.
- Economy of scale: setting up a health & wellbeing programme is feasible for an organisation such as Nottingham University Hospitals Trust with a staff head count of more than 14.500. Smaller organisations may want to consider providing their staff with free or reduced memberships for fitness schools, quit smoking therapies, etc. instead of developing their own programme.

Effects of the interventions

Effects on recruitment and retention

None of the organisations is monitoring the effects of their family-friendly practices on recruitment and retention of staff. For the *Kindergartens* in the Czech Republic, the main reason for this seems to be that it is too difficult to establish a direct link between the effects of the *Kindergartens* if you relate these to the size of the organisations. The *Kindergartens* have only limited capacity and the organisations are very large. Moreover, the Kindergarten of Thomayer Hospital informed us that when the hospital board sees that the Kindergarten is full, and that a large proportion of the children come from hospital staff, they know that the service is needed and they don't need to do any other statistics for this. Both *Kindergartens* stressed that the fact that the Kindergarten exists has a positive effect on the willingness of people to work in the hospital or to remain working there, especially considering the limited capacities in state-run *Kindergartens*.

There are no results available, and there is no monitoring or tracking, of the influence that the *Dr DOC programme (AU)* has on retention of rural GPs in South Australia. The coordinator of the *Nottingham University Hospitals Health & Wellbeing programme (UK)* informed us it is difficult to establish a direct link between the programme and recruitment and retention rates of NUH.

It should be noted that the potential effects of the *Kindergartens (CZ)* on recruitment and retention are direct but per definition of short duration. In the first place because they are only there when the *Kindergartens* are in operation. Once a Kindergarten opens its doors, it can immediately start having an effect. However, the day a Kindergarten closes its doors, it loses its (potential) effectiveness in recruiting and/or retaining staff. Secondly, the childcare facilities are only available for children in the

age of 3 – 6 years, and for Thomayer Hospital 0 – 3 years as well. Once children have got older than that, the 'problem' is solved for parents and the fact that their employer offers a Kindergarten, loses its attracting/retaining function.

The *Dr DOC (AU)* and *NUH health and wellbeing programmes (UK)*, on the other hand, will not immediately show an effect but do hold potential long-term effects which can last long after the support programmes themselves have ended. Not only because, for example, the skills obtained in coping with stress will last a lifetime, but also because support networks between GPs that were formed in the framework of the programme, can continue functioning after the programme itself has ceased to exist.

Proxy measures

The success of the *Kindergartens* in the Czech Republic can be established based on their occupancy. The *Kindergarten of Thomayer Hospital* is functioning well and is fully occupied, having more demand than supply. It has a capacity for 48 children, divided over two classes. The childcare facility for children from 0 – 3 years currently takes care of around 12 children and there is capacity for a couple more children. The *Kindergarten at the General University Hospital Prague* has a much lower occupancy; it has capacity for 24 children but per November 2014 only takes care of 7 to 8 children. This is problematic in terms of financial sustainability (see above).

Even though the direct effects of the health and wellbeing programmes on recruitment and retention cannot be established, there are indications that both programmes are successful in this regard. In 2004, five years after the establishment of the *Dr DOC programme (AU)*, fewer GPs had the intention to leave their practice within two to five years. In addition, it was reported that more GPs took care of their physical health and there were modest improvements in psychological well-being. In 2006, significant improvements were found in the level of feeling socially supported and a decrease in the number of GPs in crisis with no help. The conclusion of the researchers in 2006 was that "the Dr DOC programme provides a useful framework for future programmes aimed at reducing levels of stress and dissatisfaction among rural GPs and for reducing the number of GPs leaving rural practice".











At Nottingham University Hospitals, sickness absence rates came down significantly since the *NUH Health and Wellbeing programme (UK)* started; from 4.1 % in 2009 to 3.4% in 2013. NUH now has one of the lowest sickness absence rates in the UK. Moreover, significant progress was made on a number of key health and wellbeing indicators, such as number of staff sick for more than 28 days with mental health problems (from 3% in 2009 to 2.2% in 2012) and the percentage of staff suffering from work related stress (from 33% in 2009 to 25% in 2011). NUH has also been recognised for its health & wellbeing programme. It featured as a case study of best practice in the Final Report of the independent NHS Health & Well-being Review and was awarded a gold certificate in the NHS's Sport and Physical Activity accreditation scheme. The Trust has also been recognised by NHS Employers as a Healthy Staff Champion.

Concluding remarks

If we set the interventions included under this topic – making the hospital workplace more attractive by improving family-friendly practices – against the R&R interventions included under the seven other case topics, we see that these are more often situated at organisational level. Moreover, the interventions more often ask time investments from participants and employers have to agree with this.

4.7. Return to practice for healthcare professionals

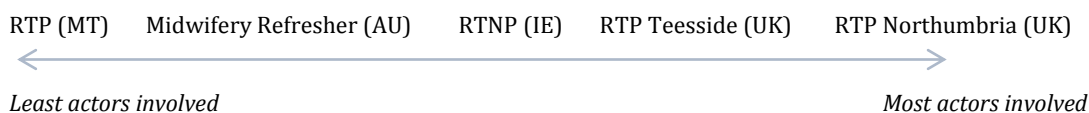
Table 10: Cases focused on return to practice measures for healthcare professionals

Case	Country	Intervention type	Running time	Case report
7.1. Return to Practice course	UK	 	1987 – no end	Appendix 7.1
7.2. Midwifery Refresher Programme	AU		2002 – 2005	Appendix 7.2
7.3. Return to Nursing Practice	IE	  	2006 – no end	Appendix 7.3
7.4. Return to practice measures	MT	 	1980s – unknown	Appendix 7.4
7.5 Return to Practice course	UK	 	1999 – no end	Appendix 7.5

Short description of interventions under this topic

All five cases included under this topic encompass educational measures, supported by attractive financial conditions, to support nurses, midwives and/or health visitors that used to be in the workforce to re-enter their profession. The *Return to Practice courses at Northumbria University, Teesside University and Tallaght Hospital and the Midwifery Refresher Programme at the Mater hospital* in Australia are situated at organisational level, whereas the government of Malta provided the *retraining courses for nurses*. Some of these programmes have run for a longer time than others and this is directly related to the time at which the respective countries were facing a shortage of healthcare professionals.

Actors – roles, responsibilities and cooperation



The way in which the RTP programmes came into being differs between the various courses. When *Northumbria University (UK)* started its course, it looked at an example from a nearby hospital (Alnwick Infirmary) and took this as starting point to develop its own RTP course. This took place on an informal basis of mutual exchange between the organisations. The *Mater Mothers' Hospital* in Australia undertook a formal review of midwifery refresher programmes to identify key elements and issues. Based on this review and in collaboration with the Australian Catholic University, it designed its own programme. Tallaght Hospital in Ireland was the only organisation to undertake a pilot Return to Practice course during the development phase of the course. On the basis of this pilot case, later Return to Practice courses were adjusted.

Currently, the content of the RTP courses is roughly comparable between the five cases, although the lengths of the programmes vary. All courses have a theoretical component and a clinical component and students are supervised and mentored during their clinical placement. Moreover, the institutions have limited freedom in determining the content of their courses. In the UK, for example, in 2014 a national toolkit has been developed by Health Education England which explains what the programmes should look like, what is the responsibility of the university, what is the responsibility of the clinical placement providers and what should be a joint thing. In Ireland, all RTP courses must be approved by the Nursing and Midwifery Board of

Ireland. In Malta, responsibility for the RTP courses lies with the Health Division of the Ministry of Health.

In the day-to-day running of the courses, different partners fulfil different responsibilities. The educational institutions provide the RTP programmes in partnership with local healthcare institutions that provide the clinical placement for students. The organisations that are responsible for the course, usually the educational institutions, fulfil a bridging role between the higher education providers and the partner placement providers, for example in making sure that enough practical placements are available. During clinical placements, students are supported and assessed by qualified mentors. The person who will take up the voluntary role of mentor is a responsibility of the practice placement provider.

Finances

Almost all RTP courses are funded by national policy bodies. Courses are almost always free of charge for participants and often they receive additional financial benefits for attending and/or finishing the course. Costs are fixed upfront as most programmes have a maximum capacity. The funding for the *RTP programmes at Northumbria University and Teesside University (UK)* are entirely paid by Health Education North East, there are no fees for students from this region. To enable healthcare professionals to return to practice, HENE in addition provides participants with a financial contribution of £500 (€630). The *RTNP course at Tallaght Hospital (IE)* is provided through a funding agreement between the Department of Health and Children and healthcare institutions. Participants receive a bursary to attend the course of €1500 from the Irish Health Service Executive. Participants that remain working in the public sector 6 months after completing the course get a further €1500 bursary. For the RTP courses in Malta, no funding information could be retrieved, although it appears as if the Malta Ministry of Health provided this.

The *Midwifery Refresher Programme at the Mater hospital (AU)* does not receive funding from policy bodies. Resources to develop and implement the Programme were readily available internally at the Hospital and through its existing collaborative partnership with the Australian Catholic University. Student fees were shared between the hospital and the university. Participants do pay a fee to attend the Programme, but this is kept considerably low compared to usual fees for postgraduate education.

Finally, it is important in thinking about the costs of these programmes that given the costs of educating new nurses, it is likely that the benefits of recruiting back nurses will always more than outweigh the costs.

Facilitators and barriers

The main barrier that the majority of the RTP courses are facing relate to time resources. Too little time has explicitly been made available to run the courses, predominantly in terms of educational time and in terms of mentoring/support time. For example at *Tallaght Hospital (IE)*, barriers in the running of the course had to do with staff availability to teach on it. Because there was no extra funding available for the programme, original staff had to take on an extra workload. Other difficulties are reported in the area of clinical placement. First of all, it is a constant challenge for educational institutions to find enough clinical placements for their students. The second challenge lies in ensuring that there is enough mentoring (a voluntary role) available in the clinical areas. Moreover, the mentor role is quite extensive and sometimes difficult to accomplish in practice because of a lack of designated time and space.

Facilitators in the programme are mainly related to the combination of theory and practice, regardless of the difficulties that are encountered in that area. Another strength of the programmes reported by *Northumbria University (UK)* is that there is an extensive application procedure. People are supported from their first phone call

onwards and this ensures that successful applicants have a higher chance of successful graduation.

For the *Mater Mothers' Hospital (AU)*, one of the success factors in establishing its Midwifery Refresher programme seems to have been the cooperation between the Hospital and the Australian Catholic University. It enabled both organisations to run the programme on a cost neutral basis. Moreover, the involvement of both clinical and academic staff strengthened the alliances of the two organisations by enhancing collegial relationships and increasing awareness of issues in education and service delivery, with the potential for further joint educational ventures. Another thing that made the programme very attractive for participants was the fact that it had limited impact on family life. To decrease the need for after school childcare, the theoretical sessions were planned within school hours and a flexible approach to scheduling of clinical hours was adopted. It is likely that the flexibility in terms of family life increased the uptake of the programme.

Replicability

The Return to Practice courses can be a helpful tool for organisations in all countries that are facing shortages of particular groups of healthcare professionals. When establishing a Return to Practice course, a number of crucial factors need to be taken into account:

- Include both a theoretical and practical component in the programme.
- Ensure that mentors in clinical practice, who take on this role on a voluntary basis, feel rewarded. If financial compensation is not possible, efforts should at least be made to ensure that mentors get designated time and a private space on the ward, to fulfil their mentoring duties.
- To increase the success rate of the programme, it is desirable to work through application procedures to make sure that potential students are ready for the RTP course.
- Create attractive financial conditions for potential students to follow the course.
- As many course participants will be (female) adults with family responsibilities, make sure that the course is designed in a flexible way so that it fits with participants' other responsibilities in life.
- Partnership working between educational institutions and clinical placement partners is essential. A clear divide of responsibilities contributes to a smooth running of the course.
- Finally, it is important in thinking about the costs of return to practice programmes that given the costs of educating new healthcare professionals, it is likely that the benefits of recruiting back professionals will more than outweigh the costs.

Effects of the interventions

Effects on recruitment and retention

Not all courses are following up their graduates to see whether they have secured employment after finishing the course. If they do so, data quality is often sketchy. For example *Northumbria University (UK)* and *Teesside University (UK)* used to track graduates with a self-administered questionnaire to establish whether they secured employment. This produced unreliable results. Therefore, in the future Health Education North East will track students' employment in local Trust's employment databases through their Nursing and Midwifery Council (PIN) Personal Identification Number. It is hoped that this will improve the quality of employment data. The *Midwifery Refresher Programme at Mater Hospital (AU)* is considered a successful

recruitment strategy with an employment rate of approximately 90% following completion of the Programme. However, no follow up data are available to determine how long midwives remain in practice afterwards. The *RTP courses in Malta and at Tallaght Hospital (IE)* are not monitoring their students after graduation.

The effects of the courses on recruitment/retention should become visible within three months of finishing the RTP programmes, considering the fact that graduates will need to go through application procedures, etc. Currently, if data on employment rates are being collected, this tells us something about the ability of participants to secure employment, not about the long-term effects. Moreover, these data apply to the success rates of the RTP courses and are not necessarily informative about the recruitment and retention rates of healthcare institutions.

Proxy measures








All organisations evaluate their *RTP programmes* via participant surveys and some also use additional measures such as focus groups. There is a high level of satisfaction among participants with the courses, especially in terms of enhancing confidence in returning to practice and meeting their learning needs. The *Midwifery Refresher Programme of Mater Hospital (AU)* also reported an additional advantage of the Programme in that it enhanced the job satisfaction of existing midwifery staff who worked with the students. Staff commented positively on students' enthusiasm and the opportunity to be involved in the programme.

Concluding remarks

In comparison to the other seven topics, the Return to Practice courses are characterised by their homogeneity; almost all RTP courses are funded by national policy bodies, free of charge for participants and often participants receive additional financial benefits for attending and/or finishing the course. Moreover, the important role of mentors in practice to turn the courses into success, clearly distinguishes these interventions from the other topics in the study.

4.8. Providing supportive working environments for the ageing workforce

Table 11: Cases focused on measures to support the ageing workforce

Case	Country	Intervention type	Running time	Case report
8.1. PAIME programme	ES		1998 – no end	Appendix 8.1
8.2. Wir sind älter als 50, na und?	DE	 	2000s – no end	Appendix 8.2
8.3. Various measures	IT		1990s – no end	Appendix 8.3
8.4. Livsfasepolitik	DK	  	2008 – no end	Appendix 8.4

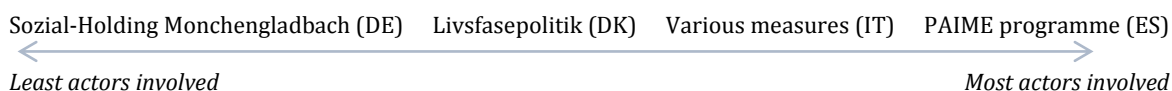
Short description of interventions under this topic

We included four cases under this topic. The *Programmea de Atención Integral del Médico Enfermo (PAIME)* [Comprehensive Care Programme for Sick Doctors] in Spain is a care programme aimed at promoting and protecting the health of physicians and make sure that doctors with mental health and/or addictive problems receive the care they need. The *Sozial-Holding der Stadt Mönchengladbach GmbH (DE)* has taken a number of measures to support the ageing workforce that is employed in its homes for the elderly. In the *Italian healthcare sector*, various measures have been taken over the last years to improve the working conditions of the aging working population and in Denmark, *Aalborg University Hospital* established a framework on how to create

attractive and flexible jobs so as to meet the individual employee's life situation, based on the regional *Livsfasepolitik* [*Life Stage Policy*].

The cases included under this topic are fairly diverse, yet they share a number of important characteristics. Most of the measures have run for over a decade, except for the implementation of the *Life Stage Policy at Aalborg University Hospital (DK)*, which took place in 2008. All encompass elements of professional and personal support and all are made up of multiple measures, or at least multiple 'options' in supporting the ageing workforce. For example the *Sozial-Holding der Stadt Mönchengladbach GmbH (DE)* offers, among other things, educational opportunities as well as a seminar and mental health support programme for the ageing workforce, whereas the implementation of the *Life Stage Policy at Aalborg University Hospital* has resulted in measures focusing on the organisation of work, education/competencies, and changes in working hours. Most cases were 'newly' invented, but the *PAIME programme (ES)* explicitly followed similar experiences of other countries, e.g. the Canada and the USA, which showed how specific programmes for ill doctors outperform general population services for this patient group, resulting in fewer dropouts from practice and a higher level of rehabilitation.

Actors – roles, responsibilities and cooperation



Two of the cases originated from the organisational level – the *PAIME programme (ES)* and the measures of the *Sozial-Holding der Stadt Mönchengladbach (DE)*. The other two cases show a clear dynamic between national/regional policies and their consequences for measures (to be) taken at organisational level. As a result of policy developments that gradually increase the pension age, the *Italian health system* has grown from a working population which was never too old, to a perspective of a working population with a considerable amount of senior workers. Consequently, various measures have been taken in to improve the working conditions of the ageing working population, including the exemption of persons with advanced age and/or reduced work capacity from working night shifts. In Denmark, the *Livsfasepolitik* [*Life stage policy*] was introduced by regional authorities to ensure that 'organisations act according to the different needs and requirements of different life phases'. Hence, the policy is specifically aimed at what organisations should do and is clearly a top down initiated measure. It is formulated very broadly and the region's sectors and local committees may draft local agreements and guidelines, as long as they are consistent with the broad outlines of the policy. Based on and within the realms of the regional *Livsfasepolitik*, Aalborg Hospital established a framework on how to create attractive and flexible jobs so as to meet the individual employee's life situation.

The *Programmea de Atención Integral del Médico Enfermo (PAIME)* was created by the College of Physicians of Barcelona and is executed by the 'Colegio de Médicos' of each Spanish region. 'Colegios de Médicos' are institutions where all practising doctors in Spain need to be registered. They act as Medical Associations and Regulatory Bodies (or Medical Councils). Every 'Colegio de Médicos' in Spain offers a PAIME outpatient service to their registered physicians. There is only one PAIME inpatient unit, located in Barcelona. The regional or national policy level is not involved in the execution of the programme, although some regions do finance the programme (see below under 'Finances').

The *Sozial-Holding der Stadt Mönchengladbach GmbH (DE)* also initiated the measures for its ageing workforce on its own initiative, based on an increasing awareness that the proportion of older workers would increase substantially in the future. It should be noted however that even though both cases were developed at organisational level, there is a difference in scope between the PAIME programme and the Sozial-Holding: PAIME is a national programme whereas the measures that the Sozial-Holding took only apply to staff working in its homes for the elderly.

Most of the measures that the Sozial-Holding has introduced were developed by the Sozial-Holding itself. In the execution of the measures, it cooperates with various partners. Of crucial importance is the Agentur für Arbeit [Agency for Employment]. Two other important partners are the Katholische Bildungsstätte für Gesundheits- und Pflegeberufe, which provides the theoretical education for the three year education for adults to become an elderly care nurse, and the Katholischen Forum für Erwachsenen- und Familienbindung which provides the Seminarprogramm 50+ that the Sozial-Holding is offering to its 50+ staff.

Finances

Information about the financial implications of interventions aimed at supporting the ageing workforce could only be retrieved for the two interventions that originated at the organisational level; the *PAIME programme (ES)* and the measures that the *Sozial-Holding (DE)* has taken. It should be noted that cost-efficiency was never the starting point for these interventions. The costs for both interventions are considerable and are largely variable, based on the number of ill physicians and older workers that make use of the opportunities offered. To be able to access the PAIME programme, doctors must have ensured that the financial costs of using the service are covered (either by reaching an agreement with the regional health authority level, providing for costs themselves, etc.). Participation in the activities that the Sozial-Holding is free for staff and there are no financial access criteria.

The costs of the *PAIME programme* amounted to €1.877.860 in the year 2011-2012. The programme is funded by the Colegios de Médicos [Medical Associations], the Fundación Patronato de Huérfanos y Protección Social de la Organización Médica Colegial (OMC) [Foundation Board and Social Protection of the Spanish Medical Colleges Organization] and most Administraciones sanitarias [health authorities]. However, because of the deep economic crisis that Spain is faced with, many regional health authorities have had to lower or even stop their contribution. The Fundación Patronato de Huérfanos y Protección Social de la Organización Médica Colegial, with its main mission to ensure solidarity among all registered doctors, by protecting and helping those (and their families) that need it, aims to ensure that all doctors that require help via the PAIME receive help.

Just as the PAIME programme, the costs of the measures that the *Sozial-Holding* is taking are considerable and also shared between different organisations. While the Sozial-Holding pays for the mental health support that it is offering to its employees and for the courses that employees follow in the Seminar 50+ programme, costs for the three year education for adults to become elderly care nurses are shared between the Sozial-Holding, the Agentur für Arbeit Mönchengladbach and the ARGE Jobcenter Mönchengladbach. The General Manager of the Sozial-Holding states that even though all the measures cost a lot of money, in the end the Sozial-Holding is more cost-efficient.

Facilitators and barriers

Because of the diverse nature of the cases included under this topic, it is difficult to establish overarching facilitating and obstructing factors. For the *PAIME programme (ES)*, we found that its confidential nature and fast way of working were key factors in the success of the programme. For the instructions that were developed for seniors employed in Occupational and Physical Therapy Department of Aalborg University

Hospital, based on the regional *Livsfasepolitik (DK)*, it was the freedom that the policy offers to adjust it to own needs that is considered a crucial success factor.

Barriers were reported in Italy around the implementation of the 2003 Biagi reform, to increase the pension age, because of long confrontations between the government and the unions (social partners). At organisational level, the 'cultural idea' to encourage early retirement hampers the introduction of measures aimed at supporting the ageing workforce.

Replicability

For all four interventions to be successfully replicated, a fair amount of financial resource is indispensable. Moreover, the *PAIME programme (ES)* and the measures taken by the *Sozial-Holding (DE)* require a large organisational framework. The *PAIME programme*, with its elaborative support structure with outpatient services and even an inpatient unit, can only be accomplished at national or (large) regional level. The measures that the *Sozial-Holding* introduced, e.g. offering mental health support and an own Seminar programme, can be accomplished by large organisations or cooperation between (comparable) healthcare organisations.

The measures taken in *Italy* and by *Aalborg University Hospital*, based on the regional *Livsfasepolitik (DK)*, touch to a large extent on issues of working conditions and working time. Oftentimes, these stand in close relationship with labour laws and labour conditions in place. Hence, these factors should be taken into consideration. In principal, however, these sorts of measures can be useful for organisations of any size, although the consequences of having to replace the night shifts for a senior employee may be different for larger organisations (with lots of manpower available for substitution) and smaller organisations.

Effects of the interventions

The impact lag of the interventions included under this topic varies from medium to long-term. Support programmes, seminar programmes and other similar measures, take their time to show an effect (if they do so at all). Where measures are concerned which linger on national or regional policies, implementation and acceptance at organisational level usually take time as well.

None of the interventions is evaluating the impact that the measures have on retaining the ageing workforce. For the measures taken in *Italy* and by *Aalborg University Hospital (DK)*, no evaluation or process measures were available at all. However, anecdotal evidence for the *Occupational and Physical Therapy Department at Aalborg Hospital* suggests that only a very limited number of senior employees use the opportunities in the department's policy for seniors, and that there is more need for specific disease policies instead of age policies.

The *PAIME programme (ES)* has helped more than 3.500 physicians since its inception in 1998. Of the doctors that have been treated by the *PAIME programme*, close to 90% per cent have recovered and been rehabilitated into the practice of medicine. Hence, these doctors have been retained for medical practice, while it is certain that without the *PAIME programme*, a substantial percentage of this group would have (been forced to) leave the profession. The *PAIME programme* is available to medical doctors from all ages, but it is mostly used by older doctors (> 51 years). In 2011, more than one third of participants were from the age category 51-60 years. And in 2012, their share had grown even further to 40%. More than half of the participants of the *PAIME programme* in 2012 were 51 years or older.

The *Sozial-Holding (DE)* does not gather information on recruitment and retention, but process measures show a high success rate for the individual measures that it has taken for the ageing workforce. For example by introducing free mental health support

for its employees, the Sozial-Holding Mönchengladbach was able to halve the number of mental health illness days since May 2012. And of the 21 adults who started their education in November 2009 to become elderly care nurses, 18 graduated in November 2012. Moreover, the Sozial-Holding has received numerous awards for its commitment to workplace health and age management.

Concluding remarks

In comparison to the other seven topics included in the study, the interventions to support the ageing workforce are characterised by their diversity. They are situated at different levels, from national policy level to organisational level, and employ a wide variety of measures to support the ageing workforce.

5. Conclusions

This report presents the findings of the eight case studies that were conducted on recruitment and retention (R&R) interventions. The aim of this study was to gain further insight into how R&R interventions are developed and implemented at both policy and organisational level, under what conditions, what the role of various actors is and what facilitators and barriers are present throughout this process. Based on input from the literature review (WP2), country respondents (WP3) and experts on recruitment and retention, and following a stepwise selection procedure, eight case topics were included in the study. The overarching theme is "Context specific R&R: matching professional needs and health system priorities". The eight selected topics take the order of a professional life cycle and are:

1. Attracting young people to healthcare
2. Attracting and retaining GPs to strengthen primary care in underserved areas
3. Providing training, education and research opportunities for a life-long career
4. Attracting nurses through the extension of practice and development of advanced roles
5. Providing good working environments through professional autonomy and worker participation
6. Making the hospital workplace more attractive by improving family-friendly practices
7. Return to practice for healthcare professionals
8. Providing supportive working environments for the ageing workforce

The study was guided by a series of scientific questions about how best to address recruitment and retention of health professionals in the context of the European Union.

5.1. Answers to the scientific questions

1. What are the roles and responsibilities of the various policy actors and stakeholders in the design and development of interventions to recruit and retain health professionals? How do they cooperate to shape strategies? How is the role of recruitment agencies governed?

Almost all interventions that were included in the study involved multiple actors, sometimes in complex configurations. Most often cooperation, to a greater or lesser extent, took place between national and regional policy levels (including various executive agencies), individual healthcare institutions, educational providers and/or local workforce agencies. In none of the cases that were studied did recruitment agencies play a role. The role of professional associations was relatively limited. Only in the case of the *PAIME support programme* for ill doctors in Spain did the Spanish medical association prove extremely important as initiator of the programme.

The partnerships that were formed were sometimes ratified through a formal cooperation agreement or Memorandum of Understanding. In cases where one organisation makes use of the resources of another organisation, license agreements are usually drafted between the organisations. License agreements were for example signed between *Flying Start NHS Scotland* and *Flying Start Queensland Health*, and will be signed between *Buurtzorg (NL)* and other home care organisations that will

start working with resources developed by Buurtzorg, such as the IT-system Buurtzorgweb.

However, in some cases cooperation took place on an entirely informal basis. This was for example the case in the *Salzburger Pflegeoffensive (AT)*, irrespective of the complex set of arrangements and high number of parties involved in this initiative, including the state of Salzburg, city of Salzburg, Diakoniewerk Salzburg, the Salzburger Landeskliniken, several other healthcare institutions in the region and the Arbeitsmarktservice Salzburg. The reason for this was that most of the partners involved already had exchange and cooperation agreements in place with the state of Salzburg in other areas. Hence, for the Pflegeoffensive, the 'informal cooperation' worked well for all parties involved. This enabled the partners to achieve a high degree of cooperation, with as little overhead as possible. The partners that are involved in the *NHS Tayside Healthcare Academy (UK)*, on the other hand, all have a service-level agreement with NHS Tayside. NHS Tayside had never worked with these organisations before. Hence, the need for formal cooperation agreements seems more urgent for partners that have no history with each other than for partners which already collaborate(d) on other issues.

How cooperation is practically enacted, for example in terms of the number of times that all partners meet each other for joint consultations, varies between interventions and can change during the running time of an intervention, depending on the phase in which the intervention finds itself. For example, the partners in the Danish *Hvid Zone campaign* met on an ad hoc basis. In the beginning there were quite a few organising meetings but as time went by, meetings became less frequent and much was dealt with via email. There seems to be no golden standard for this.

Yet one important facilitating factor in cooperation seems to be that all relevant parties should be involved in an intervention right from the start. In Estonia, for example, with the introduction of the beginners allowance for young doctors, this was and is not the case. Educational institutions are not involved in the programme and this hampers communication about this financial benefit to potential beneficiaries. On the other hand, the involvement of the Hungarian Resident Doctors Association at the beginning of the *Hungarian Resident Scholarship programme* was a key factor to the success of the programme. The *Pacte territoire santé* in France, aimed at attracting GPs to underserved areas, was developed by the Ministry of Health in close consultation with medical associations, local associations, local and regional territories representatives, and so on. All parties were involved right from the beginning in order to facilitate a smooth implementation and uptake of the *Pacte* during later stages. Or, as was stated by the Arbeitsmarktservice for the *Pflegeoffensive (AT)*, which worked in the same way: when all parties can participate in the decision making and see what their role is, then it is easier to continue the process afterwards.

For interventions that are developed at national level and implemented and executed at regional or organisational level, there is a constant reciprocal process taking place between the actors at national level and the actors at regional or organisational level. In Australia, the extension of *nurses' roles and functions* mainly resulted from decisions taken at state policy level in response to the predicted shortage of nurses. In New South Wales, for example, the Department of Health developed protocols related to task substitution that had to be implemented by individual institutions and organisations to take effect. At the same time, individual public hospitals in the state redesigned how nurses provide care, within the realms of what the law allows, as a result of the developments taking place at policy level. In France, the *Pacte territoire santé* is mostly developed at national policy level and implemented via the regional health authorities (ARS). In their turn, the ARS provide the national Department of Health with feedback, upon which the (measures of the) *Pacte* are adjusted where needed.

Where responsibilities for interventions lie at national or regional policy level, and interventions are implemented and conducted at organisational level, it is important to realise that discrepancies can arise in the shape that interventions take and hence in the R&R results that they seek. Depending on the nature of the interventions, this can be an advantage or may cause problems. If we look at the *Return to Practice courses* that were included in this study, we found that most of them are guided by broad national guidelines that they must adhere to, but individual healthcare institutions and educational institutions have considerable freedom in the precise elaboration of the curriculum. This means that programmes can easily be adapted to local needs. The same applies to the top down initiated *Livsfasepolitik [Life stage policy]* in Denmark – which offers a broad outline so that organisations can tailor the policy to their own needs – and to the case of the *Care Ambassador campaign (BE)*, where provincial platforms can use the campaign and the material and initiatives that are taken at central level, and apply and adjust them to their own local level. According to the Care Ambassador, this is one of the reasons for the success of the Campaign.

However, problematic results were also found because of the discrepancy between nationally developed guidelines and the diverse manner in which they are implemented and run at individual healthcare organisational level. The day-to-day running of the *Flying Start NHS Scotland programme*, developed by NHS Education for Scotland, is an individual healthcare organisation's responsibility. Consequently, organisations use the health system's programme differently. Some make it mandatory for new employees, others not, et cetera. Because of this plurality, it is hard to monitor the effects of the programme and to improve the programme content.

In some of the cases that were included in the study, individuals were of crucial importance, especially in the developmental phase of interventions. Their passion, credibility as healthcare professionals and their ability for coalition building proved extremely important. For example the *Australian Dr DOC programme*, which supports rural doctors, was the idea of Dr Roger Sexton, a well-respected GP. He acted as an individual champion during the early phases of the programme, was passionate and wanted to work hard for the programme. He did this in a strong partnership with the Rural Doctors Workforce Agency South Australia, whom he had approached and who supported his idea by acting as organisation champion. The same mechanism can be seen at work in the development of the *NHS Tayside Healthcare Academy*. Ms Debbie Donald developed the idea for the Healthcare Academy, was passionate about it, challenged prejudices in the organisation, was able to convince Mr Alan Boyter, who was the HR Director at the time, and together they were able to further develop the idea, build coalitions within NHS Tayside and convince the Board. In the case of the *Belgian Care Ambassador*, Mrs Lon Holtzer already had a lot of credibility in the field and was able to build from that as a platform to reach out to the provinces and organisations. In the case of *Buurtzorg the Netherlands*, it is safe to say that the organisation would never have existed without Mr Jos de Blok. Being a home care nurse himself, with management experience and a background in business administration, Jos de Blok had long envisioned a new care model in which nurses would provide community care in self-directed teams, supported by new technology and minimal administrative oversight. In 2006, together with Mrs Gonnine Kronenberg, he started the first Buurtzorg team from his home. In the years that followed, Buurtzorg quickly expanded.

Finally, for interventions that take place at an organisational level and provide some sort of support to students or healthcare professionals, the role of individual mentors cannot be underestimated. For medical interns, new staff participants in support programmes (e.g. *Graduate Nurse Programmes or Flying Start*) and participants of *Return to Practice* courses who are conducting their clinical placement, the support of a mentor in the clinical area is of crucial importance. In almost all programmes in

which mentors are involved and that conducted an evaluation survey, including the *Midwifery Refresher Programme in Australia* and *Flying Start*, participants reported that the best aspects were being supported and encouraged, while absence of supervision in the workplace was mentioned as one of the least useful aspects. Despite this importance, in many of the cases studied, time barriers were reported in the fulfilment of the mentor role. Often no designated time is made available for this. Moreover, mentors are not being (financially) rewarded for this additional role, which lowers their willingness to take up the mentoring role.

2. What is the interaction and coherence of various policy measures in health, education, employment and labour market to recruit and retain health professionals? Are there legal barriers to certain types of policy measures to recruit and retain health workers?

While the majority of cases included in our study explicitly had increased recruitment and/or retention of healthcare professionals as the point of departure, some interventions had other primary aims and considered their positive influence on recruitment and/or retention as implicit sub-aims or by-effects. For example, the four cases focusing on professional autonomous home care were mainly introduced to increase the quality of home care provision and improve patient outcomes. The positive effects on staff recruitment and retention were of secondary importance. Likewise, some of the measures introduced in the French *Pacte territoire santé*, such as allowing hospital doctors to support outpatient facilities in rural or mountain areas some days of the week, are primarily meant to increase the quality of patient care but simultaneously may increase doctor's job satisfaction. Whether recruitment and/or retention were the explicit primary aim of an intervention or not, appears to have little influence on the R&R outcomes of interventions. For example, *Buurtzorg (NL)* is highly successful in terms of recruiting and retaining staff.

Most of the R&R interventions that were included in our study were 'isolated' measures in the sense that they were not explicitly part of a coherent package of measures. Only three of the included cases constitute an explicit coherent package of measures, i.e. including different sort of measures from different domains. These are the *Pflegeoffensive Salzburg (AT)*, the *Care Ambassador campaign (BE)* and the *Pacte Territoire-Santé (FR)*. All three combine domains such as attracting new students with focusing on the unemployment pool in society or introducing task substitution. However, there also were a number of interventions which incorporated different elements and hence cannot be considered 'isolated' measures in the strict sense of the word, such as the *Dr DOC programme in Australia* (e.g. health check-ups, retreats, emergency support line), the *NUH Health & Wellbeing programme* (e.g. fitness classes, Spiritual and Pastoral care, smoking cessation) and the extensive *health-and age management policy of the Sozial-Holding der Stadt Mönchengladbach* (e.g. education, mental health support, seminar programme). Having said that, this does not mean that the other 'isolated' measures completely stand on their own. Almost all cases do in some way (un)consciously connect to- or build on existing measures and initiatives. For example, *Flying Start NHS Scotland* complements the NHS Knowledge and Skills Framework (NHS KSF). This means that the portfolio of evidence that new staff produce as part of Flying Start NHS can be used for their NHS KSF review, which is required for all NHS staff. The *Resident scholarship programme in Hungary*, aimed at supporting young medical doctors who participate in specialist training, through its requirement that resident doctors do not accept informal payments during the time they receive the scholarship, supports other measures which are taken in Hungary to stop informal payments, which also have an impact on recruitment and retention.

An important finding of our study is that a number of legal barriers have been reported for the included R&R interventions. These mainly related to cases focusing on task substitution and extended roles for health care professionals. However, in practice, legal barriers often turn out to be manageable and do not seem to result in not introducing these measures. What appears to be more common is that the introduction of measures becomes delayed (where legislation changes are required) or that the measures themselves are being adjusted to fit the legal framework. For example, the introduction of some of the measures included in the French *Pacte de territoire santé* are being delayed because legal measures are needed before they can be introduced. This is for example the case for the measures that allow hospital doctors and staff to support outpatient facilities and for the further development of teamwork. Also, in introducing a new financing system in the 'Maisons de Santé Pluriprofessionnelles', negotiations between social partners need to be finalised before anything can be changed. A change in the law on financing of social security was needed to relax the system and simplify the framework of the signing of CEPA contracts (employment contracts for public service).

An example of where a recruitment and retention intervention needed to be adjusted to fit the legal framework can be found with the Swedish *Grannvård Sverige* home care organisation. Swedish law leaves it up to each municipality as to whether private provision of care is allowed, as well as what level of care home care organisations are authorised to provide. Grannvård's home care nurses are highly educated to fully fulfil their autonomous role. Because municipal laws sometimes prohibit Grannvård nurses from performing tasks for which they have the educational qualifications, this leads to adjustments in their autonomous way of working. If they didn't agree to this, they wouldn't be allowed to work at all (for example in the municipality of Bålsta). Moreover, both *Grannvård Sverige* and *Buurtzorg (NL)* are struggling with the financial framework in which they are required to operate.

Another factor which influences the development and introduction of recruitment and retention interventions, and the way in which they can be implemented, is formed by labour market composition and conditions. For example, in France, the interest in the labour market, especially among (young) physicians, to work in independent practice is declining. Hence, one of the measures included in the *Pacte territoire santé* is aimed at developing teamwork. This measure is introduced all across France, but it is already clear that it is particularly successful in underserved areas. On the other hand, the wish for some nurses to remain working on a self-employed basis for which they are paid by fee-for-service (14.6% of all French nurses in 2009), hampers the uptake of measures aimed at task substitution and increased co-operation between doctors and nurses.

The influence of labour market conditions on R&R interventions becomes especially clear when interventions are being transferred from one context to another. After all, if interventions are developed in the context in which they will be applied, labour market conditions can be taken into account. An example of this is the replication of the professionally autonomous way of working in home care, originally introduced in the Netherlands by Buurtzorg, in the Belgian context. Because of the different labour laws in both countries, as well as the different ways of financing home care, the two Belgian home care organisations that introduced this way of working needed to make adjustments to adapt it to their context. The same would apply to many of the identified measures that focus on the ageing workforce; for example the measures taken in *Italy* and by *Aalborg University Hospital*, based on the regional *Livsfasepolitik (DK)*, touch to a large extent on issues of working conditions and working time. Often, these stand in close relationship with labour laws and labour conditions in place.

3. How are strategies developed within healthcare organisations and how do national and regional policies frame those strategies?

The genesis of interventions at the organisational level is varied and partly depends on the nature of the intervention. Some of the cases included in our study were new interventions, i.e. the idea for the intervention needed to be developed from scratch. This was for example the case for the *Healthcare Academy (UK)*, the *Dr DOC programme (AU)*, the *Flying Start NHS Scotland programme*, *Buurtzorg (NL)* and the measures that the *Sozial-Holding (DE)* took for its ageing workforce. For these new R&R initiatives, the ideas were often further developed via coalition building (for example with education providers, job agencies, etc.), partly focused on obtaining funding.

For R&R interventions that already existed, either in their own organisation or elsewhere, the most important steps in the development phase appeared to be a thorough orientation phase and 'testing' of the intervention. In this way, organisations did not need to reinvent the wheel and start-up problems could be detected at an early stage to prevent them from developing into structural problems. For example, after Queensland Health had identified the need for more structured support for new starters, it made the choice to utilise an existing programme. An investigation into existing programmes was conducted and revealed *Flying Start NHS* as an option. Likewise, Calvary Health Care ACT conducted an extensive literature review and focus groups when it wanted to reform its *Graduate Nurse Programme* and Northumbria University took the *Return to Practice programme* of a neighbouring hospital as point of departure for developing its own programme. Some organisations (subsequently) conduct some 'testing' before fully introducing the intervention. For example, *Tallaght Hospital (IE)* conducted a pilot Return to Practice course and the home care organisation *WVGK Oost-Vlaanderen* initially started with six 'expedition teams' to incrementally introduce the new professionally autonomous way of working in the organisation. Generally, organisations that introduce a recruitment and/or retention intervention do so in an incremental way and offer (financial) support where necessary. For example, NHS Scotland provided all individual NHS Boards with funding to support them in implementing *Flying Start*.

The influence of national and/or regional policies on R&R interventions developed at organisational level takes place in different ways and manifests itself at different phases of the development and implementation process of interventions. Considerable influence is executed in the originating of interventions, either directly or indirectly. We saw for example that for years, the municipality of Jyväskylä did not permit the *Huhtasuo health centre (FI)* to hire more nurses, to fill the gaps in care provision that existed because of the lack of GPs. We also saw that the Return to Practice courses in the UK and Ireland were instigated because of national programmes or rulings by the Department of Health. Other interventions also show a direct link between national or regional policies and their founding. The *Rural Clinical School at the University of Queensland* was established in response to the national Rural Clinical School initiative, *Flying Start NHS* was commissioned by the Scottish Executive Health Department, *Aalborg University Hospital (DK)* adjusted its "Instructions for Seniors employed in Occupational and Physical Therapy Department" in response to the introduction of the regional Life Stage Policy, and the *Health & Wellbeing programme at Nottingham University Hospitals* started as the 'Q Active' project partly in response to the publication of the 'Choosing Health White Paper' in the UK around that time. However, policies can also indirectly contribute to the establishment of certain interventions. Because the Czech Republic faces a shortage of public Kindergartens, resulting from reactive municipality policy in this area, the *General University Hospital Prague* and the *Thomayer Hospital Prague* saw themselves forced to run their own *Kindergartens*, in order to (re-)employ staff who struggled to find childcare for their child. In

Germany, developments in society, including the decision to increase the pension age, raised awareness in the *Sozial-Holding der Stadt Mönchengladbach* that it should focus on specific measures for its ageing workforce.

The second way in which national and regional policies can shape interventions developed at organisational level is in the way these interventions are implemented. Organisational interventions often work within national frameworks. For example, the *Rural Clinical School* operates within the framework as set by the Australian Department of Health, and the *Return to Practice courses* in the UK need to fit the national toolkit for the content of RTP courses. However, this does not necessarily have to be a problem, as long as enough space is left for organisations to adjust the practice to their own local needs. This was for example the clearly the case for the *Life Stage Policy (DK)* that was top down introduced from regional policy level but could be introduced based on own needs by Aalborg University Hospital.

The policy level also executes influence via financial arrangements. For example, in the case of the *Salzburger Pflegeoffensive*, the financial construction around the *Pflegestiftung* was partly dictated through the fact that policy requires that the *Existenzsicherung* [livelihood security] for participants is paid through the *Arbeitslosenversicherung*, which the Republic of Austria is required to pay. This was beneficial for the *Pflegestiftung*, as none of the partners involved had to appeal to its own resources for this. However, national financial frameworks can also raise obstacles in the successful working of interventions. For example, the financial system surrounding home care in Sweden, which only reimburses direct costs and not indirect costs, is unfavourable for *Grannvard Sverige*.

Finally, national and regional policies influence the effects that recruitment and retention interventions at organisational level can have. When the Irish Health Service Executive imposed a staffing embargo and organisations were not allowed to recruit nationally, there was no point in healthcare and educational institutions running their *Return to Nursing Practice courses*. Often the influence of national or regional policy on interventions at organisational level is more subtle though. An important factor is political (in)stability and (dis)continuity. The degree of political stability or continuity not only influences whether funding for interventions will be continued or not, but also the negotiations that are going on between the organisational and political levels. For example in Sweden, the home care organisation *Grannvard Sverige* was in an advanced stage of negotiations with actors at municipality level to change the home care tariff system. However, after elections were held, resulting in a political shift, negotiations had to be started again from scratch. Hence, the level of political (dis)continuity can have a significant effect on the working of interventions, in particular for interventions which have a longer impact lag and whose development may be ended before effects could reasonably be expected.

While generally, national and regional policies frame interventions at organisational level, in some cases an inverse influence is also visible. For example, the pilot projects that were conducted in France at organisational level in the wake of the Berland report, showed that task substitution could be a promising way to solve existing staff difficulties in healthcare. Based on these positive results brought forward by 'the work floor', the Ministry of Health decided to include *article 51 in the Law "Hôpital, patients, santé et territoires"* and enabled the formal arrangement of task substitution. After its initial reservations, the Jyväskylä municipality in Finland is impressed by the good results that are being obtained by the nurse-oriented Huhtasuo health centre, and it now wants to introduce the *nurse-oriented care model in other health centres* in Jyväskylä as well. In Australia, locally developed new ways of providing nursing care were publicised across the public hospital sector through the Models of Care Roadshow. This Roadshow was funded and organised by the NSW Nursing and

Midwifery Office, an agency of the NSW Ministry for Health, to showcase existing examples of innovation and engage the profession in debate around the way in which nursing and midwifery care is practised and delivered. Hence, the interventions developed at organisational level were picked up and disseminated by the NSW Department of Health. In France, the national Department of Health also tries to work as a 'disseminating vehicle' for interventions that are being developed at local level in light of the *Pacte territoire santé*.

4. Is the "effectiveness" of interventions to retain health professionals defined, monitored and measured? If yes, what methods and indicators are used, for example, to monitor staff turnover and to measure the benefits of staff retention in terms of reduced costs, improved organisational performance and quality of care?

The large majority of recruitment and retention interventions that were included in our study do not use an explicit definition of "effectiveness". In the vast majority of cases, goals are described fairly vaguely, such as: 'increasing the number of healthcare professionals' or 'supporting healthcare professionals to stay in the profession'. Measurable targets are barely mentioned, although there are a few exceptions: the *Hvid Zone campaign in Denmark* clearly stated its goal to "increase the number of persons entering training in the fields of nursing, radiography and medical laboratory technology by 44%". The *Pacte territoire santé (FR)* used to attract GPs to underserved areas also has some defined objectives, such as providing 1500 *Contract d'engagement de Service Public* in 2017.

Only a minority of the interventions included in our study have been the subject of evaluations by researchers and/or policy makers, these were mostly interventions from Anglo-Saxon countries. Most of the studies used an observational design.

It is likely that many of the interventions will consider achieving their – imprecisely described – goals as evidence of their effectiveness. In this sense, most of the included cases are in some way trying to look at the effects that they have on recruitment and/or retention numbers of staff, but they do so in different ways. A rough divide can be made between interventions which take national, regional or organisational data as 'effect measure' (e.g. national student enrolment numbers in nursing education or vacancy rates for healthcare assistants) and interventions which take the results of *their own participants* in terms of recruitment and/or retention as 'effect measure' (e.g. the number of participants of an Return to Practice course that has found employment 3 months post-graduation). Both approaches have their advantages and disadvantages. National and regional data, for example on vacancy rates or student enrolments, are usually already being monitored by agencies and readily available. However, it is difficult to establish a direct causal link between these results and a specific measure taken because of the high amount of confounding variables involved. Interventions which are looking at recruitment and retention results of their participants are able to establish a much more direct link, but their results are per definition limited to the intervention and have 'little value' for recruitment and retention effects at organisational level, let alone regional or national level.

Which particular 'effect measures' are used depends on the type and goal of particular interventions. The cases which take national or regional data as effect measure, are mostly looking at student enrolment numbers in healthcare education, changes in vacancy rates, total number of staff at different points in time and sickness absence rates. For some countries that suffer from a high outflow of healthcare professionals, predominantly Eastern and Southern European countries, the number of healthcare

professionals requesting a verification certificate for working abroad can also be a retention measure. For interventions that take the results of their own participants in terms of recruitment and/or retention as 'effect measure', the employment rates for graduates of (RTP) education and satisfaction levels with the intervention are the most important measurements. Time taken to replace staff and staff stability index (i.e. the proportion of staff that was in post at the beginning of the year that were still in post at the end of the year) are less often used. The cost-effectiveness of measures is almost never taken into consideration, as this is too complex to establish.

Effects are, almost without exception, only being monitored for a short while. As a result, only short-term effects of interventions can be established. For example, graduates from (return to practice) healthcare training are often followed up to establish whether they have secured employment, but only until a couple of months post-graduation. Whether they are still employed (in healthcare) after a number of years, remains unknown. This is problematic, also because for some (types of) interventions, it may take a while for effects to start to show.

A small number of included cases do not monitor the effects of the intervention at all. This is not related to a certain type of intervention, but can be found across all eight topics. Where people are not monitoring effects, this is often related to the difficulties in establishing a direct link between the specific intervention and (proxy measures) for recruitment and retention rates. The *Kindergartens in the Czech Republic* for example stated that it is too difficult to establish a direct link between the effects of the Kindergartens with their limited capability if you relate these to the size of the hospital organisations. Sometimes, the considerable time lag that interventions take before effects become visible is mentioned as a reason for not monitoring. This for example applies to the *extension of nurses' practice and roles*. Finally, for some cases, staff recruitment and/or retention are just not among the primary aims. However, these interventions can still have a direct and indirect effect on recruitment and retention. For example, general effects of interventions, such as better coverage of health needs in rural and underserved areas by a better geographical distribution of doctors, may also have an effect on recruitment and retention.

While effects on recruitment and retention are not always being monitored, and where they are have to deal with a number of difficulties and limitations, almost all interventions do monitor effects focusing on the process level, for example the number of programme participants, the amount of promotion being conducted, the number of scholarship applications, number of registered users, etc. etc.). Moreover, oftentimes surveys are being conducted which ask participants about the usefulness of interventions and possibilities for improvement.

5. What are the principles and processes which characterise successful as well as not successful initiatives? What can policy-makers and health managers learn from what works, what does not work and why?

As explained under question 4, most interventions do not mention specific objectives or targets. Therefore it is difficult to establish a rate of successfulness. However, across the eight topics and 40 individual cases studied, a number of facilitating elements and characteristics could be identified. It is important to emphasize that these do not necessarily result in 'effective' recruitment and retention interventions, either in terms of national/regional/organisational R&R outcomes or the 'R&R outcomes' of the intervention itself (e.g. number of participants that finds a job). However, to increase the potential successfulness of interventions, our case study research identified the following factors and characteristics as being of significant importance:

- *Individual champions.* Especially in the developmental phase of interventions, individual champions can be of crucial importance. Through our case studies, it was shown that individual champions in recruitment and retention interventions in healthcare often share a number of strengths: their passion, their credibility as (former) healthcare professionals and their ability for coalition building and developing a platform to embed the intervention in a wider context.
- *Create a support base for the intervention, from its inception onwards.* To achieve this, communication towards and consultation with all relevant stakeholders is a crucial factor. Several of the cases included in our study showed that involvement of all parties at the beginning of an intervention facilitates a smooth implementation- and uptake of the intervention during later stages. Actors are then aware of the intervention, can participate in the decision making process, feel valued, etc. These factors facilitate the processes that will follow.
- *Resource management.* Especially time resources need to be thoroughly managed. In the case studies, we found examples of cases where too little time was made available (from managerial or policy level) to implement and run interventions. We also identified cases where administrative processes were made too complex and hence time-consuming.
- *Financial resources.* For most interventions, a certain degree of financial resource is indispensable for being successful. Almost all cases included in our study received funding to cover start-up costs and most interventions remained receiving funding afterwards, sometimes from different sources. Moreover, while all interventions would welcome more financial clout, some interventions were functioning suboptimally because of a lack of financial resources. It is important to note that while interventions may generate cost-savings, for example the *Kindergartens in the Czech Republic* may save their hospitals money in searching for new staff, this often does not result in money flowing back to the interventions itself.
- *Action plan:* To have an action plan from the start of an intervention, including some well-defined targets, ensures a certain dynamic and advancement in the running of the intervention.
- *Incremental process.* Although, looking at the included cases, this appears not to be a well-tried approach in R&R interventions, the execution of a pilot can be extremely helpful in preventing problems during the later stages of an intervention. What is more common, and just as important, is that an incremental step-by-step implementation process is used for interventions. This allows for subtle adjustments along the way and may prevent bigger problems in later stages.
- *Sufficient internal technical expertise to conduct the intervention, supplemented by external professionals when required.* R&R interventions sometimes hinge heavily on qualities that are situated with different professionals (e.g. promotional campaigns often hire professional marketing/communication agencies for developing the campaign).
- *Right framework.* Interventions developed at organisational or local level need to be aware of the obstacles which regional or national legal and financial frameworks can raise and where possible adjust the intervention to this.
- *Communication.* Without timely and full communication about interventions to relevant stakeholders and target groups, the potential success rate of an intervention may descend. There are two main reasons for this: stakeholders may feel left out, resulting in a lack of commitment. Secondly, for an intervention to be picked up, people first need to be aware of the intervention.

5.2 Possibilities for replicability

One of the aims of the 'Effective Recruitment and Retention Strategies for Health Workers' study is to foster European cooperation so that countries can learn from each other's experiences and possibly exchange recruitment and retention interventions. At this moment, little cooperation seems to take place in this field. We did not identify any pan-European or multilateral recruitment and retention intervention. For some topics we did find interventions taking place on a bilateral basis though. For example, the *Flying Start programme* was transferred from Scotland to Queensland, Australia via a licensing agreement. Moreover, the *Buurtzorg* way of working from the Netherlands was taken as an inspiration and replicated in Belgium, whereas in Sweden a sister organisation was established. Yet overall, cooperation remains very limited. This does not seem to result from unwillingness. Several interventions, for example, started with conducting a (literature) search for other interventions that already existed, so they could be inspired by them (e.g. the *PAIME programme* in Spain and the *Return to Practice course* at Northumbria University). Moreover, during the interviews we conducted in the context of this study, many interviewees showed a great interest in the other R&R interventions that were included and were keen on learning more about them. The results of this case study research come towards these needs and contribute to sharing good practices and help and inspire policy makers and HRH managers to identify possible solutions for R&R in the health sector. While there may not be any cross-country recruitment and retention initiatives, funding is more regularly taking place via a pan-European fund. The European Social Fund was a recurring financial resource among interventions from all across Europe.

The degree to which R&R interventions can be replicated in other contexts within Europe depends on a number of factors:

Degree to which an intervention is influenced by the institutional and policy context

- Promotional campaigns to attract youngsters to healthcare are fairly easily transferable to other countries/contexts. While the content may need to be adjusted, based on specific contextual needs, the 'form' is highly transferable and can be introduced relatively independent of the context. Other interventions which can be introduced fairly independent of institutional and policy contexts are family-friendly measures to make the workplace more attractive and return to practice courses. These interventions will need to be adjusted to the specific context, but the context does not form a barrier. In other words, the establishment of a kindergarten will have to meet different conditions in different countries, but Kindergartens can in principal be introduced across all countries.
- The introduction of task substitutions and/or extend nurses' roles as a way to increase nurses' recruitment and retention depends on the legal and policy context of a country. The same applies to introducing the professional autonomous way of working in home care; the legal context, labour laws and reimbursement system in place in countries highly influences the working of the intervention.

Economy of scale

- Whether countries and/or organisations will be able to replicate an intervention depends on the size of the problem, the size of the target group and the size of the executing policy body/organisation in the 'adopting' country.

Financial resources available

- Some recruitment and retention initiatives cost fairly little money. For example, as in Sweden, employers can make agreements with (university) hospitals for collaboration and exchange. For many universities and university hospitals across Europe this will already be

The degree to which R&R interventions can be replicated in other contexts within Europe depends on a number of factors:

the case. However, they could use this much more in their 'hospital marketing' activities.

- On the other hand, scholarship programmes or financial incentives to attract GPs to underserved areas, can take considerable financial resources. Moreover, purely financial incentives are 'tricky' when they are attractive compared to the domestic labour market, but still considerably low when compared to labour markets in neighbouring countries.

5.3. Strengths and weaknesses of the study

The study benefits from a number of strengths, including the approach that was taken in selecting the case studies. There is a strong link between the mapping review, the input from country respondents and experts on recruitment and retention, and the case studies that are presented in this report. Because of this rich input, a high number of countries was covered in the case studies (n=21) and interventions were situated at both policy and organisational level.

Another major strength of the study lies in its case study research approach. This allowed us to study the complex phenomena that R&R interventions are, within their legal, policy, and organisational context, and to answer important 'how' and 'why' questions. Moreover, our research design was based on commonly acknowledged quality criteria for case study research, which we will discuss below and apply to our study (Cohen and Crabtree, 2008; Yin, 2009).

- Carrying out ethical research: our research has been approved by the Medical Ethical Committee of University Hospitals Leuven (BE) and King's College London (UK).
- Construct validity, i.e. the quality of the measurement instrument:
 - Multiple sources of evidence: for data collection, we made use of desk research, telephone/email interviews and case site visits. We gathered both secondary quantitative data and primary and secondary qualitative data.
 - Establishing chain of evidence: we achieved chain transparency by structurally referring to data sources and including some quotes from interviews and other data sources.
 - Member checking: interviewees were sent a summary of the interview to check for accuracy and provide feedback.
- Internal validity, constructing a plausible chain of evidence: for most cases, we were able to secure data triangulation (e.g. secondary quantitative and/or qualitative data and/or interview data) and we performed member checking (summary reports interviews). Data analysis was performed by a team of researchers.
- External validity, the domain for which findings can be generalized: by performing cross-case analysis among cases from different countries, we could determine to what extent certain findings hold true for different contexts. Moreover, this enabled us to establish criteria for replicability.
- Reliability, i.e. making the results of case studies less dependent on the original researchers and contributing to objectivity:
 - Case study protocol: at an early stage in the study, we developed a case study protocol, including an extensive topic list for interviews.

- Pilot case: a case study protocol is considered stronger if it not only contains the design and data collection plans but also shows some pilot testing hence, we conducted a pilot case for the 'Zorgambassadeur' (case 1.2) and refined the study protocol on the basis of this pilot.
- Case study database: we established a case study database.
- Interviews were conducted by one or more members of the research team. Because the same topic list was used as a starting point during all interviews, interview data could easily be compared.

One of the limitations of the study is the unequal balance between Western and Northern European countries and Central and Eastern European countries. Even though we strived for an equal representation of countries in the study, it proved more difficult to identify suitable cases from Southern and Central and Eastern European countries. This can be due to a number of facts; less recruitment and retention interventions may be available in these countries. Moreover, interventions in these countries may be less well documented. Lastly, language barriers may have prevented us from identifying these cases, although the input from country respondents in WP3 should have intercepted this potential bias. Another related potential weakness of this study is the fact that for some included cases, required language skills were not available within the research team. However, we have tried to mitigate this by working with local informants who could act as translators. For example, for the site visit to the two Kindergartens in the Czech Republic, interviews were conducted by a member of the research team together with the local informant Veronika di Cara (Czech Nurses Association), who was able to provide translation assistance where needed.

A final remark concerns the representativeness of the case studies presented in this report. The case studies are not representative of generalised experiences all across Europe, nor do they claim to be, but they do illustrate in some detail how certain countries and organisations respond to specific problems in the recruitment and retention of healthcare professionals. While results are not generalisable to cases similar to the one(s) studied, our cross-case analysis among cases from different countries, did allow us to determine to what extent certain findings hold true for different contexts.

References

Cohen, D. J., & Crabtree, B. F. (2008). Evaluative criteria for qualitative research in health care: controversies and recommendations. *The Annals of Family Medicine*, 6(4), 331-339.

Crowe, S., Cresswell, K., Robertson, A., Huby, G., Avery, A., & Sheikh, A. (2011). The case study approach. *BMC medical research methodology*, 11(1), 100.

Huicho, L., Dieleman, M., Campbell, J., Codjia, L., Balabanova, D., Dussault, G., & Dolea, C. (2010). Increasing access to health workers in underserved areas: a conceptual framework for measuring results. *Bulletin of the World Health Organization*, 88(5), 357-363.

Eisenhardt, K.M. & Graebner, M.E. (2007). Theory Building from Cases: Opportunities and Challenges. *Academy Management Journal*, 50(1): 25-32.

Foerstl, K., Reuter, C., Hartmann, E., & Blome, C. (2010). Managing supplier sustainability risks in a dynamically changing environment—Sustainable supplier management in the chemical industry. *Journal of Purchasing and Supply Management*, 16(2), 118-130.

Jelfs, E., Knapp, M., Giepmans, P., & Wijga, P. (2014). Creating good workplaces: retention strategies in health-care organizations. *Health Professional Mobility in a Changing Europe*, 345.

Stake, R.E. (1995). *The art of case study research*. London: Sage Publications Ltd.
Yin, R.K., 2009. *Case Study Research*, fourth ed. Sage, Thousand Oaks, CA.

World Health Organization. (2010). *Increasing access to health workers in remote and rural areas through improved retention: global policy recommendations*. World Health Organization

Appendix 1.1. Case report 1.1

Topic 1. Attracting young people to healthcare

Case 1.1. The *Salzburger Pflegeoffensive*, Austria



Research methods applied:

Desk research: August – September 2014

Case site visit: November 2014

1. Summary of the intervention – *Salzburger Pflegeoffensive, Austria*

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Education Financial incentives Personal and professional support
Professional group(s) targeted	Nurses and social professionals (i.e. carers or in German: <i>Pflegehilfe</i>)
Level of intervention	Regional policy level
Type of organisation	Several organisations, including the city of Salzburg, state of Salzburg, Arbeitsmarktservice Salzburg, Diakoniewerk Salzburg, several healthcare institutions in the region.
Kind of services provided by organisation	Various services
Size of organisation	Mostly medium to large organizations
Area covered	The state of Salzburg, Austria
Intervention period / duration of intervention	The <i>Pflegeoffensive</i> started in the autumn of 2010. The name as such is no longer used, but there is no expected end date for most of the measures.
Key actions	Several packages of measures have been introduced, including the introduction of a <i>Pflegestiftung</i> .
Financial investment	Considerable financial investments are required. For the <i>Pflegeoffensive</i> , these are provided by the state of Salzburg, the city of Salzburg, the <i>Arbeitsmarktservice</i> , <i>Diakoniewerk</i> and individual healthcare institutions.
Implementation strategy or processes used	The <i>Salzburger Landesregierung</i> approached the various partners involved in the <i>Pflegeoffensive</i> and asked them how they could contribute.
Day-to-day running of the intervention	At the start of the <i>Pflegeoffensive</i> and during crucial meetings, all partners would come together. But for the day to day execution of their role, they worked mainly independently.

Personnel investment	Additional HR is required but relatively limited. Most measures could be integrated in existing frameworks.
Outcome measures of the intervention	The <i>Pflegeoffensive</i> as such has not been evaluated, individual measures have though. Up to 2014, 197 persons graduated through the <i>Pflegestiftung</i> . The number of people that find a job is significantly higher than in the other Implacement foundations.

2. Rich description of the intervention

Establishment of the *Salzburger Pflegeoffensive*

In the Autumn of 2010, the state of Salzburg, in the person of the Salzburg Regional Minister for Health and Social Affairs Gabi Burgstaller, started the so-called *Salzburger Pflegeoffensive* (in English: 'Salzburg Nursing Offensive') including a package of measures to recruit and retain nurses which has been extended in the years thereafter (Salzburger Landeskorrespondenz, 2011). The name *Pflegeoffensive* is no longer used and the public marketing has ceased since 2014. However, most measures are being continued by the various partners (Beck, 2014; Steinlechner, 2014).

Reasons for the establishment of the *Salzburger Pflegeoffensive*

The *Pflegeoffensive* was started by the Salzburger Landesregierung to reduce the growing shortage of qualified nurses that was found by the Salzburger Landeskliniken, the Diakonie and the City of Salzburg (Steinlechner, 2014). Even though the opportunities to become a nurse are becoming more diverse in Austria, it has proven to be difficult to fill training places. In the spring of 2010, for example, only 26 of the 60 places that were offered by the Salzburger Landeskliniken were filled and in autumn 2010 only 66 of the 90 places available were filled (Salzburger Landeskorrespondenz, 2011). In the year 2020, there will be an expected shortage of 599 carers (535 nursing staff, 64 nursing assistants) in the hospitals of the state of Salzburg. This corresponds to a shortage of around 13 percent. At the same time, there will be an expected shortage of 311 carers (93 nursing staff, 218 nursing assistants) across the nursing care facilities of the social sector in the state of Salzburg, corresponding to a shortage of around 10 percent. Decisive for this are the increasing demand and the loss of staff mainly through retirements (Rottenhofer et al., 2013).

Decreasing the shortage of nurses is also expected to counteract the related and massive care- and support problem that Salzburg is facing (Rottenhofer et al., 2013).

Objective of the intervention

The goal of the *Pflegeoffensive* is to reduce the growing shortage of qualified nurses in the state of Salzburg (Salzburger Landeskorrespondenz, 2011).

Key objectives of the *Pflegeoffensive* are to (Rottenhofer et al., 2013):

- Increase the number of education places and the quality of nursing education
- Increase the attractiveness of the nursing profession
- Increase staff retention
- Increase the efficiency of health and care provision by competence-oriented analyses

Type of intervention

Promotional campaign, including a package of measures for the recruitment and retention of nurses and social professionals (i.e. social caregivers in elderly care, care assistants, etc.).

Professional group(s) targeted

The *Pflegeoffensive* is targeted at recruiting and retaining nurses and social professionals (i.e. carers or in German: *Pflegehilfe*), and recruiting people into appropriate educational pathways. Via the *Pflegestiftung*, part of the *Pflegeoffensive*, special attention is being devoted to people who are currently unemployed and women who are returning to work (Salzburger Landeskorespondenz, 2011).

Level of the intervention

Regional (Salzburger) policy level.

Area covered

The state (in German: *Land*) of Salzburg in Austria. In 2012, the focus of the *Pflegestiftung* was on the mountain districts in Salzburg (Salzburger Landeskorespondenz, 2013).

Running time of the intervention

The *Pflegeoffensive* was started in autumn 2010. While the political marketing of the *Pflegeoffensive* has ended now, the process and the measures continue, including the *Pflegestiftung* and the *Diakonie Implacement-Stiftung Salzburg*. The *Pflegestiftung* will continue till the end of 2016. It will then be decided whether an extension is needed and meaningful. There is no expected end date for the *Diakonie Implacement Stiftung* (Steinlechner, 2014; Winding & Zlöbl, 2014).

Implementation strategy

When the Salzburger Landesregierung started thinking about how to solve the predicted shortages of nurses, back in 2008, 2009 they approached a number of parties, including the Arbeitsmarktservice Salzburg and the Diakoniewerk Salzburg (Steinlechner, 2014; Winding & Zlöbl, 2014). Hence, the *Pflegeoffensive* was an impulse from the Landesregierung and the labour market policy and other actors only reacted when asked.

The Salzburger Pflegeoffensive

To achieve the goals of the *Pflegeoffensive*, three interdependent packages of measures were introduced (Rottenhofer et al., 2013):

- Measures in the area of recruitment
- Measures in the area of education
- Measures in the area of retention

1. Measures in the area of recruitment

Support initiatives that make nursing more visible and popular

Initiatives which are already making nursing more visible, such as the Salzburg nursing days (ww.pflege-salzburg.at, "Junge Pflege" etc.), were supported and promoted. The aim is to ensure networking and cooperation between health and social services institutes and to give interested people a practical insight into the nursing profession. In addition, the Salzburger Landeskliniken in 2012 and 2013 held a communication campaign entitled "Take care of your dream!", which was very successful.

Occupational guidance

Personal contacts are of great importance in the course of career choices. "Care Ambassadors" should provide realistic information about nursing (for example through anecdotes, responsibility and the consequences of nursing activities) and share their "passion" with pupils of general education and vocational schools.

Professional orientation internships

Short-term effective and transparent regulated transition solutions for easier access paths in nursing and creating incentives for this

With the establishment of the *Implacementstiftung Pflege* there is already an instrument of support available in Salzburg that should be continued. In the future, the training fee for nursing students ("pocket money") should be competitive with the training fee of other professions. Professional development opportunities should be offered. In particular, thought should be given to enabling Fachkarrieren for nursing assistants and helpers.

2. Measures in the area of education*Increasing the number of training places*

To achieve a higher number of nursing graduates in a timely manner, training places should be increased from the year 2013. With the increase of training places, an increase in the teaching staff must be achieved as well.

Short-term effective and transparent regulated transition solutions for easier access paths in nursing and creating incentives for this

Training of additional health and nursing school teachers

The training of teachers for health and medical care is offered part-time as part of a university training course. The next university course for teachers in health and care professions (Master of Health Professional Education) will begin in Salzburg only in the spring of 2015.

Two concrete measures being taken in the area of education are the introduction of the Pflegestiftung in 2010 and the introduction of the Diakonie Implacementstiftung. These will be discussed in more detail below.

3. Measures in the area of retention*Development of a strategy for the systematic improvement of working conditions*

Individual measures to improve working conditions should target participation and individuality in the service plan development, health promotion and the development of age-appropriate roles. As a sustained and systematic strategy, the findings of the magnet hospital studies should be interpreted and implemented for all services of the health and social work in the state of Salzburg.

Investment in the quality/competence of the lower and middle management

Staff nurses, head nurses and head nurses are key staff members between the higher management level and the employees on the workfloor. The professional leadership function of the lower and middle management should be strengthened.

Flexibility in the provision of services between inpatient and outpatient nurse facilities in the social sector

Raise awareness of the achievements of nursing "internally" and obtain culture of appreciation and creation

The perception and recognition of the effectiveness of nurses' own actions are important for motivation and job satisfaction. The recognition of the achievements of nurses is essential, especially in socially marginalized areas such as long-term care and elderly care.

Support facilities with the modification of the skill and grade mix

Next to these three packages of measures, other measures are being taken to retain those who are already working within nursing. There are, for example, numerous possibilities to obtain and maintain job satisfaction. For continuing professional development, seminars about burn-out prevention, work coping coaching, and focused seminars for employees of 44 years and older are being offered (Salzburger Landeskörrespondenz, 2011).

The Pflegestiftung

Implacementstiftung concept

The main focus of the Arbeitsmarktservice Salzburg (AMS) is deploying labour market promotion-resources to help the unemployed to stop their unemployment and provide perspective so that they have better opportunities in the labour market. Since the year 2000, the AMS has developed an instrument or basis concept all throughout Austria, the so-called 'Implacement-Stiftung' [in English: placement foundation]. This is a construction that was approved by the social partners. Through the Implacement-Stiftung, companies are offered the opportunity to recruit new staffs that is qualified in accordance with the company's operational requirements. If companies have a shortage of staff which they cannot fill through the market, the Implacementstiftung can help. It is a coordinated concept. When unemployed are interested in following education in an area in which a company has determined a shortage, the Land Salzburg and the respective company that are participating both pay part of the educational costs for the new staff. Moreover, the Existenzsicherung [in English: livelihood security] of participants is paid for through the Arbeitslosenversicherung [in English: unemployment insurance] (Steinlechner, 2014).

So the construction of the Implacementstiftung not only leads to a decrease in the number of unemployed people, but also to a decrease in problems that companies are facing in terms of staffing (Steinlechner, 2014).

Pflegestiftung

When the Salzburger Landesregierung in 2008, 2009 approached the Arbeitsmarktservice with their question for help in terms of the predicted shortages in nursing, the AMS said: the regional Arbeitsstiftung Salzburg [in English: job foundation] is willing to fund a foundation which works just as the Implacementstiftung but then focussed solely on nursing, but this must be under the condition that the Salzburger Landeskliniken and other nursing institutions also cooperate and co-financing this Pflegestiftung. The partners agreed and in 2010 the Pflegestiftung was introduced within Salzburg. It is still running up to this day. The Pflegestiftung will continue till the end of 2016 and perhaps 1 or 2 years more. The Arbeitsmarktservice will start the discussion in due time whether an extension is needed and meaningful for all participants (Steinlechner, 2014).

A prerequisite for participation in the *Pflegestiftung* is a registration with the Arbeitsmarktservice (Steichner, 2014). Other prerequisites are governed by the Gesundheits- und Krankenpflegegesetz (GuKG), and include (AMS, 2014):

- the necessary physical and mental fitness to fulfil professional nursing duties;
- the necessary trustworthiness to perform professional nursing duties;
- and the successful completion of ten school grades.

Unemployed people and people returning to work are pointed to the possibility of the *Pflegestiftung* in their consultations with the Arbeitsmarktservice. Consultations are being conducted with interested persons during an initial consultation, which includes: financial aspects, formal criteria, language skills, family environment, etc. The main results are forwarded to the respective school of nursing and there checked again. In the case of positive feedback, the candidates are invited to do a detailed test and an interview with the school. Subsequently, the interested persons attend some 'taste-days' in companies where the entire internship will take place later. Finally, the school and internship company must decide whether the candidates will be accepted in the programme (Salzburger Landeskörrespondenz, 2011).

The theoretical training for participants is provided by the Schools for Health and Medical Care (SALK, Krankenhaus Schwarzach, Krankenhaus Zell am See, Schule für Sozialbetreuungsberufe Saalfelden, BFI). The practical training partners are, among others, Salzburger Landeskliniken, Diakonie, Stadt Salzburg, Seniorenheime der Gemeinden Salzburg, Lebenshilfe, Seniorenheime Pro Humanitate rotes Kreuz.

The Arbeitsmarktservice Salzburg supports the *Pflegestiftung* on a continuous basis. That has routinized. The operational part works very well. The AMS is educating like before, but the Land Salzburg pays a little bit less places than 2 years ago. This is due to the fact that predicted shortages now appear to be less severe than a couple of years ago. Should the shortages rise again, the number of subsidized educational places will be increased again as well (Steinlechner, 2014).

Other instrument: Fachkräftestipendium

Another instrument that is being used to increase the number of nurses and nursing assistants in Salzburg is the *Fachkräftestipendium*. Adults that wanted to follow specialized education were often facing financial hurdles. While scholarships were available for those who wanted to study at a university, there were none for adults who wanted, for example, to follow education to become a nurse. In order to support training in those areas where the lack of skilled labour is particularly large, including nursing, the *Fachkräftestipendium* [in English: professional scholarship] was introduced on 1 July 2013. The aim is the up-skilling of workers and improve their opportunities on the labour market (Steinlechner, 2014).

Diakonie Implacment-Stiftung Salzburg

The Diakoniewerk Salzburg has developed its own Implacment-Stiftung. The goal of the Diakonie Implacment-Stiftung Salzburg is to coordinate the needs-based training between job seekers and companies. This foundation focuses mainly on training for nursing jobs that are not offered by the Landeskliniken, i.e. the jobs for social professionals [fachsoziale Kräfte]. The carrier organisation is an Oberösterreichische basis construction, as they already have an Implacmentstiftung for other nursing

jobs. The one in Land Salzburg covers the nursing jobs that are not covered by the AMS Pflegestiftung. So the Diakoniewerk mostly works within the structure of its own Oberösterreichische Foundation and there is not so much cooperation with the Pflegestiftung, at least not where structure is concerned. But both concepts must be financed through the Arbeitslosenversicherung. So that is why the Arbeitsmarktservice also has access for their clients, unemployed, to the Foundation of the Diakoniewerk (should people be interested in this) (Steinlechner, 2014).

Organisational framework

Partners and cooperation

Many parties were involved in the Pflegeoffensive, including; Land Salzburg, city of Salzburg, Diakoniewerk Salzburg, the Salzburger Landeskliniken and the Arbeitsmarktservice Salzburg. At the start of the discussion about the Pflegeoffensive, all parties were involved. Next to quasi-bilateral discussions, it was important that during crucial meetings all partners were literally sitting on one table. The fact that all partners were involved has been important for the development of the Pflegeoffensive. It eased the political decision process. It reduced the risk of developing false images of each other, or false feelings of competition. And when all parties can decide and see what their role is, then it is easier to continue the process afterwards, and to make sure that no false debates start to exist in publicity. Considering the high number of different actors that are involved in this area, this is important (Steinlechner, 2014). The parties involved in the Pflegeoffensive did not sign a formal cooperation agreement. The AMS states that it already has exchange and cooperation lines with Land Salzburg in other areas. The view of the AMS is that there should be lots of cooperation, but with as little overhead as possible. Money can better be used at operational level (Steinlechner, 2014).

Role of the Arbeitsmarktservice

The Arbeitsmarktservice is primarily involved in the *Pflegeoffensive* through the *Pflegestiftung*, by offering support for interested people who are looking for a training place through the *Pflegestiftung* and support for people involved in the *Pflegestiftung*.

Role of the Diakoniewerk Salzburg

Follows.

Facilitators in the running of the intervention

The fact that all partners were from the beginning involved in the Pflegeoffensive has been important for the development of the Pflegeoffensive. It eased the political decision process. It reduced the risk of developing false images of each other, or false feelings of competition. And when all parties can decide and see what their role is, then it is easier to continue the process afterwards, and to make sure that no false debates start to exist in publicity. Considering the high number of different actors that are involved in this area, this is important.

Barriers in the running of the intervention

There were a number of problematic factors in the running of individual measures taken in light of the Pflegeoffensive:

- As said before, the main focus of the Arbeitsmarktservice Salzburg is deploying labour market promotion-resources to help the unemployed to stop their unemployment and provide perspective so that they have better opportunities in the labour market. For the labour market situation in which Salzburg currently finds it, this is not so easy. The problem is that the training (levels) of the unemployed do not 'fit' the shortages that exist within nursing. This applies to education into nursing as well as nursing jobs (Steinlechner, 2014).
- Even though the number of people that find a job through the Pflegestiftung is high, it is not always easy for the institutions involved and that are providing funding for the training. Because it is also a market and once graduates have finished their education, they are free to choose their place of employment. There is no requirement for graduates to start working in the institution where they did their internship. So for smaller education institutions, this causes considerable problems. They invest money and time and it is harder for them to recruit graduates than it is for the bigger institutions. It is more difficult for them to cope with this than for the bigger institutions that have more financial clout (Steinlechner, 2014).

Finances

Financing of the Pflegestiftung

The Pflegestiftung is governed by contractual relationships. This also requires the funding in the framework of the unemployment insurance. There are also formal amount relationships (Steinlechner, 2014).

The state of Salzburg assists the *Pflegestiftung* via its labour market policy funds. In this way, the state ties the *Pflegestiftung* to the already existing *Implacementstiftung*, via which 350 unemployed Salzburgers find new career prospects annually. For 2013, the total budget that the state of Salzburg invests is €763.000, a budget for 350 people (Salzburger Landeskorespondenz, 2011). The Land Salzburg pays the Pflegestiftung management, which lies with the regional Arbeitsstiftung.

The Land also pays the AMS for what it needs to do in terms of the Pflegestiftung (Steinlechner, 2014).

The total costs for one nurse training place, i.e. for one participant, via the *Pflegestiftung* can be broken down as follows (Salzburger Landeskorespondenz, 2011):

- €16,668: Training costs (costs paid by institutions)
- €7,200: Scholarship (costs paid by institutions)
- €2,180: Staff selection and supervision (costs paid by state of Salzburg)
- €19,980: Costs of living (costs paid by Arbeitsmarktservice)
- €6,364: Sozialversicherung [Social security insurance] (costs paid by Arbeitsmarktservice)
- €200: Stipendium [Subsidy amount] (costs paid by institutions)

The requirement for the participating institutions to pay participants a subsidy amount that is 200 euro per month can be a financial burden for institutions, especially for educations that last longer (Steinlechner, 2014).

The big advantage of the Pflegestiftung construction is that the Arbeitsmarktservice must not deploy resources for the labour market promotion, because the educational costs and the Stipendium and the Existenzsicherung [livelihood security] are paid by third parties. The Existenzsicherung is paid through the Arbeitslosenversicherung which the Republic of Austria is required to pay and not the AMS. That's very special for the AMS that it does not have to take into account those financial things, because they are paid through the Arbeitslosenversicherung. According to the AMS, these sort of things determine whether something will function or not (Steinlechner, 2014).

In addition to maintaining the Pflegestiftung, means of labour market resorts were used to finance the training of nursing assistants to become graduate nurses

In order to realize an impulse for the training of graduate nurses, support from the state of Salzburg to assume the cost of the theoretical training of nursing assistants to become graduate nurses was established in July 2011. The minimum duration of training is two years full-time. The costs are approximately € 7300, - per person; 27 people have begun such training so far, 10 more places are available (Salzburger Landeskorespondenz, 2013).

3. Results of the intervention

Results of PR measures

The “*Pflege deinen Traum!*” [in English: “Take care of your dream!”] campaign, organised by the Salzburger Landeskliniken in 2012 and 2013, obtained good results. The number of candidates in the *Gesundheits- und Krankenpflegeschule* [general health and nursing schools], for nursing, mental health and nursing assistants, almost doubled from from 217 to 416 between 2012 and 2013.

Results of the Pflegestiftung

Since the *Pflegestiftung* was established in 2011, the following results have been achieved. A total of 274 persons has started training or already completed their training, including:

- 106 persons in generally qualified health nursing
- 2 persons in children and youth nursing
- 136 persons in nursing assistant
- 30 persons to mental health workers and nurses

For the year 2013, the *Pflegestiftung* had 140 training places available (Salzburger Landeskörrespondenz, 2013).

At the time of writing (November 2014), approximately 210 people are participating in the *Pflegestiftung*. These are the ones that are now in education. There are approximately 100 new entrees per year and the education lasts for about 2 to 3 years. The AMS monitors whether graduates find a job in nursing after finishing their education up till 3 months after they have finished their education (Steinlechner, 2014).

Up to 2014, 197 persons graduated through the *Pflegestiftung*. The number of people that find a job is significantly higher in the *Pflegestiftung* than in the other Implacement foundations. So it is running very well (Steinlechner, 2014).

Graduates are being monitored after three months to see whether they have found a job. It doesn't do this any longer because the connection between education and employment is already questionable after one year, because of the number of other confounding factors. As someone who has done an education through the AMS becomes unemployed again after 2 or 3 year, the AMS of course looks back. But it does not do this systematically. This is also because the AMS is an operating institution and not a research institution (Steinlechner, 2014).

Even though the number of people that find a job is high in the *Pflegestiftung*, it is not always easy for the institutions involved and that are providing funding for the training. Because it is also a market and once graduates have finished their education, they are free to choose their place of employment. There is no requirement for graduates to start working in the institution where they did their internship. So for smaller education institutions, this causes considerable problems. They invest money and time and it is harder for them to recruit graduates than it is for the bigger institutions. It is more difficult for them to cope with this than for the bigger institutions that have more financial clout (Steinlechner, 2014).

References

Arbeitsmarktservice (2014). Teilnehmerinnen bzw. Anforderungsprofil.

Beck, D. (2014). Interview during case site visit Recruitment and Retention study. Land Salzburg.

Rottenhofer, I., Zsifkovits, J., Schuchter, P. (2013). *Pflegepersonalprognose Salzburg Gesundheits- und Sozialbereich*. Gesundheit Österreich Forschungs und Planungs GmbH.

Salzburger Landeskorrespondenz (2011). *Stiftung bringt nächsten Impuls für die Salzburger Pflegeoffensive*. Salzburger Landeskorrespondenz, 7 January 2011.

Salzburger Landeskorrespondenz (2013). *274 zusätzliche Pflegerinnen und Pfleger durch Pflegestiftung*. Salzburger Landeskorrespondenz, 12 April 2013.

Steinlechner, S. (2014). Interview during case site visit Recruitment and Retention study. Arbeitsmarktservice Salzburg.

Winding, K. & Zlöbl, S. (2014). Interview during case site visit Recruitment and Retention study. Diakoniewerk Salzburg.

Appendix 1.2. Case report 1.2

Topic 1. Attracting young people to healthcare

Case 1.2. 'De Zorgambassadeur' [The Care Ambassador], Belgium



Research methods applied:
Desk research: April – May 2014
Case site visit: May 2014

1. Summary of the intervention – ‘De Zorgambassadeur’ [The Care Ambassador], Belgium

Dimension of interest	Categories/description
Objective of the intervention	Recruitment
Type of intervention	Education Mix/other
Professional group(s) targeted	The goal is to support the inflow of people in the healthcare sector, with a focus on nurses, carers and nurse auxiliaries
Level of intervention	Regional policy level
Type of organisation	The ‘Care Ambassador’ was created by and is employed by the Flemish Government
Size of organisation	Large
Area covered	Province of Flanders in Belgium.
Intervention period / duration of intervention	The function of Care Ambassador was created in 2010 and has run non-stop ever since. The mandate of the Care Ambassador ends by November 2014.
Key actions	Various, including mini campaign (2011) and multi-year campaign ‘A healthcare job: I’m going to do it!’
Financial investment	Additional financing is required, but costs are relatively limited (salary costs and campaign costs). For the Care Ambassador, this is paid by the Agency Care and Health, a supportive service of the Flemish government
Implementation strategy or processes used	No formal implementation strategy was followed; it was quite an ‘ad hoc’ process. A build-up of the promotion campaign was agreed upon with the commercial communication agency.
Day-to-day running of the intervention	Promotional campaign, lectures, consultations with the field, and so on
Personnel investment	Additional HR is required, but limited. Most work is done by the Care Ambassador (part-time function of 0,5 FTE) with support from an external communication agency. However, considerable people invest time on a

	voluntary basis
Outcome measures of the intervention	Important parameters are the number of newly enrolled students in care and welfare education and the vacancy rate in the care and welfare sector. These have been improving since the introduction of the Care Ambassador, but no direct causal relationship can be established.

2. Rich description of the intervention

The case under study

The function of 'Care Ambassador' (in Dutch: *Zorgambassadeur*) that was introduced in Flanders, Belgium in 2010 and the accompanying promotion campaign.

Establishment of the function of Care Ambassador

The function of Care Ambassador, as it currently exists in Flanders, originated via two different pathways.

- 1) When Lon Holtzer, the current Care Ambassador, was Nursing Director at the University Hospital Leuven (2006-2010), she came to the conclusion that the inflow of nurses needed to be increased. Therefore, she and Xavier Lemaitre brought together a group of people coming from the healthcare and educational sectors to see how the various initiatives that were already underway in different Flemish provinces could join forces. The group came to the conclusion that there needed to be a person who would collect and coordinate all information concerning nursing. The group created a job profile and sent this to the Flemish Minister of Health.
- 2) The Flemish Minister of Health, Welfare and Family Jo Vandeurzen stated immediately at the beginning of his appointment in 2009 that work needed to be made of work in the health sector with a view on the expected shortages. Hence, he was sympathetic to the proposal of Ms. Holtzer's discussion group to set up a coordinating role for nursing. In May 2010, the action report of the Minister 'To make work of work in the healthcare sector' [in Dutch: 'Werk maken van werk in de zorgsector'] was published and the need for a coordinating role in nursing was included.

These two, partly overlapping, developments led to a vacancy for the function of 'Commissioner for the Promotion of Healthcare Jobs' which was issued in September 2010 by the Flemish Minister of Health.

Reasons for the introduction of the function of Care Ambassador

Belgium faces a growing shortage of healthcare staff for the coming years. It has been predicted that 31,1% more nurses will be needed in 2020 than in 2010, while the amount of additional carers needed in 2020 is predicted to be even higher with 57,9% (Vandeurzen 2010). At the same time, working in the healthcare sector has a negative image; it is considered as underpaid hard work, with irregular working hours, and so on (Holtzer 2012). To tackle these issues and meet the expected healthcare staff shortages, the Flemish Minister for Welfare, Health and Family Vandeurzen in 2010 introduced the Action plan 'To make work of work in the healthcare sector' (in Dutch: '*Werk maken van werk in de zorgsector*'). This plan focuses on the inflow, flow and retention of staff in the healthcare sector.

The Action plan summed up some starting points for actions focussed on the recruitment of health workers, including enhanced coordination of the various promotion campaigns for health workers across Flanders so as to achieve higher efficiency and effectiveness. To achieve this goal, the function of *Zorgambassadeur* (Care Ambassador) was created and in November 2010 Eleonora (Lon) Holtzer was

appointed as Care Ambassador for Flanders (Holtzer 2012). She has fulfilled the role of Care Ambassador ever since. The role of the Care Ambassador is to be the face of and lead the Flemish campaign for promoting working in the healthcare sector.

Objective of the intervention

The 'Care Ambassador' is a recruitment intervention, primarily aimed at young people. The goal of the Care Ambassador is to support the (future) inflow of people in the healthcare sector both quantitatively and qualitatively by developing and running a coordinated campaign for the promotion of healthcare jobs in Flanders. The focus of the assignment is on the recruitment of nurses, carers and nurse auxiliaries¹ (Dutch job titles: *verpleegkundigen*, *verzorgenden* and *zorgkundigen*) (Holtzer 2012).

The function of Care Ambassador is built on three main pillars (Holtzer 2011):

- To be the 'face of the healthcare jobs' in Flanders
- To focus on recruitment into healthcare and improving the image of the healthcare sector
- To set up and work out promotion campaigns for working in healthcare

Type of intervention

Promotional campaign for the promotion of healthcare jobs in Flanders.

Level of the intervention

The intervention is run at regional level. Belgium is a federal state and the 'Care Ambassador' is a function that was created by the Flemish Minister for Welfare, Health for Flanders and falls under the responsibility of the Flemish Region (in Dutch: *Vlaams Gewest*). The function does not exist in other regions in Belgium nor at federal level.

Running time of the intervention

The function of Care Ambassador was created in 2010 and Eleonora (Lon) Holtzer was appointed as Care Ambassador for Flanders at the 1st of November of the same year (Holtzer 2012). The intervention has run non-stop ever since. The mandate of the Care Ambassador ends by November 2014 and at the time of writing it is not yet known whether the function will be continued afterwards (this is also dependent on the new Flemish Minister of Health which still needs to be elected).

Profile of the Care Ambassador

The way in which the function of 'Care Ambassador' is fulfilled, is highly dependent on the person who has got the function and there is not one perfect way to do the job. Nonetheless there are a number of criteria which all candidates should fulfil:

- The person should have a background in healthcare, as this creates goodwill among the sector.
- The person should be familiar with the healthcare sector.
- The person should be somewhat experienced, have credibility and be able to deal with the media.
- The person should have a substantial network.

¹ The job of 'nurse auxiliary' (*zorgkundige*) exists in Belgium since 2006. Nurse auxiliaries are specifically educated to assist the nurse, under his/her supervision, with care provision, health education and logistics in the context of activities as coordinated by the nurse within a structured team (Mistiaen *et al.* 2011).

Implementation strategy for the intervention

No formal implementation strategy was followed for the intervention; it was quite an 'ad hoc' process. However, a clear build-up of the promotion campaign was agreed upon with the commercial communication agency.

- Spring 2011: start with short mini-campaign
- First year of the big campaign (2011): focus on the healthcare sector itself
- Subsequently (from the end of 2011 onwards): focus shifted externally to attract 'the general public' to a job or education in health care.

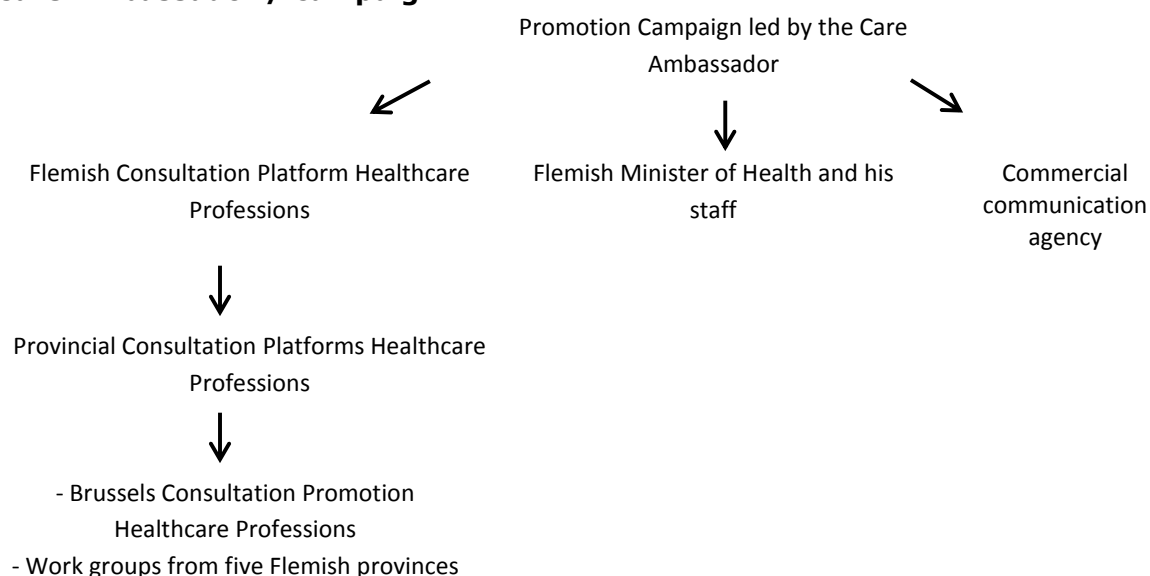
More information on the campaigns can be found below under the subheading 'Campaigns'.

Organisational framework supporting the function of Care Ambassador

The organisational framework that supports the function of Care Ambassador was developed by the Care Ambassador herself together with an employee of the Flemish Minister of Health:

- At regional policy level, the Care Ambassador is supported in her work by the Flemish Minister of Health and his staff.
- Support is also coming from the Flemish Consultation Platform Healthcare Professions (Dutch: *Vlaams Overlegplatform Zorgberoepen*). This is a diverse group of people brought together by the Care Ambassador and it is mainly made up of representatives from the healthcare sector and the educational sector.
- A level below the Flemish Consultation Platform Healthcare Professions are the Provincial Consultation Platform Healthcare Professions (Dutch: *Provinciaal Overlegplatform Zorgberoepen*); one from each of the five Flemish provinces and one from the capital Brussels. The Provincial Platforms are built up in the same way as the Flemish platform, but with *local* people from the health and education sectors.
- Additionally, the promotion campaign is supported by a commercial communication agency.

Figure 1: Schematic overview of organisational framework supporting the Care Ambassador / campaign



Formalization of cooperation agreements

In 2011, the cooperation between the provinces and the Flemish Community Commission [Dutch: *Vlaamse Gemeenschapscommissie*] on the one hand and the Flemish Minister for Welfare, Health and Family on the other hand was arranged by the closing of a covenant. In the covenant it was stated that the provinces were required to help improving the inflow in the healthcare sector. Recently, this cooperation has been accommodated in a so-called management agreement [Dutch: *beheersovereenkomst*].

Flemish Consultation Platform Healthcare Professions

Initially, the Flemish Consultation Platform Healthcare Professions [VOPZ] was mainly made up of people coming from the healthcare and educational sectors. Later the group expanded with people coming from policy agencies (such as the Flemish Service for Employment and Vocational Training VDAB) and other cabinets (such as Employment and Education). This has been crucial, according to the Care Ambassador, "because you can't do anything if you don't get assistance from others". The Care Ambassador is the chair of the VOPZ. Together with the Care Ambassador and the professional communication company, the VOPZ develops the Campaign and determines what the most important messages should be.

Provincial Consultation Platforms Healthcare Professions

There are six Provincial Consultation Platforms Healthcare Professions; one from each of the five Flemish provinces and one from the capital Brussels. They are built up in the same way as the Flemish platform, but with local people from the healthcare and educational sectors. They use the campaign and the material and initiatives that are taken at central level, and apply and adjust them to their own local level, according to necessity. For example, for some provinces, ethnic cultural minorities is a main issue while for others it isn't. So even though the Campaign is conducted under one regional

heading, each Provincial Platform can emphasize the points that are most important to them. According to the Care Ambassador, this is one of the reasons for the success of the Campaign.

The Provincial Platforms focus on elaborating both Flemish and local initiatives to recruit and retain healthcare professionals within the provinces. Each of them also specifically develops initiatives and projects for their own area. For example, the Brussels Consultation Promotion Healthcare Professions (Dutch: *Brussels Overleg Promotie Zorgberoepen*) developed the following initiatives over the last years (BOPZ, 2014):

- The V-team: in which two carers visit second-class students in vocational education that will have to make a choice with regards to their study direction by the end of the year. The two carers tell about their experiences in healthcare and try to enthuse students to choose a care direction.
- 'Jobhoppen': all second year nursing students from Brussels are invited to this one-day event. The day starts with breakfast, then they are taken to several hospitals and local services, they have lunch with home nurses and they get all practical information about applying and working in healthcare.
- Internship mentor (*Stagementoraat*) Brussels: a consultation platform in which the work field and educational field jointly work on extending quality internships and internship mentoring for nursing students in Brussels.
- A publication with all Dutch healthcare courses in Brussels for people enter a degree programme in a non-standard way

Financial investment

Additional financing is required for this intervention, but costs are relatively limited.

The function of Care Ambassador has two main costs:

- The salary of the Care Ambassador, which is a part-time function (0,5 FTE).
- The costs of the promotion campaign (including costs for the commercial communication company, television ads and so on). The total budget for the campaign is approximately €250.000 annually (Vandeurzen 2014).

All costs are covered by the Agency Care and Health [Dutch: *Agentschap Zorg en Gezondheid*], a supportive service of the Flemish government.

The participants in the Flemish Consultation Platform Healthcare Professions and the Provincial Consultation Platforms Healthcare Professions are not financially compensated for their (time) investments. According to the Care Ambassador, the limited financial resources are not a disadvantage, quite the opposite: "I don't have money. And actually I think that is quite OK. It gives a different way of working. Actually the campaign floats on intrinsic motivation. Actually, that is a very powerful weapon."

Campaigns

Right after the Care Ambassador was installed in her function in 2011, a clear build-up of the promotion campaign was agreed upon in close cooperation with the commercial communication agency CHOCO:

- Spring 2011: start with short mini-campaign
- First year of the big campaign (2011): focus on the healthcare sector itself
- Subsequently (from the end of 2011 onwards): focus shifted externally to attract 'the general public' to a job or education in health care.

Campaigns – Mini campaign (spring 2011)

The first campaign that was started by the Care Ambassador right after she was elected was a short-term campaign that mainly focused on nursing and caring. The Care Ambassador was appointed in 2011 and she did not want to 'lose' spring 2011, in which many young people make their study choice. Hence, the mini-campaign 'Become a Caregiver' (in Dutch: 'Word zorgverlener') was started. This campaign ran from May 2011 until November 2011 and focused on high school graduates. The campaign was built up of four elements:

1. A short promotional movie was made
2. A press release was issued
3. On Nurses Day 2011, a bus ride was made by the Care Ambassador and the Flemish Minister for Health Vandeuren during which they visited six care settings to promote the healthcare sector.
4. The website 'www.wordzorgverlener.be' was launched.

Even though the mini-campaign was quite successful, considering the short amount of time in which it was created, the starting point for the Care Ambassador was always that there should be a multi-year strategy had to be developed.

Campaigns – Multi-year campaign 'A healthcare job: I'm going to do it!'

The multi-year campaign 'A healthcare job, I'm going to do it!' [in Dutch: 'Een zorgjob: ik ga ervoor!'] was launched on December 1, 2011 and is still ongoing. The multi-year campaign has a broader focus than the mini-campaign and focuses on all 'bottleneck-jobs' (in Dutch: knelpuntberoepen), as defined by the Flemish Service for Employment and Vocational Training (VDAB), within the healthcare and welfare sector. Bottleneck-jobs are jobs for which it has proven to be difficult to fill in. By showing the width of the sector and the variation in healthcare jobs, many people are being addressed. Or in the words of the Care Ambassador: "The fact that you offer people a choice pays off."

In the summer of 2011, the commercial communication agency *CHOCO* was approached to assist with the development of the multi-year campaign. In close cooperation with the Care Ambassador the multi-year strategy was developed. It was decided to give the campaign the following build-up:

1. The first year of the campaign is focused exclusively on the healthcare sector itself to get them aboard for the promotion of the sector.
2. Afterwards, the campaign will start focusing on the general public.

It should be noted that the role of *CHOCO* has meanwhile been taken over by the communication agency *Kunstmaan*. The most important fact is that the Care Ambassador is continuously being professionally supported in the running of the Campaign.

First phase multi-year campaign – Focus on healthcare sector

During the first year of the campaign the Care Ambassador gave lots of lectures for people from the healthcare sector itself. These included healthcare facilities, umbrella organisations, mutual insurances, schools, et cetera. The aims were:

- To ensure that people working in healthcare propagate their job in a positive way
- To make sure that the healthcare sectors feels the need for a joint campaign

The Care Ambassador labels this as a very important part of the campaign: "I am not the care ambassador, the real care ambassadors are the people who stand on the bed and who talk in an enthusiastic, positive and realistic way about their job".

During this first phase, the Care Ambassador has tried to:

- Raise awareness for the prevailing and future need in terms of healthcare staff by showing objective numbers and data.
- Carry out the message that the glass is half full and not half empty. The approach was not to sell pink clouds but in cooperation with the care sector work on honest communication *with* a positive approach.
- She also cooperated with the trade unions during this phase and told them that they have the same goal; that there needs to be sufficient healthcare staff.

A concern which the Care Ambassador still has at this moment is that the Campaign and its aims are better known by the management and executive level, as they are the ones who come to study days and lectures, and less so by healthcare staff on the floor.

After this first phase, the Campaign focused towards strategies for the external general public to enthuse them for a job or education in healthcare.

Second phase multi-year campaign – Focus on general public

The primary target groups of the campaign are youngsters who are in the final year of their education and need to make a decision about their further study and lateral entrants. The campaign aims to:

- Inform them about the diversity that the healthcare sector offers in terms of jobs
- Motivate them to choose a job in health care
- Increase the positive image of health care

The campaign is primarily run through the central website www.ikgaervoor.be, which forms an important information point. In addition to the website, much use is being made of social media. The Care Ambassador is active on Facebook, Twitter and LinkedIn². She uses these media for different purposes: Facebook is primarily for the general public, Twitter is mostly for the press and LinkedIn is for professional matters. In the beginning of the Campaign, the Care Ambassador was helped by the professional communication agency in how to deal with all of these media.

In addition, advertisements have been published in print magazines, on TV and on other websites. Moreover, information posters about the campaign were distributed amongst schools.

Under the heading of the Care Ambassador and the campaign 'A healthcare job: I'm going to do it!' many different initiatives and actions have been taken. The campaign 'A healthcare job: I'm going to do it!' serves as an umbrella for all these actions and initiatives. Local initiatives keep existing and are still being developed, but fall under

² FB: www.facebook.com/zorgjob, TW: twitter.com/Zorgambassadeur, LI: www.linkedin.com/in/lonholtzer

the central extensive well-known denominator 'I'm going to do it!'. According to the Care Ambassador, this is part of the success: "It is as with Coca-Cola. Everybody knows Coca-Cola, but if Coca-Cola stops with advertising, their sales will drop".

Below, a non-exhaustive overview will be given of actions and initiatives that have been undertaken or are being supported by the Care Ambassador and/or the multi-year campaign 'A healthcare job: I'm going to do it!'.

'Imagine moments' [in Dutch: 'inleefmomenten']

The so-called 'inleefmomenten' [imagine-moments] give people the possibility to get a taste of the healthcare sector. During an imagine-moment, people get the chance to walk with a healthcare professional for one day in the institution of their choice to get a taste of the ins and outs of the job. The number of imagine moments is still increasing. An important boost was given by famous Belgian field rider Bart Wellens, when he participated in an imagine moment during the Belgian TV programme VOLT. During this programme, the Care Ambassador could also explain the initiative. Afterwards, many requests for an imagine moment were being made.

Service Points Care

The Service Points Care [in Dutch: Servicepunten Zorg] are being introduced throughout Flanders and are situated within 'job-shops' of the Flemish Service for Job Mediation and Vocational Training (Dutch: Vlaamse Dienst voor Arbeidsbemiddeling en Beroepsopleiding). Within the *Servicepunten Zorg*, everyone can get information about labour market conditions and labour regimes within the health care sector, his or her career opportunities in the sector, educational requirements to work in the sector, vacancies and people can get support and guidance if they wish so. These Service Points Care are very important, as the Care Ambassador explains: "Because you make a combination of people who can do employment mediation, but who also know the guidance to the sector very well".

Healthcare Ambassadors East-Flanders

In 2012, the province of East Flanders (in Dutch: Oost-Vlaanderen) developed the idea to use healthcare ambassadors to jointly – from their own pleasant experiences on the work floor – spread a strong and positive image of the healthcare sector in East Flanders. On the 22nd of November 2012, 70 healthcare ambassadors were officially appointed (Provincie Oost-Vlaanderen, 2014). These ambassadors are people who work in healthcare and have been trained to become ambassadors for their job. At first, their ambassadorship was on an 'internal' base. After a while, they also started to promote their job and the healthcare sector in general on all sorts of 'external' occasions, such as study selection fairs for youth (VIVO 2012).

Other examples of actions and initiatives undertaken or supported by the Care Ambassador / multi-year campaign during the period 2011-2014:

- The Care Ambassador gave 88 readings/presentations for various stakeholders in the period 2011- June 2012
- 'Day of Health Care' (Dutch: 'Dag van de Zorg'), this day has been organised since 2012. Health care facilities open their doors for everyone who is

interested to contribute to a positive image of the healthcare sector. See the website www.dagvandezorg.be for more information.

- Starting on the 6th of May 2013, the 'spring campaign' was conducted, including posters, advertisements on television and YouTube and Facebook banning.
- Development of posters for potential caregivers with mirror paper on it. So when people look at the poster, they can see themselves in a health care job.
- In 2014: TV campaigns on the stations *Eén* and *Canvas*, including an add in which the diversity of professions in healthcare is emphasized and attention is being paid to the possibility of registering for a 'inleefmoment' (imagine moment).

As said before, the mandate of the Care Ambassador ends by November 2014 and at the time of writing it is not yet known whether the function will be continued afterwards. However, at this moment the Campaign does have a number of main points it focuses on:

- New ways are being sought to motivate youngsters to choose for further education in health care. The Campaign needs to continue reinventing itself. The Care Ambassador mentions the example of the 'Inleefmomenten' (imagine moments) which other sectors do not have yet; the Campaign needs to continuously renew itself to retain this lead.
- To make current healthcare workers more aware of the campaign and motivate them to promote working in health care
- To create a sufficient amount of high quality internships for nursing and caring students
- More attention for specific target groups, including ethnic-cultural minorities, jobseekers and lateral entries (Dutch: *zij-instromers*)

Moreover, in collaboration with the production company *Kunstmaan*, a matrix has been developed to see which target groups need most attention. Special attention will be paid to how the campaign can be tailored at subsectors such as elderly care and mental health care, and also how men can be brought more into the picture in the campaign.

3. Results of the intervention

Considering that the function of Care Ambassador primarily focuses on nurses, carers and nurse auxiliaries, the outcome data presented will refer to these three professional groups. Moreover, process data on actions undertaken under the leadership of the Care Ambassador will be presented where available.

3.1 Outcome measures: student enrolment numbers and vacancy rates

The most important parameters by which the success of the campaign and the function of 'Care Ambassador' are measured are the number of newly enrolled students in care and welfare education and the vacancy rate in the care and welfare sector. The inflow into care and welfare education can be measured on a yearly basis. The vacancy rate is calculated once every three months by the Flemish Service for Employment and Vocational Training [Dutch: VDAB, Vlaamse Dienst voor Arbeidsbemiddeling en Beroepsopleiding]. Tables 1 to 5 give an overview of these parameters over the last years.

Table 1: Evolution inflow of 'generation students' in Bachelor Nursing in Flanders, 2004-2013

	2004	2005	2006	2007	2008	2009	2010	2011	2012	2013
Bachelor Nursing	1.108	1.307	1.321	1.812	1.746	1.898	2.288	2.390	2.274	2.253

Source: Overview tables Care Ambassador 2013-2014

Table 2: Number of nursing students in Flanders, October 2004 – October 2012

	2004	2005	2006	2007	2008	2009	2010	2011	2012
Bachelor and HBO5	9267	9418	10002	10188	10927	12040	13698	14596	15415

Source: Vandeurzen (2013)

Table 3: Number of students in vocational secondary education (BSO) and technical secondary education (TSO) direction Person Care, in Flanders, 2006 – 2014

	06-07	07-08	08-09	09-10	10-11	11-12	12-13	13-14
Total BSO	11.272	11.462	11.510	11.661	12.030	12.513	12.672	12.985
Total TSO	19.274	20.123	20.321	20.585	21.104	20.807	20.894	21.464

Source: Vandeurzen (2013); Overview tables Care Ambassador 2013-2014

Table 4: Number of students that started nursing and caring education with VDAB-contract

	2010	2011	2012
Nursing	2.585	2.836	3.219
Caring	1.485	1.442	1.524

Source: Overview tables Care Ambassador 2013-2014

If we look at table 1, we see that the increase in the inflow of 'generation students' – i.e. students who enrol for the first time in higher education immediately after finishing high school, mainly 18-19 year olds – in the Nursing Bachelor is spectacular. Between 2004 and 2013, their number more than doubled. The total number of nursing students also shows an increasing line for the same period (see table 2) just as the number of students Person Care in vocational secondary education (BSO) and technical secondary education (TSO), as shown in table 3.

Special mentioning should be made of the number of students that has started nursing and caring education with a contract of the VDAB. This contract was introduced to help unemployed people who want to retrain themselves. For nursing education, this number increased with 25% from 2010 till 2012 (see table 4).

Table 5: Number of nurse/carer vacancies (VDAB) in Flanders, December 2007 – December 2012

	2006	2007	2008	2009	2010	2011	2012
Nurses	782	911	1124	1317	1507	1750	1370
Qualified carers	154	181	402	400	440	592	494

Source: Vandeurzen 2013

Table 6: Number of nurse/carer vacancies in Flanders (March each year), 2010-2014

	2010	2011	2012	2013	2014
Nurses	1310	1584	1793	1448	1069
Carers	578	722	710	372	230

Source: Overview tables Care Ambassador 2013-2014

While the number of students in nursing and care education increased over the past few years, the number of nurse/carer vacancies in Flanders decreased (see tables 5 and 6).

Reflections on outcome data

The Care Ambassador and the accompanying campaign generate outcome data which are relatively 'easy' to measure and monitor over the years or months respectively (student enrolment numbers and vacancy rates). However, at the same time it should be noted that no causal relationships can be made between the introduction of the Care Ambassador and the data presented here. Other variables, such as the economic crisis which has hit Belgium over the last few years, can also have had a significant impact on the data presented. For example, in times of economic crisis, people tend to choose for relatively 'secure' job markets, such as healthcare. It is impossible to separate these motivations from the effects that the Care Ambassador and related actions have had on recruitment into healthcare. Nonetheless, since the introduction of the Care Ambassador in 2010, recruitment and enrolment numbers into healthcare education/jobs have improved significantly and this is at least partly due to the efforts of the Care Ambassador and the Campaign 'A healthcare job: I'm going to do it!'

3.2 Process data

These data refer to actions and initiatives which were taken by the Care Ambassador and/or the campaign 'A healthcare job: I'm going to do it!'.

Effectiveness of Servicepunten Zorg (Servicepoints Care)

By the end of 2011, the first four *Servicepunten Zorg* were established in Flanders. During the first ten months that they were running a total of 1.677 persons were screened for a healthcare job (of which 905 belonged to one of the target groups such as cultural-ethnic minorities) and 315 people actually started healthcare education after having had a consultation at one of the *Servicepunten Zorg* (Vandeurzen 2013).

Facebook visits and 'likes'

Between the 1st of December 2011, when the campaign 'A healthcare job: 'I'm going to do it!' (Dutch: 'Een zorgjob: ik ga ervoor!') officially started, and 13 June 2012, the Facebook page of the campaign was visited by 65.252 unique visitors, who on average stayed on the page for 2 minutes. More than one fourth of the visitors returned to the page. Detailed analyses showed that the behaviour of visitors was different in May (when the Youth Campaign started) than in the previous months. This suggests that the site was visited more by young people in May, while previously the site was visited more by healthcare professionals. This pattern was in line with what was strategically planned.

At the 14th of June 2012, the Facebook page had 1.918 'likes'. As of today (01-07-2014), the Facebook page was 'liked' 5.590 times.

Data related to the media spring campaign 2013

On the 6th of May 2013 the 'spring campaign' started, including posters, advertisements on television and YouTube and Facebook banning. Nearly 9,000 posters - which consisted of five different versions - were spread over 70 secondary schools and via the organizations of all partners (via the Flemish Consultation Platform Healthcare Professions VOPZ). The TV advert was broadcasted 350 times on Flemish channels focused on youth. The YouTube advert was watched from beginning till end by 67.000 people and 6.100 of them clicked through to the website www.ikgaervoor.be. Facebook adverts attracted 10.647 people (mainly youth between 16 and 21 years) to the website. During the campaign, 25.096 unique visitors visited the website.

The influence of the campaign on the number of requested 'Inleefmomenten' (imagine-moments) was significant. In May 2013, there were 121 requests and in the first half of June 2013 there were 117 requests (Vandeurzen, 2013).

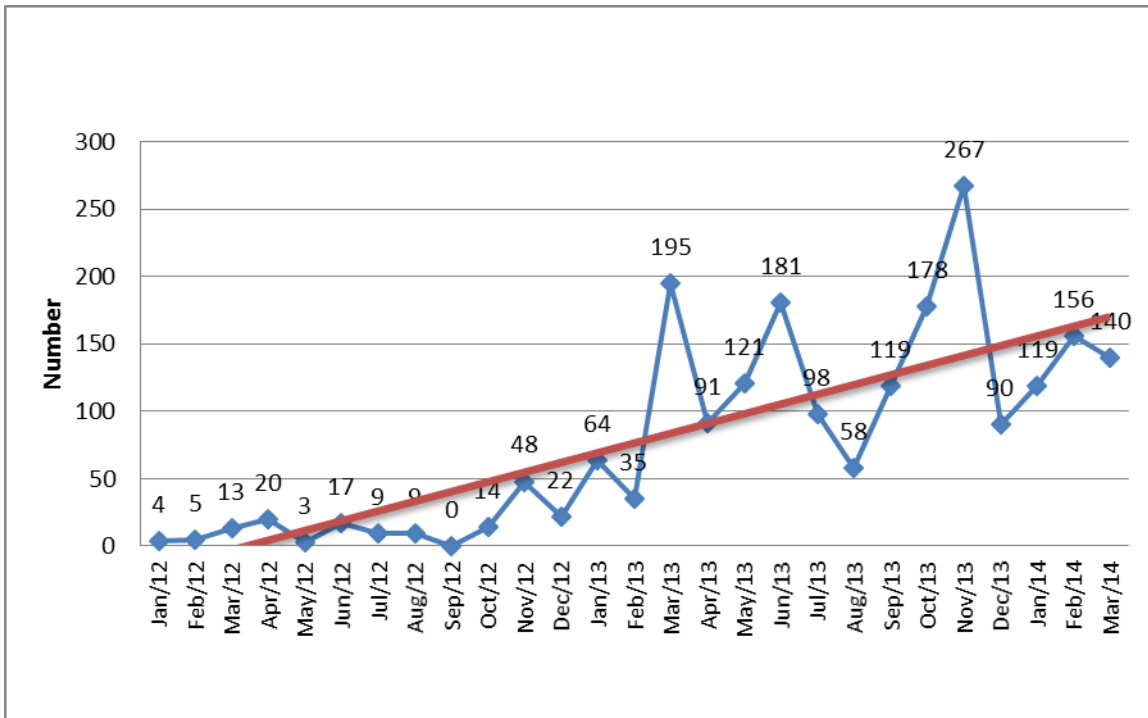
Requests for 'imagine moments' [inleefmomenten]

The number of requests for imagine moments [inleefmomenten] is strongly related to certain media activities. For example, on the 6th of March 2013, the famous Belgian field rider Bart Wellens participated in an imagine moment on a Flemish television show and the Care Ambassador could explain something about the 'inleefmomenten'. The impact of this media action is clearly visible in the data; in March 2013, there is a peak in requests (see figure 2 on the next page).

Reflections on process data

The advantage of the process data as presented above is that they are easily measurable. For example in the case of the television programme with the famous Belgian field rider, it is immediately visible in the website visits and requests for 'imagine moments' that this is an effective way to reach many people and make them interested in the campaign. By looking at these process data, the effectiveness / success rate of certain sub-interventions or actions can be established. However, it should be noted that these data do not necessarily tell something about the outcome data. While many people may visit the website, for example, this doesn't tell you anything about whether they will start with a job or education in healthcare.

Figure 2: Evolution of the number of requests for 'inleefmomenten' [imagine moments], January 2012- March 2014



References

Agentschap Zorg en Gezondheid (2014). Wie werkte er in 2009 in de Vlaamse algemene ziekenhuizen? <http://www.zorg-en-gezondheid.be/Cijfers/Zorgaanbod-en-verlening/Ziekenhuizen/Wie-werkte-er-in-2009-in-de-Vlaamse-algemene-ziekenhuizen/>

Algemene Directie Instellingen en Bevolking (2014). Statistieken van Bevolking: http://www.elections.fgov.be/fileadmin/user_upload/Registre/fr/statistiques_population/population-bevolking-20140101.pdf

BOPZ (2014). Brussels Overleg Promotie Zorgberoepen. <http://www.huisvoorgezondheid.be/zorgverlener/brussels-overleg-promotie-zorgberoepen> (accessed: 09-05-2014).

HealthMatters (2011). Country Profile: Belgium <http://healthmatters4.blogspot.be/2011/01/country-profile-belgium.html>

Holtzer, E. (2011). Een half vol glas met aantrekkelijke zorgberoepen. Probleemsituering en plan van aanpak. Presentatie. *Zorgnet Vlaanderen*, 10 juni 2011.

Holtzer, E. (2012). Promotiecampagne 'Een zorgjob: Ik ga ervoor'. Tussentijds verslag. (Promotion campaign 'A healthcare job: I'm going to do it!'. Interim report.)

Kesenne, J. (2012). De financiering van de gezondheidszorguitgaven in België. *Gids op Maatschappelijk gebied*, 2012.

Mistiaen, P., Kroezen, M., Triemstra, M., Francke, A.L. (2011). Verpleegkundigen en verzorgenden in internationaal perspectief. Een literatuurstudie naar rollen en posities van beroepsbeoefenaren in de verpleging en verzorging. Utrecht: NIVEL.

Ognyanova, D., Maier, C.B., Wismar, M., Girasek, E., Busse, R. (2014). Mobility of health professionals before and after the 2004 and 2007 EU enlargements: evidence from the EU PROMeTHEUS project. In: Buchan et al. (Eds). Health Professional Mobility in a Changing Europe. Volume II.

Planbureau (2014). Resultaten van de Bevolkingsvooruitzichten 2000 – 2050. http://www.plan.be/websites/pp091/nl/html_books/maltese_3n12.html

Provincie Oost-Vlaanderen (2014). Zorgambassadeurs Oost-Vlaanderen. http://www.oost-vlaanderen.be/public/welzijn_gezondheid/zorg/promotie_zorgberoepen/zorgambassadeurs/

Statistics Belgium (2014). Sterftetafels en levensverwachting. http://statbel.fgov.be/nl/statistieken/cijfers/bevolking/sterfte_leven/tafels/

Studiedienst van de Vlaamse Regering, 2013. Vlaanderen in cijfers 2013.
<http://www4.vlaanderen.be/dar/svr/afbeeldingennieuwtjes/algemeen/bijlagen/2013-10-14-vic2013.pdf>

Vandeurzen, J. (2010). Werk maken van werk in de zorgsector van 21 mei 2010. Actieplan ter bevordering van de werkgelegenheid in de zorgsector.

Vandeurzen, J. (2013). Terconceptnota aan de leden van de Vlaamse Regering. Betreft: Actieplan 'Werk maken van werk in de zorgsector'- 2.0. De Vlaamse Minister van Welzijn, Volksgezondheid en Gezin.

Vandeurzen, J. (2014). Bijlage 4. Horizontaal Gelijkekansenbeleid – Financiering – Schrift. vraag van Ann Brussel dd. 7/1/2014.
www.vlaamsparlement.be/Proteus5/getFile.action?id=519230

Appendix 1.3. Case report 1.3

Topic 1. Attracting young people to healthcare

Case 1.3. 'NHS Tayside Healthcare Academy', Scotland



Research methods applied:

Desk research: August – September 2014

Case site visit: November 2014

1. Summary of the intervention – ‘NHS Tayside Healthcare Academy’, Scotland

Dimension of interest	Categories/description
Objective of the intervention	Recruitment
Type of intervention	Education Personal and professional support
Professional group(s) targeted	People from socially deprived backgrounds, with a specific focus on young people. They are prepared for jobs in health and social care.
Level of intervention	Organisational
Type of organisation	NHS Tayside is a territorial health authority in Scotland and the largest employer in the region.
Kind of services provided by organisation	NHS Tayside is responsible for delivering healthcare to around more than 400,000 people living and working in the region.
Size of organisation	Large
Area covered	Tayside region in Scotland, UK, approx. 389,000 inhabitants
Intervention period / duration of intervention	The Academy was implemented in 2006 and was given substantive status in 2007. There is no expected end date.
Key actions	Preparing those from socially deprived backgrounds for band 1-3 positions in NHS or private social care, and SQV level 2 jobs in health and social care, through education and support.
Financial investment	Additional financing is required. For the NHS Tayside Healthcare Academy pilot money was provided by the Scottish Executive. Afterwards, funding was provided by the NHS Tayside Board, education funding and Jobcentre Plus funding, among others.
Implementation strategy or processes used	Step-wise but relatively informal approach: idea developed, taken to the Board of NHS Tayside, networking, receiving pilot money, developing

	Healthcare Academy.
Likelihood of acceptance and/or uptake of the intervention by different groups of stakeholders	Especially in the beginning, the Healthcare Academy had to fight several prejudices in the NHS and externally. Now, the vast majority of NHS employees are supportive of the programme although some hard-core opponents remain.
Personnel investment	Relatively limited at NHS Tayside (2 FTE). Lot of work is been done by partner organizations in their various roles.
Outcome measures of the intervention	Since the start, almost 1000 people have accessed the range of programmes delivered by the Academy. Approx. 70% of graduates of the pre-employment course achieve employment. However, the success of the Academy is not about big numbers, it's about small things. There are very powerful stories, like people who are taking their children on a holiday for the first time. Over the years, the Academy received various awards for its achievements.

2. Rich description of the intervention

The case under study: NHS Tayside Healthcare Academy

In 2006, the NHS Tayside Healthcare Academy was established. The Healthcare Academy targets the long term unemployed, those on incapacity benefits, those from socially deprived backgrounds, and aims to implement the philosophy of creating employment to sustain health, by offering opportunities and preparing people for real jobs in NHS Tayside (Smith & McEwen, 2006). Engagement with young people is regarded as a core element of the Academy. Over the past years, the Academy partnership has engaged with young people to provide opportunities for work placements and experience, and to facilitate greater access to careers in care (NHS Tayside, 2012).

Reasons for the establishment of the NHS Tayside Healthcare Academy

In 2005, the Board of NHS Tayside was presented with a radical Human Resources & Organisational Development (HR & OD) Strategy. One of the fundamental principles of the strategy was that the NHS should use its position as an employer to provide individuals with training, work experience and employment, as part of a socially responsible recruitment policy (Boyter & Donald, 2014). In 2006, in recognition of the positive impact of employment on poverty, and to confirm its commitment to social responsibility within Tayside communities, NHS Tayside launched the pilot NHS Tayside Healthcare Academy. This pilot was based on the NHS Tayside Strategic Workforce Plan (2006), which was approved by the Board in 2006 and is a key part of the Inclusion and Diversity Agenda. The Strategic Workforce Plan highlighted the negative effects of joblessness across both rural and urban Tayside communities, both in terms of individual physical and mental ill health, and the negative ripple effect of poverty within local societies. In 2007, the substantive status of the Healthcare Academy was confirmed by the NHS Tayside Board (NHS Tayside, 2008; 2012).

Objective of the NHS Tayside Healthcare Academy

The NHS Tayside Healthcare Academy is designed to address future demographic and labour market trends. With partners, it addresses these issues, challenges existing cultures and creates career opportunities in health and social care ensuring a locally recruited and sustainable quality healthcare workforce responsive to local population need (NHS Tayside, 2008). The Healthcare Academy aims to implement the philosophy of creating employment to sustain health, by offering opportunities and preparing people for real jobs in NHS Tayside. It targets the long term unemployed, those on incapacity benefits and those from socially deprived backgrounds, with a specific focus on youth (Smith & McEwen, 2006; NHS Tayside, 2011).

The Guiding Principles of the Academy are (NHS Tayside, 2012):

- To work within the context of socially responsible recruitment.
- To contribute to the overall and long term health of the region through access for people not in work to employment and development opportunities.
- To provide access to training aimed at generating quality services with a focus on essential support work.

- To work with NHS Tayside departments and colleagues to facilitate development in essential support work in line with national and professional drivers.

Type of intervention

The NHS Tayside Healthcare Academy is mainly an educational intervention, but also provides considerable professional and personal support.

Professional group(s) targeted

Those from socially deprived backgrounds, with a specific focus on young people, are prepared for band 1-3 positions in NHS or private social care, and Scottish Vocational Qualification (SQV) level 2 jobs in health and social care, and business and administration (NHS Tayside, 2012).

Level of the intervention

Organisational level.

Area covered

The Tayside area, a region in the North East of Scotland.

Running time of the intervention

The NHS Tayside Healthcare Academy was implemented in 2006 and was given substantive status by Tayside NHS Board in 2007 (NHS Tayside 2008). There is no expected end date.

Implementation strategy

Development of the idea of the Healthcare Academy

The journey of Ms Debbie Donald, currently Associate Director for Workforce Planning at NHS Tayside, with the Healthcare Academy began in 2005. She was a newly appointed Board level workforce planner at that time. Ms Donald has a background in nursing, mainly paediatrics, and she also worked as a health visitor in the community. Hence, she had seen the impact of unemployment on families and she started seeing second or third generation families that had never had employment.

When she first went in and did the profiling of the NHS workforce she came to the conclusion that it was quite 'elitist' and that it had a professional focus. At the same time, she found herself working in an environment where across the geography of Tayside there were real areas of urban deprivation. She then thought: the NHS is the greatest employer in the region and poverty is the greatest deterrent of ill health. The NHS could provide the kind of jobs which would allow people to get themselves out of poverty. She started working on this idea and took it to the Board. Ms Donald stated that the NHS should start recruiting from its local communities and help to break down the links between poverty and ill-health, by challenging prejudice and increasing access to employment, universities and colleges. The NHS is putting in place public health strategies which are about helping people to take control themselves. If it is able to look at employment strategies which allow people to enter healthcare at different levels, and give them opportunities and careers, then that would be a really future-focused public health strategy. Moreover, it would be a

recruitment and retention strategy for the NHS. This was viewed as a very radical idea (Donald, 2014).

Influence of clinical background

Ms Donald personally thinks that if she hadn't been exposed to poverty as a nurse and health visitor, she wouldn't have come up with the idea for the Healthcare Academy. As a health visitor she had a really deprived case load. The town where she worked had lost all its traditional industry. So the young people who were growing up there had no opportunity for employment. Ms Donald saw lost opportunity (Donald, 2014).

Implementation process of the Healthcare Academy

When Ms Donald then got employed at workforce planning in a HR department, because of a restructuring in the NHS, she felt as if the HR people were alien to the reality she had seen. HR is a technical role and Ms Donald was bringing ideas which challenged the way they used to work. Recruitment and retention strategies were not targeted at the labour market the NHS was working in, they were 'elitist'. The HR people wanted the professional and predictable people to come in and be interviewed. Ms Donald then said: we are a healthcare provider, we need to provide an example for others and be more inclusive in our employment strategies. She challenged them for example by saying: we as the NHS offer mental health services. Part of mental health patients' recovery is to get them back into employment. It's one in four who have mental health problems. She would say this in a room with 20 people and that would work (Donald, 2014).

To get the Healthcare Academy of the ground in 2005, Mr Alan Boyter, who was the HR Director at the time, and Ms Donald worked as a team. Ms Donald came with the idea and passion and Mr Boyter came from an HR background. She challenged him and changed his view. Subsequently, at Board level, he acted as the person who allowed Ms Donald access to the right people.

Another pivotal thing during this phase was the involvement of Professor Tony Wells. He had a background in mental health nursing and Ms Donald spoke with him as well. So these were catalysts all along which allowed Ms Donald to get into the right audiences.

The proposal for the Healthcare Academy was subject to consultation within NHS Tayside and responses were not universally supportive and exposed a set of values and prejudice against socially excluded people. Where this prejudiced view emerged, and was contrary to organisational objectives, it was confronted. Whilst the result of the consultation was positive over all, there was (and still is) a level of opposition based on inappropriate beliefs, some of the strongest opposition came from nursing colleagues. Also there was opposition from senior colleagues who tried to block the proposal or to limit its ambition, this does continue. Nonetheless and undeterred the originators of the concept took the results of the consultation and the proposal itself to the Board of NHS Tayside (Boyter & Donald, 2014).

When the Board was convinced, the struggle began to get the Healthcare Academy started and to get financing. Ms Donald and Alan Boyter went down to the Government and pitched what they wanted to do. They persuaded the Government and received start-up pilot money to set up a programme. One of the reasons why the Academy received Scottish government money, was because the programme was new. A similar programme wasn't in existence. After receiving the pilot money, Ms

Donald approached (what was then) Dundee College to develop an initial programme and Jobcentre Plus to help identifying the client group.

In 2005, a project manager was employed to set up the programme. She still works for the Academy. She also came from a clinical background as occupational therapist. So the crucial partners to get the programme running were: NHS Tayside Board with the help of Alan Boyter and Professor Wells, the Scottish Executive who provided the start-up money, Jobcentre Plus that helped in identifying the client group, and Dundee College who was the first education partner to come on board.

The NHS Tayside Healthcare Academy

6-week Pre-Employment course

The Academy opened with a 6 week Pre-Employment Programme (Boyter & Donald, 2014). This is an induction programme which gives people all the essential training to come and work in the health sector in entry level jobs (Donald, 2014).

Recruitment for the 6-week Pre-Employment course

Participants for this course are recruited through Jobcentre Plus. Many of the participants of the six-week course come from social deprivation, recovering from addictions and all sorts of challenges (Donald, 2014). Individuals who express an interest in attending the Academy are invited to an information session, where they learn more about the programme. If they wish to continue they are required to attend an interview, and a recommendation about acceptance, deferment or non-acceptance is made at this time. Individuals, who are accepted on to the course, undergo OHSAS screening and Enhanced Disclosure checks. They are then invited to attend Worknet, an employment skills course offered by Careers Scotland and in Dundee given an additional opportunity to access a Dundee City Council initiative aimed at promoting skills in literacy and numeracy (NHS Tayside, 2008). Box 1 shows the pre-employment recruitment process (NHS Tayside, 2012).

Box 1: pre-employment recruitment process

- During HCA course, presentation to students by Placement Coordinator on Recruitment Process
- Students complete generic (electronic) application form
- Students send completed application form to Placement Coordinator by email
- Placement coordinator sends completed forms to designated contact in Workforce Employment Services
- At course completion, Placement Coordinator sends list of eligible candidates to designated contact in Workforce Employment Services
- Workforce Employment Services hold list for reference
- Placement coordinator emails completed forms to designated contact in Workforce. Placement coordinator sends weekly list of jobs to HCA Services
- HCA candidates return list with indication of job interest to Employment Services
- Candidates will receive information on interview times and location + Job Interview dependent on person spec and relevant qualification/experience
- Workforce Employment Services send Monthly update on numbers in employment to HCA

- HCA log numbers in Data sets

Course content

Local colleges in partnership with Health and Social Care departments deliver the 6-week pre-employment course. The basic course is developed across Tayside in Angus, Dundee and Perth and Kinross with delivery reflecting local Health and Social Care service requirements. Course content places an emphasis on mandatory skills training, an insight into NHS Tayside and partner Councils as employers and most importantly, the ethos of care and needs of the individual. The students potentially have ten to twelve days on placement within a cross section of areas, to practice the skills and knowledge gained within the College whilst seeing how each area impacts upon and contributes to care delivery (NHS Tayside, 2008).

Support during course

As many of the participants come from social deprivation, recovering from addictions and have all sorts of challenges, a support network is developed around them so the Healthcare Academy can help them through their own personal challenges as well as providing them with the necessary induction to safely employ them (Donald, 2014). During the course, it is also crucial that potential barriers around childcare, transport, and adjusting to the work routine are recognised. Relevant partners such as Jobcentre Plus must be maintained in a communication loop to provide appropriate support. This may relate to advice on benefits such as working tax credit (NHS Tayside, 2011).

Employability and Employment Transition

In line with the tracking period laid down by Skills Development Scotland, the Placement

Coordinator sends out job vacancies for six months for band 1-3 positions following graduation.

However, support is not time limited and the Healthcare Academy team and partner agencies maintain on-going contact with graduates (NHS Tayside, 2011). All participants are offered a guaranteed interview at the end of their six weeks and provided on-going support whilst in their first year of employment. Should people be not job-ready at the end of the six weeks, the Academy has Skills Development Scotland to carry on the journey and remains in contact with them. People will then get a guaranteed interview within 6 months after completion of the programme. The people who are employed on entry-level jobs after they finish their course receive on-going support in the workplace by Healthcare Academy team members. Because the cohorts are small enough, the Academy is able to do that. All the people who do the mandatory 6-week Pre Employment Course, get a certificate so they are employable. They can work with the NHS or in social care with a private provider (Donald, 2014).

After the first cohort finished the six-week course, it proved so successful that the Healthcare Academy got substantive money from the Board (Donald, 2014). The six week course is now an eight week course. The Pre Employment Training Courses across the educational Colleges are refined to reflect locality needs were delivered in partnership with local Colleges and Councils across Angus, Dundee and Perth and

Kinross. The model remains widely regarded as transferable across care based organisations (NHS Tayside, 2013).

The Academy opened with the 6 week pre-employment programme. Subsequently, the curriculum offered expanded to offer 20 and subsequently 36 week Foundation programmes, and apprenticeships (Boyter & Donald, 2014).

20-week pilot SVQ 2 level course

Commencing September 2007 a 20-week pilot course designed to provide students with three core units towards a Scottish Vocational Qualification (SVQ) level 2 in Health and Social Care was delivered by NHS Tayside in partnership with Dundee College. The course delivered mandatory skills training in line with the 6-week pre-employment course, but also provided three core SVQ2 units. These units relate to Communication, Health and Safety and Professional Practice.

Placements varied, but each had a clinical basis and focused in areas where recruitment and retention could be problematic or developing in line with Central Government guidelines. Placements were therefore identified and offered within Critical Care, Allied Health Professions, Mental Health, Women and Child Services and Community Nursing. Managers, Placement Providers and clinical supervisors were completely committed to and supportive of the course.

The students generally responded extremely well to the demands of the NHS. Ten students completed this pilot and nine gained employment in healthcare. The Healthcare Academy was allocated Scottish Government funding for those who obtained employment in health and wished to continue education. Of the nine who had obtained education, three continued to nurse training.

36-Week SVQ2 Health and Social Care Course

The excellent feedback received from managers regarding the 20 week pilot course led to a joint 36-week SVQ 2 level foundation programme funded through Dundee College bursaries and the European Social Fund. The course is delivered with Dundee Social Work Department and the course is administered via a Partnership Group of College, Council, NHS and Private Healthcare providers. This course commenced in September 2008 (NHS Tayside 2008).

The 36-week bursary based course allows students with a focus on care services to access an SVQ2 vocational qualification in Health and Social Care through placement provision in the Public Sector. There is no age restriction on recruits to the course. The aim of this course is to equip students who will work and develop careers in the care to meet the needs of local service users by maintaining and improving the high standard of care currently being delivered (NHS Tayside 2011). The course is delivered by the Health and Social Care Academy partnership of Dundee College, Dundee City Council Social Work Department, Gowrie Care and NHS Tayside (NHS Tayside, 2013). Guaranteed interviews for those who successfully complete the course are honoured by all partners for a period of 6 months from course completion (NHS Tayside, 2014).

In 2013 -2014 15 NHS placements were offered to students of the SVQ 2 course. This was a reduction on the previous placement count of 25, and was in response to the increase of University based degree nursing and Higher National Certificate nursing students within NHS Tayside. Placements were not easily available in traditional areas;

therefore the rationale around this SVQ 2 group was re-examined (NHS Tayside, 2014).

36-Week SVQ2 Business and Administration

A 36 week course designed to lead to an SVQ level 2 in administration commenced in September 2011. This multi-agency partnership is a pilot programme delivered via Dundee College, NHS Tayside Dundee City Council Social Work Department, Tayside Fire and Rescue. Based on the pilot Administration course, it was decided that it will continue running. Feedback has been overwhelmingly positive with reference both to student performance and also to the support given by Dundee College. This course has potential to fully engage with the Young Person's agenda, proving a valuable skill set plus work based experience to promote robust engagement with the job market (NHS Tayside, 2012).

Organisational framework

NHS Tayside is responsible for delivering healthcare to around more than 400,000 people living and working in the region. NHS Tayside is one of 14 territorial health authorities in Scotland. It has a teaching board (i.e. linked to a university medical school – Dundee) with a revenue budget in the region of £750 million with approximately 14,000 employees. NHS Tayside is the largest employer in the region (Boyter & Donald, 2014).

The NHS Tayside Healthcare Academy was given substantive status by Tayside NHS Board in 2007. The NHS Tayside Healthcare Academy is directly responsible to the Associate Director of Human Resources – Resourcing and is embedded in NHS Tayside Human Resources Directorate; Employability Services (NHS Tayside, 2013). When the Academy was being established it had 3 FTE (AfC 8A, 6 and 4). In April 2010, an Assistant Practitioner Project Coordinator came into post, funded for a period of 23 months by the Scottish Funding Council (NHS Tayside, 2011). As the development became mainstreamed it moved to its permanent establishment of 2 FTE (AfC 8A and 4) (Boyter & Donald, 2014).

The initial team consisted of:

- Development officer: acts as Operational Line Manager for the Healthcare Academy Team, and is responsible for identifying development areas relating to the Healthcare Academy and establishing viable and sustainable systems to allow their implementation
- Development practitioner: a central figure for queries and concerns, linking as necessary to other partners, setting up support networks, contact points, and in developing a Former Students Association
- Administrator and Placement Co-ordinator: ensures smooth co-ordination of the administration required by all student cohorts, including communication across partners and with placement providers.

In 2013-2014, Dundee & Angus College employed a staff member with the remit to provide follow up support to students in employment and also to confirm employment status for participants. This has proved extremely helpful in terms of reporting non NHS outcomes to the Funding Body (NHS Tayside, 2014).

Partnership working

Before starting the Healthcare Academy, NHS Tayside did not have links with Jobcentre Plus. When the Healthcare Academy started, Ms Donald was relatively new in post and had few links with the colleges, Skills Development Scotland etc. However, during the start-up and running of the Healthcare Academy, partnerships were developed with other organisations, including the colleges, Jobcentre Plus, Skills Development Scotland and Barnardo's Scotland. Hence, NHS Tayside started working with organisations it had never worked with before. The Healthcare Academy would contact organisations and ask them; we have a very vulnerable person, what can you do (Donald, 2014)?

Across Tayside, the Academy is now firmly based in clear and committed partnership based workforce planning, reflecting joint local, regional and national initiatives. A key strength of the Academy is in the robust partnerships established across health, education, social care and both statutory and non-statutory agencies (NHS Tayside, 2011). The NHS Tayside Healthcare Academy works in close partnership with Jobcentre Plus (and their identified contractors Triage and Claverhouse Group), Skills Development Scotland, Dundee & Angus & Perth College; Angus Social Work and Health, Dundee City Council Social Work Department, Perth and Kinross Housing and Community Care, representatives of the independent and voluntary sectors and NHS Tayside (NHS Tayside, 2014). All partners are fully committed to promoting good practice in socially responsible recruitment, and in promoting excellence in standards of practice for people entering support services who will have the responsibility of delivering care to local communities (NHS Tayside, 2012).

The Healthcare Academy has also been engaged in further development of partnerships with regional and national agencies, such as NHS Education for Scotland, the Sector Skills Council and the Vocational Learning Network to ensure that activities reflect national education and workforce developments (NHS Tayside, 2012).

When the partnership with Barnardo's Scotland was set up in 2009, the Healthcare Academy had by then employed an additional staff member who was a nurse with a mental health background; this was beneficial to this cohort of people on the Healthcare Academy to provide additional support. The Healthcare Academy was taking really vulnerable young people as part of their recovery programme to Barnardo's Scotland who would provide them with work experience (Donald, 2014).

Nurse Bank

The Academy works closely with NHS Tayside centralised Nurse Bank to provide opportunities for students to access a variety of positions within the organisation. Experience has shown that for some students who may have commitments relating to child or elder care, this method of working provides both employment and flexibility. Support from the Nurse Bank has been extremely important to the academy, as swift entry to the Bank maintains momentum for students around gaining substantive employment immediately post course conclusion. Additionally, the Nurse Bank and Nursing Education have been extremely supportive of the whole Academy process through engaging in developing clear and relevant evaluation processes (NHS Tayside, 2014).

Cooperation and roles

There is a working-group for the Healthcare Academy. All the core partners get together on a two-monthly basis. They then do programme planning, review the past two months, look at new developments and share challenges. It is chaired by a non-Executive board member of NHS Tayside and all partners are welcome to come. It is quite an informal group and more of a learning forum, and a development forum.

The roles that all partners have within the Healthcare Academy scoped out from their own organisations. So the colleges are the education providers, Jobcentre Plus provides their role through their core function, which is getting people in employment and out of benefits. Then NHS Tayside provides the placement and the learning and the Healthcare Academy team. So all partners are working in their own organisational commitments, but come together in the partnership.

NHS Tayside has a service-level agreement with all partners (Donald, 2014).

Role of the education partners (Angus, Dundee, Perth and Kinross Colleges)

Each pre-employment programme has been developed with full involvement and advice from education partners. The role of Further Education Colleges across Tayside, with their familiarity with multi agency working and placement administration has been crucial to the partnership, particularly as each of the 3 colleges has specific knowledge and experience of local population needs and education profiles. The course is constantly reviewed and adapted by the partners to meet the developing needs of the local population and in line with local, regional and national NHS and Social Care service requirements (NHS Tayside, 2008).

Facilitators in the running of the intervention

Around the start of the Healthcare Academy, there were a number of crucial partners to get the programme running were: NHS Tayside Board with the help of Alan Boyter and Professor Wells. They provided Ms Donald, who had come up with the idea, with access to the right persons. Subsequently, the Scottish Executive who provided the start-up money for the Healthcare Academy. Lastly, Jobcentre Plus that helped in identifying the client group, and Dundee College who was the first education partner to come on board.

In the running of the programme, the partnership working that is taking place is of crucial importance. The fact that all partners are working in a role through their own core function, are working in their own organisational commitments, makes this partnership successful and sustainable.

Barriers in the running of the intervention

Around the time of introduction and up to this date, there has been a level of opposition to people from socially deprived background becoming NHS colleagues. This is based on inappropriate beliefs. Some of the strongest opposition came from nurses. Also there was opposition from seniors who tried to block the proposal for the Healthcare Academy or to limit its ambition. Because of a competitive managerial environment, managerial commitment to implementation also remains variable. This is despite the success of the Healthcare Academy model (Boyter & Donald, 2014).

Finances

A lot of the money for the Healthcare Academy comes from the education funding, which is drawn down centrally, and from the Jobcentre Plus funding (Donald, 2014).

Pre Employment Training Course funding

Funding for the Pre Employment training courses is supplied through the Training for Work Programme supplied through Skills Development Scotland and delivered by all partners with particular reference to Angus, Dundee and Perth Colleges to reflect area profiles and identities.

The funding body requires that students funded through this initiative should achieve employment within 26 weeks of course completion to register as an employment outcome. The outcome must also involve the successful student working for 16 or more hours per week or 60 hours per month (NHS Tayside, 2011; 2013). These requirements reflect Central Government regulations and cannot be altered. Failure to achieve these targets for at least 50% of completing students may affect future levels of funding (NHS Tayside, 2012).

36-Week SVQ2 Health and Social Care funding

Course delivery is through the on-going and robust partnership of Dundee & Angus College, Dundee City Council, Gowrie Care and NHS Tayside. Funding is provided through the Skills Development Scotland Employability fund (NHS Tayside, 2014).

36-Week SVQ2 Business and Administration funding

This course is funded by Dundee College (NHS Tayside, 2012).

General budget

NHS Tayside funds the salaries of a dedicated team (Boyter & Donald, 2014). The Academy has been allocated a recurring annual budget to address marketing, and purchasing and replacement of uniforms. A non-recurring payment was allocated in the first instance to provide uniform and marketing stock (NHS Tayside, 2008). Since its inception, the Academy has maintained its annual budget of £5,000. The focus remains on uniform supply and laundering with some capacity for marketing and support for events and education (Donald, 2014; NHS Tayside, 2014).

Funding of the Assistant Practitioner Project Coordinator

In April 2010 the Assistant Practitioner Project Coordinator came into post, funded for a period of 23 months by the Scottish Funding Council (NHS Tayside, 2011).

Specific funding

Specific funding comes from Job Centre Plus and Barnardos. This is mostly associated with specific clients (Boyter & Donald, 2014).

Conditions for replicability

For organisations that are also thinking about introducing a model similar to the Healthcare Academy, several factors appear to be of core importance and should be taken into consideration:

- Establishing a sufficient level of support for the initiative within the organisation and fight prejudices.

- Strong partnership working
- The Academy has a 'maximum capacity': if the Healthcare Academy grows too big, it would risk what has been its success. To achieve the level of success it has, it needs to have people to complete the programme and then be able to support them into employment. If the numbers are too big, this can't be done (Donald, 2014).
- According to Ms Donald, the Healthcare Academy model could easily be replicated across any public sector organisation. She states: "Certainly, there are a wealth of opportunities to take the model of the Healthcare Academy and replicate it elsewhere." One could actually turn these into public sector academies, not healthcare academies. One could look at creating them, maybe regionally. It just needs the will for it to happen (Donald, 2014).

3. Results of the intervention

Since the Tayside Healthcare Academy opened, almost 1000 people have accessed the range of programmes delivered by the Academy partnership; gaining skills, training and essential work experience (Donald, 2014). The growth of the Healthcare Academy over the years has been in the programmes it offers and not so much in the number of participants. Because the Academy has to provide a high level of support, it needs to be not too intimidating for the client group. Moreover, it can't become too big because placements in the organisations are needed. Ms Donald stated: if we grow too big, we would risk what has been a success. To achieve the level of success we have, we need to have people to complete the programme and then be able to support them into employment. If the numbers are too big, we couldn't do it (Donald, 2014).

Outcomes on recruitment and retention

Even though the numbers of the Healthcare Academy are relatively small, it gives NHS Tayside a pool of people to fill up posts. Moreover, under the banner of the Healthcare Academy, NHS Tayside also developed apprentices after a gap of 22 years. So it starts providing young people from a socially excluded background with employment. This has had an impact on employment or vacancies as well because NHS Tayside has got this cohort or pool of people, who are work-ready for entry-level jobs (Donald, 2014).

Qualitative outcomes

Managers report that Healthcare Academy graduates clearly understand the responsibilities of working in healthcare. Yet perhaps the greatest improvement for the candidate themselves is in greater confidence levels. Many candidates have experienced long term barriers to work and enter the Academy with low self-esteem. At the end of the programme, students have marketable and desirable skills and new aspirations for the future. They have often completed a personal journey and the transformation is inspiring and emotional (NHS Tayside, 2008). As Ms Donald explained, rather than bringing forward the message 'we manage our vacancies better because of this', the most powerful measure of the Healthcare Academy is that it has probably changed people's thinking about recruitment, changed the 'elitist' view about who NHS Tayside recruits. The success of the Healthcare Academy is not about the big things or the big numbers, it's about small things. There are very powerful stories, like people who got their driving license or are taking their children on a holiday for the first time (Donald, 2014).

Awards

Over the years, the NHS Tayside Healthcare Academy and its partners received various awards for their achievements. In 2007, the NHS Tayside Healthcare Academy picked up the 'Recruitment and Retention' award at the 2007 Health Service Journal Awards. The Health Service Journal Awards celebrate excellence in the provision of healthcare across the UK and had more than 1100 entries in the 2007 competition (NHS Tayside, 2007). In 2010, NHS Tayside and Dundee College were commended for the work on the Healthcare Academy at Scotland's Colleges Business to College Awards (Locate Dundee, 2010). In 2013, the Perth and Kinross Health and Social care

Academy received the 'Supported Employment Provider of the Year' award at the Tayside Business Diversity Awards 2013 (NHS Tayside, 2014).

Outcomes Pre Employment course

Objectives of the course are measured primarily through job outcomes. While entry to Health and Social care employment is emphasised, there are no restrictions to employment in other areas, and links have been successfully initiated with private health providers in Angus and Perth and Kinross. Nevertheless, to comply with Department of Work and Pensions directives and funding agency regulations, students must successfully secure employment within 6 weeks following the completion of the Pre-Employment course, if funded by New Deal, and within 26 weeks if funded by Training for Work programmes (NHS Tayside, 2008).

Between 2006 and 2011, the Health and Social Care Academy has been involved with (NHS Tayside, 2011):

- 9 Pre-employment cohorts in Angus
- 16 Pre-employment cohorts in Dundee
- 6 Pre-employment cohorts in Perth

From these cohorts across Angus, Dundee and Perth there have been:

- 416 students commenced the Pre-employment course
- Of these 416 students, 361 students completed the course (86.8%)
- 17 students who completed the course progressed to further education
- 272 students accessed employment within 6 months (75.3%)

Table 1: details Angus Statistics: 2006-2011

Cohort	Started Course	Completed Course	% Completed Course	Total Employed	% Employed
Angus 1	14	11	78.6%	4	36.4%
Angus 2	14	14	100%	10	71.4%
Angus 3	12	9	75.0%	7	77.8%
Angus 4	12	9	75.0%	8	88.9%
Angus 5	14	12	85.7%	10	83.3%
Angus 6	11	10	90.9%	6	60.0%
Angus 7	14	12	85.7%	8	66.7%
Angus 8	14	14	100%	5	35.7%
Angus 9	13	13	100%	4	30.8%

Source: NHS Tayside, 2011

Employment achievement 6 months of completing the course for Angus:

NHS: 35.5%

Council/Social Care: 12.9%

Independent sector: 50.0%

Voluntary: 1.6%

13 students progressed to further education.

Table 2: details Dundee Statistics: 2006 -2011

Cohort	Started Course	Completed Course	% Completed Course	Total Employed	% Employed
Dundee 1 - 10	144	120	83.3%	102	85.0%
Dundee 6	14	10	71.4%	8	80.0%
Dundee 7	15	15	100%	13	86.7%
Dundee 8	15	13	86.7%	11	84.6%
Dundee 9	17	16	94.1%	10	62.5%
Dundee 10	13	13	100%	12	92.3%
Dundee 11	13	13	100%	11	84.6%
Dundee 12	15	14	93.3%	12	85.7%
Dundee 13	15	14	93.3%	11	78.6%
Dundee 14	15	14	93.3%	11	78.6%
Dundee 15	12	12	100%	7	58.3%
Dundee 16	13	12	92.3%	11	91.7%

Source: NHS Tayside, 2011

Employment achievement 6 months of completing the course for Dundee:

NHS: 77.0%

Council/Social Care: 3.0%

Independent sector: 19.4%

Voluntary: 0.6 %

4 students progressed to further education.

Table 3: details the Perth and Kinross Statistics: 2006-2011

Cohort	Started Course	Completed Course	% Completed Course	Total Employed	% Employed
Perth 1	12	11	91.7%	7	63.6%
Perth 2	12	10	83.3%	9	90.0%
Perth 3	12	11	91.7%	7	63.6%
Perth 4	13	11	84.6%	10	90.9%
Perth 5	11	7	63.6%	6	85.7%
Perth 6	11	8	72.7%	6	75.0%

Source: NHS Tayside, 2011

Employment achievement 6 months of completing the course for Perth:

NHS: 26.7%

Council/Social Care: 13.0%

Independent sector: 57.8%

Voluntary: 2.2 %

The Academy has continued to support Pre Employment courses between 6 - 8 weeks duration across the region. Percentages to date of students from this programme achieving employment across sectors remain healthy at 70% since 2006 (NHS Tayside, 2012). Between August 2006 and April 2013 43 pre employment courses were successfully completed across Tayside with 568 people participating (NHS Tayside, 2013). In 2013-2014, there were 7 pre employment courses with 90 participants successfully completed across Tayside (NHS Tayside, 2014).

Outcomes 36-Week SVQ2 Health and Social Care Course

Outcomes of the 36-Week SVQ2 Health and Social Care Course on employment and further education are reported in table 4 below.

Table 4: Outcomes SVQ2 Health and Social Care course 2010 and 2011 cohorts

	N completing course	N gaining employment	Higher Education	NHS	Dundee City Council	Private Sector	Voluntary Agency	Work unrelated to Health	Not recorded
2010	22	15 (68%)	6 (27%)	2	2	5	4	2	1
2011	38	14 (37%)	7 (18%)	?	?	?	?	?	-

Source: NHS Tayside, 2011; 2013

36-Week SVQ2 Business and Administration

This course was delivered by Dundee College in partnership with Children at Home, NHS Tayside and Dundee University. In 2012, 10 students took part in the course with 8 students successfully completing the course. Outcomes related to employment in the

private sector and progression to HNC Business and Administration (NHS Tayside, 2013).

References

Boyster, A. & Donald, D. (2014). NHS Tayside Healthcare Academy. Personal communication.

Donald, D. (2014). Interview for the Recruitment and Retention study during case site visit.

Locate Dundee (2010). *Top Award for Dundee College*. 30-03-2010. Available on: <http://www.locate-dundee.co.uk/news/top-award-for-dundee-college> (accessed on: 15-10-2014).

NHS Tayside (2007). The Staff Magazine for NHS Tayside Issue 33 December 2007.

NHS Tayside (2008). Healthcare Academy Annual Report 2007-08. NHS Tayside.

NHS Tayside (2011). Healthcare Academy Annual Report 2010. NHS Tayside.

NHS Tayside (2012). Healthcare Academy Annual Report 2011. NHS Tayside.

NHS Tayside (2013). Healthcare Academy Annual Report 2012-2013. NHS Tayside.

NHS Tayside (2014). NHS Tayside Employability Services. Healthcare Academy Annual Report 2013-2014. NHS Tayside.

Smith, A. & McEwen, R. (2006). NHS Tayside Health Care Academy. Presentation. NHS Tayside

Appendix 1.4. Case report 1.4

Topic 1. Attracting young people to healthcare

Case 1.4. "Ich Pflege, weil..." campaign, Germany



Research methods applied:

Desk research: August – September 2014

1. Summary of the intervention – “Ich Pflege, weil...”campaign, Germany

Dimension of interest	Categories/description
Objective of the intervention	Recruitment
Type of intervention	Education/promotional campaign
Professional group(s) targeted	Predominantly high school students
Level of intervention	Policy
Type of organisation	German Ministry of Health
Kind of services provided by organisation	Various
Size of organisation	Large
Area covered	Germany
Intervention period / duration of intervention	The Ich Pflege, weil... campaign started in September 2009.
Key actions	Various actions were undertaken, including: visits of Minister of Health to diverse institutions in which nurses are working, pictures around the "Ich Pflege, weil..." campaign were published in daily and weekly newspapers, school visits, visits to healthcare institutions, "open door day" of the Federal Ministry of Health, etc.
Financial investment	Additional financing is required. This campaign is funded by the MoH.
Day-to-day running of the intervention	No information could be retrieved.
Personnel investment	Limited additional HR is required.
Outcome measures of the intervention	No information could be retrieved.

2. Rich description of the intervention

Case under study

The German "Ich Pflege, weil..." campaign, established in September 2009.

Reasons for the establishment of the "Ich Pflege, weil..." campaign

In Germany, the aging population will lead to additional demand for labour in health care. If one would only apply the current ratio of nurses to patients, with unchanged frameworks in the future, then in 2040 there will already be a shortage of around 550,000 additional professional geriatric nurses. Hence, German society becomes more and more reliant on people who devote themselves to health care- and geriatric nursing (in German: Kranken- und Altenpflege) or will do so in the future (Bundesministerium für Gesundheit, 2009).

Objective of the intervention

The main aims of the "Ich pflege, weil..." campaign are to increase the recognition within society for the nursing profession and to promote vocational choices among young people into nursing education. At the start of the "Ich Pflege, weil..." campaign, the Minister of Health Ulla Schmidt stated that: "With the action, we want to obtain more recognition from society for nurses. Nursing jobs are jobs with a future. It needs to become clear with how much engagement nurses enable patients to live their lives in dignity" (Bundesministerium für Gesundheit, 2009).

Type of intervention

Recruitment intervention via promotional campaign.

Professional group(s) targeted

Level of the intervention

Policy level.

Area covered

Germany.

Activities undertaken as part of – or related to the "Ich pflege, weil..." campaign

Various activities have been organised as part of the "Ich pflege, weil..." campaign (Bundesministerium für Gesundheit, 2014):

- Throughout the years, several so-called nursing ambassadors and/or nurses were invited to the Ministry of Health for a talk with the Minister of Health about their profession and the issues they are struggling with.
- The Minister of Health has made several visits to diverse institutions in which nurses are working, such as homes for the elderly but also hospitals.
- From 21 March to 2 April 2013 pictures were published in daily and weekly newspapers around the action "Ich Pflege, weil..." campaign. The motivation of the nurses was the focus of the pictures.

- The Minister of Health visited schools to discuss nursing with students.
- Students visited healthcare institutions to become familiar with nursing jobs.
- During the “open door day” of the Federal Ministry of Health, participants of the action “Ich pflege, weil...” were set in the Spotlight.
- *DaSein* campaign (in English: To be there campaign). The Federal Ministry of Health invited nurses to exhibit a very personal perspective on care. Nurses selected their favourite photos from numerous submissions that show aspects of nursing care. The exhibition with snapshots from the world of care could be seen by over 100 exhibitions throughout Germany in September / October 2014. See also website: <http://www.dasein-ausstellung.de/>

“Ich pflege, weil...” and exhibition “Eine neuer Blick auf die Pflege”

To put the value of the nursing profession at the centre of society’s awareness, since 2008 the Federal Ministry of Health has tried to get the issues of aging and nursing care at the centre of attention under the headline “Ein neuer Blick auf die Pflege”.

In addition to the presentation of nursing care in nursing homes (photo exhibition “A new look at nursing care”) and the activation of young people for these issues (theater competition “Season! Theater around ageing”), it’s also about the assets, the nurses, whose important work should be appreciated. In September 2009, the action was “Ich pflege, weil...” was started online.

In the online exhibition on the website of the Ministry, nurses get a face and voice, through photos and personal short texts by nurses.

The Federal Ministry of Health calls on nurses to participate in the campaign and become a nursing care ambassador. In this way, the action can help to strengthen the social standing of the nursing profession and to promote appropriate vocational choices among young people (Bundesministerium für Gesundheit, 2009).

Running time of the intervention

The “Ich pflege, weil...” campaign was introduced in September 2009.

Organisational framework

“Ich pflege, weil...” campaign is conducted by the Ministry of Health, in cooperation with educational institutions and healthcare institutions.

Finances

No information could be retrieved.

3. Results of the intervention

No information could be retrieved.

References

Bundesministerium für Gesundheit (2009). *Bundesgesundheitsministerin Schmidt: Pflegeberufe brauchen mehr gesellschaftliche Anerkennung. BMG Aktion "Ich pflege, weil" vorgestellt.*

Bundesministerium für Gesundheit (2014). *Ich pflege weil... Termine und Aktionen.* Available at: <http://www.ich-pflege-weil.de/ueber-die-aktion/weitere-meldungen.html> (accessed 20-11-2014)

Appendix 1.5. Case report 1.5

Topic 1. Attracting young people to healthcare

Case 1.5. Hvid Zone campaign, Denmark



Research methods applied:

Desk research: August – September 2014

Email interview: October 2014

1. Summary of the intervention – Hvid Zone campaign, Denmark

Dimension of interest	Categories/description
Objective of the intervention	Recruitment
Type of intervention	Education/promotional campaign
Professional group(s) targeted	High school students
Level of intervention	Policy
Type of organisation	Consortium: Ministry of Education, Ministry of Health, Danish Regions, Danish municipalities, Danish Nurses Organisation, Danish Bio analysts, Danish Society of Radiographers and University Colleges
Kind of services provided by organisations	Various
Size of organisations	Medium to large
Area covered	Denmark
Intervention period / duration of intervention	The three year campaign ran between 2009 and 2011.
Key actions	The emphasis of Hvid Zone was on TV, digital and social media. White Zone was also included in activities of professional schools and events were organised throughout the country.
Implementation strategy or processes used	No information could be retrieved. However, in the beginning there were quite a few organizing meetings between the partners, but as time went by meetings became less frequent and much was dealt with via email.
Financial investment	Additional financing is required. All parties that participated in the Hvid Zone campaign paid part of the costs. Specific amount was based on the number of members of a certain organisation. E.g. the Danish Regions contributed 3 million Danish Kroner (€402.411) in total. The Radiography Council paid three times 7.500 Danish krone (€1.007).
Personnel investment	Limited, no new HR needs to be attracted by organisation.
Outcome measures of the intervention	The results for the increased uptake of the

	three educational programmes are: bio-analyst training: 81% increase, radiography 84% increase and nursing 53% increase between 2008 and 2011.
--	--

2. Rich description of the intervention

Reasons for the establishment of the *Hvid Zone* [White Zone] campaign

Between 2009 and 2011, a number of parties in Denmark ran a three-year recruitment campaign to increase the number of persons entering training in the fields of nursing, radiography and medical laboratory technology. The campaign was called the 'Hvid Zone' campaign [White Zone Campaign] (Danske regioner, 2012).

Objective of the intervention

The overall objective of the recruitment campaign was to train a sufficient number of nurses, radiographers and laboratory technicians, so that social needs are met. Hence, the 'Hvid Zone' campaign was aimed at increasing the number of persons entering training in the fields of nursing, radiography and medical laboratory technology over three years with 44% (Danske regioner, 2012). Complementary goals were to increase awareness of these areas of study and the healthcare sector as potential workplace (Hvid Zone, 2009).

Type of intervention

The 'Hvid Zone' campaign was a promotional campaign aimed at recruitment.

Professional group(s) targeted

The Hvid Zone campaign focused on the inflow of students in the fields of nursing, radiography and medical laboratory technology. The primary target group were young people aged 17-25 years (Danske Bioanalytikere, 2014; Hvid Zone, 2009).

Level of the intervention

The Hvid Zone campaign was ran at national and regional levels all across Denmark, predominantly at policy level (Ministry of Education, 2009).

Area covered

Denmark.

Running time of the intervention

The three-year recruitment campaign 'Hvid Zone' ran between 2009 and 2011 (Danske regioner, 2012). There are no plans to re-run the campaign in the future.

Organisational framework

The Hvid Zone campaign was ran by a consortium of the Ministry of Education (Undervisningsministeriet), the Ministry of Health (Ministeriet for Sundhed og Forebyggelse), Danish Regions (Danske Regioner), Danish municipalities, professional organisations (Dansk Sygeplejeråd, Danske Bioanalytikere, Foreningen af Radiografer i Danmark) and University Colleges (Professionshøjskolernes Rektorkollegium) (Danske regioner, 2012). In 2009, Mr Bent Hansen, President of the Danish regions stated that a national common approach is needed, and I am pleased that the parties have come together both at the organizational level, but also nationally and regionally (Ministry of Education, 2009). The parties met on an ad hoc basis. In the beginning there were

quite a few organizing meetings but as time went by, meetings became less frequent and much was dealt with via email (Danske Bioanalytikere, 2014).

Key activities of the intervention

Hvid Zone was intended to raise awareness and to attract young people with the promise of "the start of an intensive future." The creative directors have therefore focused on the intensity of life as a medical laboratory technologist, radiographer and nurse. The emphasis of the campaign was on the requirements for these jobs of having overview, courage and a drive to work with sick or vulnerable people. The name Hvid Zone (White Zone) and the logo with the red cross (see below) was inspired by the hospital sector and the strong teamwork that exists between health professionals.

Figure 1: Hvid Zone campaign logo



The emphasis of the Hvid Zone was on digital media, including social media like Facebook. In addition, TV spots, TV sponsorship and advertising both nationally and locally were used. White Zone was also included into the existing websites for programmes and activities of professional schools.

The campaign included the following elements and media (Hvid Zone, 2009):

- TV commercials and sponsorship, viral, online banners for web
- White Box
- Viral Movie seeding via the Internet
- Search package (Google Adwords Campaign), to attract viewers to home page
- Online banner campaign, to attract viewers to home page and create applicants for training
- The campaign home page www.hvidzone.dk
- Social media

In addition, events were organised throughout the running time of the intervention and throughout the country. For example when the Hvid Zone was in its second year of running, the campaign was re-launched with a series of events around the country. For example there was an event at the main train station in Copenhagen to engage students and random passers-by.

Implementation strategy

No information could be retrieved about the implementation strategy of the Hvid Zone campaign. However, one informant told us that in the beginning there were quite a few organizing meetings but as time went by, meetings became less frequent and much was dealt with via email (Danske Bioanalytikere, 2014).

Finances

All parties that participated in the Hvid Zone campaign paid part of the costs. The specific amount of the financial contribution was based on the number of members that a certain organisation had. Hence, organisations with many members contributed more to the campaign (Danske Bioanalytikere, 2014).

The Danish Regions have contributed 3 million Danish Kroner (€402.411) in total to the campaign, while more than 70,000 Danish kroner (€9.389) in unused funds have been returned (Danske regioner, 2012).

The Radiography Council (Radiograf Rådet in Danish) paid three times 7.500 Danish kroner (€1.007) to this campaign. When the Hvid Zone campaign was finished, they were returned 500 Danish kroner (€67) (Radiography Council, 2012).

The Danske Bioanalytikere paid the following amounts (Danske Bioanalytikere, 2014):

2009: 25.000 Danish Kroner (€3.358)

2010: 25.000 Danish Kroner (€3.358)

2011: 22.884 Danish Kroner (€3.074)

2012: 14.160 Danish Kroner (€1.902).

3. Results of the intervention

Increase in student enrolment numbers

The goal of the Hvid Zone campaign was to increase the number of persons entering training in the fields of nursing, radiography and medical laboratory technology with 44%. An evaluation shows that in all three programmes, recruitment has increased even more. The results for the increased uptake of the three programmes are:

Bio-analyst training: 220 more applicants in 2011 than in 2008 (81% increase)

Radiography: 130 more applicants in 2011 than in 2008 (84% increase)

Nursing: 1236 more applicants in 2011 than in 2008 (53% increase)

The evaluation also shows that the campaign has helped to increase the general knowledge of the three courses (Danske regioner, 2012).

Table 1: Increase in number of applications in 2009 and 2011, relative to 2008

Education	Increase 2008-2009	Increase 2008-2011
Bio-analyst	59%	81%
Radiography	115%	84%
Nurse	30%	53%

Source: Ministry of Education

The Danske Bioanalytikere organisation mentions that the number of applications for all three programmes rose significantly. In 2012, vacant nurse study places were found in 17 out of 22 schools. In Biomedical Laboratory Scientists schools, only 1 out of 5 places were vacant and there were no vacancies at all in the three Radiography schools (Danske Bioanalytikere, 2014).

Proxy measure: Hvid Zone campaign awarded

In 2009, the Hvid Zone received an honorary award by the International Advertising Association. One of the main reasons that the campaign was awarded was because the campaign had showed positive results already shortly after its establishment. Moreover, the campaign was complimented because it "goes straight to the heart of the young" (Ministry of Education, 2009).

References

Danske Bioanalytikere (2014). Email interview.

Danske regioner (2012) *Dagsorden for bestyrelsesmødet den 27. januar 2012, Punkt 14, generelle orienteringer, sagsnr. 12/37*, København: Danske Regioner. <http://www.regioner.dk/om+danske+regioner/dagsordener/dagsordener+for+bestyrelsesm%C3%B8der+i+2012/dagsorden+for+bestyrelsesm%C3%B8de+den+27,-d-,+januar+2012/punkt+14+-+27,-d-,+januar+2012>

Danske Bioanalytikere, 2014. Personal communication to Recruitment & Retention study by email. 21 November 2014.

Hvid Zone (2009). Analyse og effekt af Hvid Zone kampagnen. Hvid Zone.

Ministry of Education (2009). Festlig kampagnestart i Hvid Zone på Rådhuspladsen. 30-04-2009.

Ministry of Education (2009). Hvid Zone-kampagne hædret. 16-11-2009.

Radiography Council (2012). Minutes of the central executive committee meeting February 6, 2012

Appendix 1.6. Case report 1.6

Topic 1. Attracting young people to healthcare

Case 1.6. Project Zorgtrailer [Care trailer], the Netherlands



Research methods applied:

Desk research: August – September 2014

1. Summary of the intervention – Zorgtrailer, the Netherlands

Dimension of interest	Categories/description
Objective of the intervention	Recruitment
Type of intervention	Education
Professional group(s) targeted	Students in the third and fourth grade of pre-vocational secondary education-sector Care and Welfare
Level of intervention	Organisational
Type of organisation	The Florence Nightingale Institute is a knowledge centre for the history of nursing and caring.
Kind of services provided by organisation	Primarily activities across the country (such as photo exhibitions), education and research
Size of organisation	Small
Area covered	The Netherlands
Intervention period / duration of intervention	5th of January 2010 until the end of 2012
Key actions	An important part of Project Zorgtrailer is the multimedia info trailer that comes to schools. Teachers also receive an educational package and schools can request a guest lecture and/or a theater performance.
Financial investment	Additional financing is required for this intervention. The Zorgtrailer was financed by the Dutch Ministry of Health, Welfare and Sport.
Implementation strategy or processes used	The Florence Nightingale Institute was supported in the development and creation of Project Zorgtrailer by the youth communication agency YoungWorks.
Day-to-day running of the intervention	Responsibility of the Florence Nightingale Institute.
Personnel investment	Additional HR is required, but limited. The project was run by a Project Manager who was employed by the Florence Nightingale Institute ran and

	coordinated the project.
Outcome measures of the intervention	No evaluation has taken place to what extent the Zorgtrailer project increased the number of nursing students.

2. Rich description of the intervention

Establishment of Project Zorgtrailer

Project Zorgtrailer started on the fifth of January 2010. Project Zorgtrailer is an educational programme specifically aimed at young people. An important part is the purpose-built truck that comes to schools.

Reasons for the establishment of Project Zorgtrailer

In 2010, the Dutch State Secretary for Health, Welfare and Sport Jet Bussemaker stated that the recruitment of healthcare professionals 'is of vital importance'. In the Netherlands, huge shortages in healthcare are expected. In 2010, it was expected that if things would not change, there will be a shortage of half a million healthcare professionals in 2025 (Trouw, 2010).

At the same time, the healthcare sector has a negative image amongst young people. Young people have little expectations of working in health care in terms of career possibilities, task package and salary. As a result, they often do not take healthcare jobs into consideration when thinking about a follow-up study (Dichtbij, 2010; Trouw, 2010).

Objective of the intervention

Project Zorgtrailer aims to enthuse young people for a job in healthcare. The slogan of the project was: "Healthcare, you forget that it is work" (V&VN, 2010). One of the main focuses of the project was on dispelling prejudices about working in healthcare and informing young people about all the things a job in healthcare has to offer (Dichtbij, 2013; Rijksoverheid, 2010).

Type of intervention

Promotional campaign for nursing.

Professional group(s) targeted

Students in the third and fourth grade of pre-vocational secondary education- sector Care and Welfare (in Dutch: voorbereidend middelbaar beroepsonderwijs- sector Zorg en Welzijn) (Dichtbij, 2013).

Level of the intervention

Organisational level.

Area covered

The Netherlands

Running time of the intervention

The Zorgtrailer opened its doors for the first time on the 5th of January 2010. The project ran for three years until the end of 2012 (Rijksoverheid, 2010; Youngworks, 2012).

Project Zorgtrailer

Project Zorgtrailer is an educational programme specifically designed for pre-vocational secondary education students. An important part of the programme is the specially built 14 meter-long truck that comes to the schools. This multimedia trailer features interactive touch screens and a 3D cinema. Through an educational game, the Care Check (a career test), a historic group photo and a movie in 3D students can experience the particular aspects of working in health care. The movie that is shown is a fictional story, with actors from the famous TV series Spangas! (Dichtbij, 2013; Rijksoverheid, 2010).

In the Zorgtrailer, students are accompanied by an educational assistant of the Dutch Florence Nightingale Institute. Additionally, teachers receive an educational package on the history of- and working in healthcare, to use after the visit of the Zorgtrailer. In this way, students can consider whether working in healthcare may be something for them. In addition to the Zorgtrailer, schools can request a guest lecture and/or a theater performance about working in healthcare. The theatre performance was called "The Care Academy". This is a rousing, interactive theater performance at school which takes the students to the care training of the future (Near, 2013; National Government, 2010).

On the website of the Florence Nightingale Institute, choosing for a job in healthcare is also being encouraged. Via five different short movies boys and girls are acquainted to working as a nurse in a hospital, as carer in care for the disabled or a nursing home, and with a job in home care or mental health care (V&VN, 2010).

Implementation strategy

In 2009, the Florence Nightingale Institute was supported in the development and creation of the Project Zorgtrailer by the youth communication agency YoungWorks (YoungWorks, 2012).

Organisational framework

Project Zorgtrailer was developed by the Dutch Florence Nightingale Institute and financed by the Ministry of Health, Welfare and Sport (Rijksoverheid, 2010). It was run by a Project Manager who was employed by the Florence Nightingale Institute and assisted in the running and the coordination of the project.

Finances

Project Zorgtrailer was financed by the Dutch Ministry of Health, Welfare and Sport (Rijksoverheid, 2010).

Conditions for replicability

- Considerable financial resources
- One organisation who takes responsibility for coordinating the activities

3. Results of the intervention

No evaluation has taken place to what extent the Zorgtrailer project increased the number of nursing students. At the beginning of Project Zorgtrailer it was expected that 180 schools in the Netherlands would participate and 30.000 students would attend the Zorgtrailer (Trouw, 2010). However, it is not known how many students actually visited the Zorgtrailer.

Process measures

Youngworks, a company for youth communication, evaluated the impact of the visit that students made to the Florence Nightingale Institute. Youngworks performed a 0 and 1 measurement to determine the effect of the visit of pre-vocational secondary education students to the Florence Nightingale Institute. This evaluation showed that students were generally positive about the information they received about the history of nursing and care. They remembered much from their visit and could also tell spontaneously about it. About the form in which they received this information, students were less positive. On the basis of the research, no differences were found between the 0 and 1-measurement in terms of intention to opt for a career in the care sector. For most students, their intention was not changed on the basis of the visit to the Florence Nightingale Institute (Youngworks, 2012).

References

Dichtbij (2013). *School vraagt aandacht voor de Zorg*. <http://www.dichtbij.nl/waterweg/wonen/artikel/2618459/school-vraagt-aandacht-voor-de-zorg.aspx#> (accessed 29-10-2014)

Rijksoverheid (2010). *Zorgtrailer als eerste op Maris College Den Haag*. <http://www.rijksoverheid.nl/nieuws/2009/12/29/zorgtrailer-als-eerste-op-maris-college-den-haag.html> (accessed: 29-10-2014)

Trouw (2010). Baan in de zorg is meer dan snot afvegen.

Verpleegkundigen & Verzorgenden Nederland (2010). *Zorgtrailer op pad voor zorgpersoneel*. <http://www.venvn.nl/Actueel/Nieuwsarchief/tabid/1789/Articleid/2191/mid/3452/Default.aspx> (accessed: 29-10-2014)

Youngworks (2012). Effectmeting 2: Bezoek aan het FNI. Kwalitatief onderzoek naar hoe jongeren hun bezoek aan het FNI beleven.

Appendix 2.1. Case report 2.1

Topic 2. Attracting and retaining GPs to strengthen primary care in underserved areas

Case 2.1. Pacte Territoire Santé, France



Research methods applied:

Desk research: August – September 2014

Telephone interviews: September 2014 (national Department of Health) and January 2015 (regional health authority of the Centre region)

Case site visit: December 2014

1. Summary of the intervention – Pacte Territoire Santé, France

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Mix, package of measures
Professional group(s) targeted	Medical students, general practitioners and to a lesser degree other healthcare professionals.
Level of intervention	Policy
Type of organisation	Ministry of Health
Kind of services provided by organisation	Various
Size of organisation	Large
Area covered	France (with specific focus on underserved areas)
Intervention period / duration of intervention	The <i>Pacte territoire santé</i> was launched in December 2012. There is no expected end date for the measures
Key actions	Package of various measures (12 in total).
Financial investment	Additional financing is required. The <i>Pacte territoire santé</i> is financed by the Ministry of Health.
Implementation strategy or processes used	The <i>Pacte territoire santé</i> was developed by the MoH, in close consultation with medical associations, local associations, regional territories representatives, etc. The <i>Pacte</i> was launched in December 2012. Afterwards, implementation started. Implementation is conducted by the regional entities of the MoH (Agences régionales de santé) in close cooperation with the people who the measures concern, i.e. medical doctors, professional medical associations, local GPs, educational institutions and so on.
Day-to-day running of the intervention	Responsibility for day-to-day running of measures lies at regional level.
Personnel investment	Additional HR is required. At national MoH people work (parttime) on the <i>Pacte</i> , at regional MoH level people work on the <i>Pacte</i> and for example for measure 4, new staff needs to be hired.

<p>Outcome measures of the intervention</p>	<p>The implementation and working of the Pacte territoire santé is constantly being monitored by the Ministry of Health. A first thorough evaluation of the effect of the Pacte is expected at the beginning of 2015, but the first indicators are encouraging, for example in the number of CEPA contracts signed.</p>
---	---

2. Rich description of the intervention

Establishment of the *Pacte territoire santé*

In December 2012, the *Pacte territoire santé* was launched by Marisol Touraine, the French Minister of Social Affairs and Health. The *Pacte territoire santé* contains 12 specific commitments to fight the lack of healthcare professionals in underserved areas (DGOS, 2013).

Reasons for the establishment of the *Pacte territoire santé*

The Pacte was launched because of two main reasons: firstly in order to address the problems that exist in underserved areas, secondly in order to improve the response to the needs of the population, especially those who face chronic diseases (Braichet & Schneider, 2014b).

On average, France has a sufficient number of medical doctors. The density of medical doctors is 334 medical doctors per 100.000 inhabitants. In the last decade, the *Numerus Clausus* of the medical students was regularly increased. Hence, the problem lies not in the number of medical doctors but in their distribution over France (Braichet & Schneider, 2014a). Doctors have total freedom of settlement; they can start their practice wherever they want. There is no enforcement action in place to force a geographic rebalancing of medical density across the country (DGOS, 2013). This has resulted in a concentration of medical doctors in the big cities (e.g. Paris, Nice, etc.) and a lack of medical doctors especially in the suburbs and rural areas.

A quarter of the French population lacks doctors near their place of residence, primarily in rural and suburban areas. Where coastal and town centres are full of doctors, rural and mountainous areas and a number of difficult urban areas are facing a shortage of doctors and other health professionals (DGOS, 2013).

Hence, France is focusing its retention policy on 'underserved areas', including not only rural areas but also suburbs and other areas that face a lack of medical doctors and other categories of health professionals (Braichet & Schneider, 2014a).

Objective of the *Pacte territoire santé*

The *Pacte territoire santé* is aimed at recruiting and retaining medical doctors in underserved areas. To address the lack of medical doctors in underserved areas, the Ministry of Health has developed a number of incentives. It chose for a *coherent package of incentives* rather than mandatory policies. Actually, while successive governments during the last two decades adopted different but small measures to address the medical shortages in underserved areas, there was not a global and coherent approach. That is why, in 2012, the Ministry of Health launched its *Pacte territoire santé*, which contains a coherent package of 12 measures and incentives, divided in three packages, aimed at addressing the shortage of medical doctors in underserved areas (Braichet & Schneider, 2014a).

Type of intervention

The *Pacte territoire santé* contains a package of measures, divided in three main parts: changing the training and supporting the establishment of young doctors, transform the conditions of practice of health professionals, investing in isolated areas.

Professional group(s) targeted

Predominantly medical students and general practitioners, and to a lesser degree other health professionals.

Level of the intervention

National policy level, executed by regional agencies of the Department of Health.

Area covered

All underserved areas across France.

Running time of the intervention

The *Pacte territoire santé* was launched in December 2012. There is no expected end date for the measures.

Implementation strategy

Once it was decided that a Pacte would be introduced, the most important decision that then needed to be made was whether the new programme would be more about incentives or more about mandatory measures. Finally, it was decided to develop a programme based on incentives and not mandatory measures. This was because mandatory measures would probably have been difficult to accept by medical doctors and their professional associations. In France, GPs, medical doctors have total freedom of settlement. This is also why it was decided to work with incentives for the Pacte (Braichet & Schneider, 2014b).

A 'pacte'

The previous programme on recruitment and retention that was developed by the previous government had some individual, rather stand-alone measures, and did not have a global coherence. One of the assets of the *Pacte territoire santé* is that it is a coherent package of 12 measures. All regions have to implement the 12 commitments but they can adapt them to the local context (Deschamps et al., 2015; Braichet & Schneider, 2014b).

The *Pacte territoire santé* is called a 'pacte' because it is a sort of informal agreement. It is a representative name to point out that several partners, particularly the Ministry of Health and the health workers and professional organisations, agreed to work together and to implement these measures. A 'plan' or 'programme' would sound more like a top down thing, which this explicitly is not. A Pacte is more representative, because there were consultations with different parties, etc. The 'Pacte' is not legally binding, but it is a good agreement for these particular measures.

During the development process of the Pacte, there were and there are still a lot of discussions with the regional entities, the so-called *Agences Régionales de Santé* (ARS) (Deschamps et al., 2015). Because the Pacte was so thoroughly consulted with all partners, and consensus was reached, no serious resistance against the Pacte existed or exists. The MSP is a good example; this is a measure which corresponds to the expectations of the new graduates and young medical doctors (to want to work in a team, etc) (Braichet & Schneider, 2014b).

The *Pacte territoire santé* was launched in December 2012. Afterwards, the implementation could start. The Pacte is imposed top-down on the regional health authorities. The implementation takes time, as a number of the measures that are proposed in the package needed or still need legal measures (e.g. measures number, 5 and 10). At the time of writing (September 2014), most of the measures have been implemented. For other measures, the implementation is on-going (Braichet & Schneider, 2014a).

The implementation is conducted by the regional entities of the Ministry of Health (ARS). There is a lot of cooperation in this with the people who the measures concern, i.e. medical doctors, professional medical associations, local GPs, educational institutions and so on. The regional health authorities do encounter some problems in implementing all twelve measures, though. For some measures, legal and financial efforts are required from the central Department of Health, but these have not yet been fulfilled. This hampers the implementation of some of the measures in some of the regions (Deschamps et al., 2015).

Next to the implementation, a package of communication means has been used to make these people aware of the programme. Brochures and a kit of communication were developed, there is a specific page on the website of the Ministry of health (<http://www.sante.gouv.fr/le-pacte-territoire-sante-pour-lutter-contre-les-deserts-medicaux>), there were presentations about the measures at different professional exhibitions and there were press releases and statements by the Ministry of Health. Because of all this communication, the *Pacte* is now fairly well-known (Braichet & Schneider, 2014a).

The *Pacte territoire santé*

The *Pacte territoire santé* includes 12 significant reforms to attract and retain human resources for health (HRH) in underserved areas across France. The 12 measures are divided among 3 main packages.

Package 1. Changing the training and facilitate the establishment of young doctors

Commitment 1: an internship in general medicine for all students

This measure requires all medical students to do a mandatory internship in general practice. This can be done anywhere in France, not necessarily in underserved areas (Braichet & Schneider, 2014a). The objective of this measure is to generate among medical students a fair knowledge of- and appreciation of general medicine. Young people need to be inspired to settle in general medicine, so it is essential to encourage and facilitate training in this area.

In addition, students will be encouraged to do their internship in remote areas - more than 15 km from the place of training or residence - through the creation of a fixed transport allowance of € 130 per month.

Installed GPs have a direct role to play in training their young colleagues: they are the key link in the development of appropriate training, especially "outside the wall" of hospitals. Since 2012, the number of tutors has increased significantly: an additional 8% was recorded during the academic year 2012-2013.

Achievements since 2012:

- Expansion of the number of students completing an internship in general medicine.
- Already 8 regions where 100% of students do their internship with GPs (Languedoc-Roussillon, Midi-Pyrénées, Auvergne, Alsace, Lorraine, Champagne-Ardenne, Franche-Comté and Limousin).
- Financial support for students and interns who conduct their internships in areas far from their places of training.

Examples from the regions:

- PACA: Student Financial Assistance realizing their internship in the Alpes de Haute Provence through a partnership between the regional health agency (ARS), the General Council, the Faculty of Medicine, primary health insurance fund (CPAM) and the county council of the Medical (CDOM).
- Poitou-Charentes: communication campaign on controlling internship with independent doctors.
- Nord-Pas-de-Calais: financing of training sessions to master the course.
- Languedoc Roussillon: financial support for interns in general medicine to encourage them to achieve their training among GPs in underserved areas and multiprofessional nursing homes

Commitment 2: 1500 employment contracts for public service by 2017

This measure was introduced in July 2009 already, but it was not successful because it was too complicated. Hence, in new Pacte, this measure was simplified and further improved (Braichet & Schneider, 2014b). It aims to encourage medical students to serve in underserved areas after finishing their education. By signing the contract they receive a fellowship of €1200 a month while in medical school, provided that they realize 165 patient consultations per month, and commit to serve in an underserved area after they finish their education. The time they commit to serve is similar to the time they receive the fellowship. Medical students can choose whether they want to sign the contract for a minimum of two or more years. So for example, if they commit to serve in underserved areas for three years, they will benefit of three years of fellowship (Braichet & Schneider, 2014a).

Because the younger generation is a priority for the French government, it wanted to reinforce the signing of contracts for public service commitment by students and interns. Therefore, it needed to change the existing system which was too complicated, too small and too little known. Hence, the law on financing of social security for 2013 relaxed the system, simplifying the framework of CEPA in medicine and opening contracts to dental students. The number of CESP contracts (contrats d'engagement de service public) signed to date is 591, already 40% of the target of 1500 in 2017 (this is the CESP 2017 goal).

Achievements since 2012:

- Increase between 2012 and 2013 of 65% of the contract signed (591 in total), this is already 40% of the 2017 target (which is 1500).
- The law on financing of social security for 2013 relaxed the system, simplifying the framework of CEPA in medicine and opening contracts to dental students.

Examples from the regions:

Diverse initiatives to promote CESP contracts:

- Alsace and Champagne-Ardenne: establishment of weekly hotlines in medical schools to inform students and interns to this measure.
- Auvergne and Picardy: communication campaign during the selection period and during the induction seminar for new interns, individualized support by the signatories.

Commitment 3: 200 territorial general practitioner (PTMG) contracts

This measure aims to promote the activity of young graduated medical doctors in underserved areas by securing their first two years of installation. Similar to measure two, it is a sort of contract for young medical doctors who accept or agree to settle in underserved areas. In this case they receive a minimum salary, regardless of their number of patients, and in addition they receive better social protection. This includes sickness leave and maternity leave, which is particularly important for female doctors, and the number of young female doctors in France is increasing (Braichet & Schneider, 2014a). Concrete and subject to a minimum of activity, the beneficiary receives additional remuneration ensuring a gross monthly income of € 6,900, hence a net monthly income of € 3,640 (DGOS, 2013; Ministère des Affaires sociale et de la Santé, 2014).

This measure is operational since September 2013 and is very successful. Following the success of this device, 200 additional contracts will be offered in 2014. It should be noted that medical students who received the benefits of measure number two can afterwards also receive the benefits of measure number three (Braichet & Schneider, 2014a).

Achievements since 2012:

- Creating the device and opening 200 contracts in 2013
- Opening 200 new contracts in 2014, meaning a total of 400 new GPs in 2 years in underserved areas.

Examples from the regions:

Mobilization around the PTMG which resulted in active communication campaigns and a significant adhesion of young doctors:

- Rhone-Alpes: communication campaign among medical schools, private doctors' unions and regional associations of health professionals (URPS).
- Aquitaine: communication campaign to all interns, doctors registered for less than a year and all substitutes out the underserved areas in the region.
- Center: Information county councils and funds primary health insurance.

Commitment 4: a reference system in each region

To ease the installation of physicians, each region in France now has a person specifically in charge to support students, interns and young professionals in installing themselves in the region. For example, they provide support in looking for a good place, and so on (Braichet & Schneider, 2014a). These people, 1-3 within one region, work for the ARS and do not (necessarily) have a medical background (Braichet & Schneider, 2014b). They can offer a "unique regional window". During this first year of implementation of the Pacte, the referring facilities have been particularly active on

the diversification of internship locations, commitment to public service contracts and working with territorial general practitioners (DGOS, 2013; Ministère des Affaires sociale et de la Santé, 2014).

Achievements since 2012:

- Effective implementation of a reference system in each region
- Strengthening the provision of online services

Examples from the region:

Various initiatives have been developed to facilitate installation and exercise:

- Picardie: creation of the Facebook page "Du stylo au stétho [From the pen stethoscope]" dedicated to training, installation and medical practice in the region (over 650 "likes").
- Ile-de-France: in each department reception in local offices of all students, domestic or health care professional carries an installation project.
- Bretagne: annual action programme for simplifying the installation of GPs conducted jointly by 20 regional partners. A specific leaflet has been produced especially to explain the steps to follow when installing

Package 2. Transform the conditions of practice of health professionals

The second package of the Pacte focuses mainly on working conditions and facilitating a team approach. It has two goals:

1. To improve working conditions for young medical doctors
2. To enable patients to benefit from better care, particularly from a team of health workers (instead of one health worker)

Commitment 5: develop teamwork

The aim of this measure is to (Ministère des Affaires sociale et de la Santé, 2014):

- Support the organization of health professionals, also to facilitate the comprehensive care of patients.
- Create installation conditions that are especially attractive in underserved areas.

Young medical doctors and other health workers often don't like to work alone. They would like to work in a team, to work and speak with colleagues, in order to exchange ideas and so on. This also enables them to have more flexible working times, including part-time work. This measure is introduced all across France, but is particularly successful in underserved areas (Braichet & Schneider, 2014a).

Achievements since 2012:

- Doubling of the number of 'maisons de santé pluriprofessionnelles' (corporations established between medical professionals, paramedics and pharmacists): 370 in 2013 against 174 in 2012.
- Generalization of current experiments on compensation teams of health professionals.
- 600 'maisons de santé pluriprofessionnelles' should be open in 2014.

It is good to note that for the multiprofessional approach, there are 2 different categories:

- Maisons de santé pluriprofessionnelles (MSP)
- Centres de Santé (CdS), health centres. There are 2000 CdS.

Health centres are usually more public than MSP which are only private and more available for people without good social protection, people who do not have private insurance. There are lots of CdS in the big cities. Another big difference between the MSP and CdS is that CdS are employers. For patients, CdS are free of charge. MSP are new for some years and developed with a different approach. Regardless of the legal status, the health workers who work there are all in private practice (Braichet & Schneider, 2014b).

Negotiations are also taking place about a change in the model of income. Currently in France, all GP and medical doctors who work in private practice work via fee for service. There is a need to adapt that. The idea is to introduce a way of payment that is still fee for service, but this fee will not only cover the costs of the doctor, but for the whole team. That means that if a chronic patient in a *maison de santé pluriprofessionnelle* (or centre de santé) starts with a visit to the GP, and the GP refers to physiotherapist, etc., then the patient will make one payment for the entire MSP and then the MSP will divide the payment among the different healthcare professionals. Currently, experimentations with this way of working are going on in 300 sites. However, in France social security is the responsibility of professional organisations, not the state. The negotiations about this are still going on (Braichet & Schneider, 2014b).

Commitment 6: bring primary health centers and universities closer to each other

This measure is aimed at promoting primary health care, particularly in primary health centres. Through the development of internships and research projects about primary health care, it tries to improve the links between the universities, health centres and health workers (Braichet & Schneider, 2014a). It wants to innovate community care by opening up clinical and research activities.

Early 2014, the hospital clinical research programme (PHRC) was expanded to include primary care. Now, nursing homes and health centers may relate directly – and independently of a hospital – to research projects.

Examples from the regions:

Research projects outside the walls of the hospital:

- Rhone-Alpes: PRISM project (Pluri-professionalism and risk management with a multi-faceted programme in primary care) which carries, within health homes and health centers, better detection of- and fewer adverse events (healthcare associated medication errors).
- Bretagne: project "Network for Clinical Investigation in risk prevention for the general population," which sets up cooperation between tutors from the University of Brest and GPs to develop research processes around clinical depression.

Commitment 7: develop telemedicine

Telemedicine already existed before the Pacte started, but mainly in hospitals. The Pacte aims to develop telemedicine in the private sector and in the medico-social sector (Braichet & Schneider, 2014b). The aim of further developing telemedicine is reducing the geographic and demographic constraints for young doctors by developing innovative ways of organizing care. This is a good way to recruit newly graduates to settle in underserved areas because they will feel less isolated as they can communicate with colleagues in hospitals or in the big cities. If they face medical problems they can share radiography or medical exams and so on with colleagues to have support via telemedicine (Ministere des Affaires sociale et de la Santé, 2014).

Nine regions were selected in order to promote telemedicine thanks to new way of financing and payment. All of the 26 regions were consulted, and these nine regions agreed and responded enthusiastically. Subsequently, a number of legal and technical criteria were applied, by the ARS and national level, and they were selected. One of the challenges that the Ministry of Health is now dealing with is how to pay the GP and other health professionals? Is consultation by telemedicine the same as a face to face consultation? (Braichet & Schneider, 2014b).

During the past years, the development of telemedicine has been reflected in the development of pilot projects for the management of stroke (CVA) in acute phase, defined as national priority.

Three regions (Burgundy, Nord-Pas-de-Calais, Franche-Comté) have set up organizations allowing emergency services to support more than 3,500 patients per tele-expertise and remote support, in line with the neuro-vasculaires unites (UNV) and other agencies. Other regions gradually engage in the management of stroke telemedicine: in half of them, telemedicine is already a reality (Ministere des Affaires sociale et de la Santé, 2014).

Achievements since 2012:

- Impetus and support for the development of telemedicine in the hospital sector, with promising results for example in the treatment of stroke.
- Extension in 2014 of this dynamic in the ambulatory sector

Examples from the regions:

- Auvergne: ambulatory monitoring of heart failure patients that is based on a technology platform consists of a shared medical record, a remote monitoring system daily patient weight and an aid to the management of the system last.
- Cardiauvergne: regional service serving severe heart failure whose condition required at least one hospitalization, follows to this day an active membership of 500 patients.
- Liberal nurses, equipped with smartphones, ensure the collection of clinical signs during their visits to patients' homes. The platform includes a system generating, from the uploaded data, alarm messages - emails or SMS sent to the doctor - and alerts triggering early intervention by nearby health professionals.

Commitment 8: accelerate task shifting

With task shifting, it is hoped that time will be saved for medical practitioners to return to their core business while nurses and other health workers (e.g. ophthalmologists/orthoptists) take on tasks that were previously performed only by medical professionals. This measure aims to develop a new and innovative approach or organizing healthcare.

Related goals are:

- Improving the monitoring of chronic disease and access to care, reducing waiting times for patients to get an appointment.
- Creating "new" jobs respecting safety practices.

The transfer of skills finds its concrete expression through cooperation models between health professionals, approved by senior health authorities that ensure the quality and safety of practices. For example, at national level, the cooperation protocol between ASALEE nurses and general practitioners on screening for smoking disorders, monitoring of diabetes and cardiovascular risk has received specific funding. In December 2013, 337 physicians participated in the experiment to implement the protocol, supported by 115 nurses. In 2014, a second wave of deployment of the ASALEE protocol is provided.

With regards to new jobs, from the 2016 academic year a new job will appear; the nurse clinician. This role will free up medical time and respond more effectively to patients' demands, for example in oncology (Touraine, 2014).

One of the priorities under this measure is the fact that France has a long waiting list for patients to consult an ophthalmologist. So via a protocol, task shifting between ophthalmologists to orthoptist are progressively being implemented. One of the challenges is how to finance this, what to pay to the ophthalmologist and optician and how to keep the quality of care high (Braichet & Schneider, 2014b).

Examples from the regions:

Protocols noticed in general practice:

- Haute-Normandie: protocol on the immunization schedule - consultation, prescription and vaccination decision by a nurse instead of a doctor - which reduces consultation time for patients and saves doctors time.

Package 3. Investing in isolated areas**Commitment 9: ensuring access to emergency care in less than 30 minutes by 2015**

This measure has two goals:

- Improve the situation of the 2 million people who live more than 30 minutes of access to urgent care, all across France
- Train, equip and pay the corresponding physicians SAMU (MCS) (doctors who provide first care on a voluntary bases in emergency situations in regions where access to urgent care is more than 30 minutes away).

Achievements since 2012:

Significant changes in the number of MCS - from 150 in 2012 to 650 in 2014 - to improve access to emergency medical care for more than a million French. Appropriate action plans, adapted to the specific needs of each territory, were built by the regional health agencies (ARS) in the first half of 2013.

Examples from the regions:

- Rhone-Alpes: action plan for better recognition of MCS by allocating them more materials and equipment and improving their training and compensation.
- Centre and Limousin: SMUR mobilization and network of MCS to the nearest place of intervention and/or as soon as available, by opening up the borders of the administrative organization. Specifically, a correspondent for the SAMU doctor can intervene in a neighbouring department.

Commitment 10: allow hospital doctors and staff to support outpatient facilities

This measure enables a hospital doctor to work some days a week in rural or mountain areas to support his colleagues over there. The goals of this measure are to:

- Meet the needs of the population in developing the partnership between the city and the hospital.
- Create attractive installation conditions, especially in underserved areas

This combination has an additional benefits; it increases the diversity of the hospital doctor's practice (Braichet & Schneider, 2014a)

Example from the regions:

- Rhone-Alpes: provision of a practitioner of the hospital from Roanne to temporarily overcome recruitment difficulties in a nursing home in Régnny, which is a region lacking health professionals

Commitment 11: adapt the local hospitals and empower Centre Hospitalier Régional (Regional Hospital Center)

This measure aims to meet the needs of the population in restructuring the organisation and partnership between health facilities, at the regional and local level (Braichet & Schneider, 2014a). The measure aims to support local hospitals and remove legal and financial obstacles they face, so that they can better cooperate with physicians. Similarly, regional and university hospitals must complete a real mission coordination on their territory. Moreover, the law on financing of social security for 2014 allows the maintenance of local hospitals in isolated areas. The activity of these health facilities is essential care to the population.

Examples from the region:

- Center: a voluntary reorganization of health care delivery: creating a center between the hospitals of Chateauroux and Blanc which includes, under the coordination of a referring physician, medical and paramedical personnel who work in the emergency units of two locations based a single planning, training, procedures and protocols for common load.

Commitment 12: strengthen health centers

This measure aims to strengthen public health centers. There are two different sorts of advantages:

- For medical doctors: they get their salary from the health centre. The majority of the new generation of medical doctors prefers to be employed rather than be in private practice.
- For patients: in these health centres, patients benefit from a team work and coordinated care and relatively cheap medical care.

Hence, this measure works particularly well for underserved areas as underserved areas often have a relatively large population of citizens with lower- and middle social-economic backgrounds (Braichet & Schneider, 2014a)

Example from the region:

Pays-de-la-Loire: in 2012 in Connerre a centre was opened combining two GPs and a dentist, who will be joined by other experts in 2014, allowing the catchment area of about 9000 people to benefit from a growing supply of care.

Organisational framework

At the level of the National Ministry of Health, several units are involved in the Pacte, focusing on different elements of the Pacte. At national level, the conceptual work, communication, etc. takes place. Implementation of the Pacte takes place in the regions through the Regional Health Authorities (Agences Régionales de Santé or ARS). Appropriate action plans, adapted to the specific needs of each territory, are for example built by the ARS. In addition to the ARS, many more people are involved by the Pacte and its implementation (Braichet & Schneider, 2014b).

There is a good cooperation taking place in this regard between the central national Department of Health and the regional health authorities (ARS). The ARS feel they are truly involved in the Pacte and feel that their concerns are taken aboard. Currently, a 'Pacte 2.0' is in the making and the ARS of the Centre region feels that the concerns of the regions are well processed in this new version of the Pacte (Deschamps et al., 2015).

Finances

There is not one global budget or financing dedicated to the Pacte. Most of the measures are financed by the Sécurité Sociale. Some of these measures which are totally new, like the PTMG, need to find new financing. Other measures, like MSP, could be financed by different partners, especially local partners. By consequence, it is difficult to know the global budget of the Pacte. It is clear however that considerable financial means are involved in introducing this package of measures.

Commitment 1: an internship in general medicine for all students

Students are encouraged to do their internship in remote areas - more than 15 km from the place of training or residence - through the creation of a fixed transport allowance of € 130 per month.

Commitment 2: 1500 employment contracts for public service by 2017

By signing the contract to serve in underserved areas after finishing medical education, medical students receive a fellowship of €1200 a month while in medical school, provided that they realize 165 patient consultations per month, and commit to serve in an underserved area after they finish their education. The time they commit to serve is similar to the time they receive the fellowship (Braichet & Schneider, 2014a).

Increase between 2012 and 2013 of 65% of the contract signed (591 in total), this is already 40% of the 2017 target (which is 1500).

Commitment 3: 200 territorial general practitioner (PTMG) contracts

If students sign a PTMG contract, they receive a gross monthly income of € 6,900, hence a net monthly income of € 3,640, regardless of their number of patients. In addition they receive better social protection. This includes sickness leave and maternity leave, which is particularly important for female doctors (Braichet & Schneider, 2014a; DGOS, 2013; Ministère des Affaires sociale et de la Santé, 2014).

- 200 contracts were opened in 2013
- 200 contracts will be opened in 2014, meaning a total of 400 new GPs in 2 years in underserved areas.

Commitment 5: develop teamwork

In 2012, there were barely 170 'maisons de santé pluriprofessionnelles'. There are 370 today and there will be at least 600 by the end of 2014. These new structures are implanted throughout France, thanks to the efforts of professionals and elected officials. But also because the Minister extended new funding to 150 new multi professional teams, which corresponds to an average of € 50,000 per team (Touraine, 2014).

Commitment 7: develop telemedicine

The Minister has mobilized substantial funds through the "digital hospital" programme, which has devoted almost € 400 million over five years (Touraine, 2014).

Facilitating factors

- An important facilitating in the acceptance of the measures in the Pacte was that it was developed as a Pacte; instead of using mandatory measures, the Pacte is based on incentives. Moreover, all relevant stakeholders were involved right from the beginning.
- Sharing of good practice: the objective of the experiments of some of the measures that are taking place in some of the regions is to share successful interventions from one region with the other regions. The successful interventions are disseminated via different ways; website, articles, conferences, etc. This enables a smooth sharing of knowledge.

Barriers

- Currently, some of the measures of the Pacte which have to be implemented by the regional health authorities cannot be implemented, because financial and/or legal efforts that are required from the central Department of Health have not yet been fulfilled (Deschamps et al., 2015).

3. Results of the intervention

One of the main goals of the Pacte is to get people to underserved areas. There are two sorts of measures for the success of the Pacte (Braichet & Schneider, 2014b):

1. Some are short term and linked to the Pacte: for example, the number of contracts signed, number of MSPs, etc. Also important is to have a measure of satisfaction.
2. Long term results in public health approach: these will take more time to become visible. In five to ten years, it will become clear whether public health indicators of the population in these regions, particularly underserved areas, have improved or stagnated, etc. A long term evaluation is not yet planned, but it is agreed that this will take place.

The implementation and working of the *Pacte territoire santé* is constantly being monitored by the Ministry of Health. It is a continual process of evaluation. Three times a year, the ARS received questionnaires from the Ministry of Health and they conduct a survey in their region. Then the ARS gather information and send the results to the national Ministry of Health. Based on these survey, the first results of this feedback were published on February 2013 and the second after two years implementation will be soon publicly available. The National Ministry of Health also conducts visits to the ARS and holds regular meetings with the ARS in Paris. From this discussions and meetings, interesting information is collected. So the Pacte is constantly adapted to the latest findings (Braichet & Schneider, 2014b).

There is a good cooperation taking place in this regard between the central national Department of Health and the regional health authorities (ARS). The ARS feel they are truly involved in the Pacte and feel that their concerns are taken aboard. Currently, a 'Pacte 2.0' is in the making and the ARS of the Centre region feels that the concerns of the regions are well processed in this new version of the Pacte (Deschamps et al., 2015).

The first indicators of the Pacte are encouraging; the Pacte is welcomed by health professionals and it is well-known. This was challenging, as the dissemination of a new programme always is (Braichet & Schneider, 2014b). Moreover, for example for measures 2 and 3, the numbers of signed contracts is increasing. In addition, at the national ministerial level, every two months there is a meeting between the Ministry of Health, agencies in charge of health, the Ministry of universities and Research, and other partners. Moreover, there are regular meetings, approximately four times a year, with the people who are in charge in implementing the *Pacte* in the regions to exchange ideas, actions, problems, ways to improve the measures and so on (Braichet & Schneider, 2014a).

It is early to monitor all the effects that the *Pacte territoire santé* has on recruitment and retention numbers. However, for instance, concerning the first package which is implemented, the Ministry of Health states that the first indicators are encouraging. For measures 2 and 3, the numbers of signed contracts is increasing. For measure 4, every region now has a reference point for new doctors and this means that these measures work and are attractive for the students and medical doctors. Moreover, the reactions from medical doctors and students are quite positive.

However, the Ministry of Health also indicates that even though the first indicators are good and hopeful, more time is needed to see if these measures also generate a long-term effect (Braichet & Schneider, 2014a).

Some first outcomes of specific measures as they were recorded in 2014:

Commitment 1: an internship in general medicine for all students in 2017

In 2011, only 42% of all students did an internship in general medicine. In 2013, their number had risen to 60%. Moreover, in eight regions - Languedoc-Roussillon, Midi-Pyrénées, Auvergne, Alsace, Lorraine, Champagne-Ardenne, Franche-Comté et Limousin – already 100% of students are doing their internship in general medicine (Touraine, 2014; Ministère des Affaires sociales et de la Santé, 2014).

Commitment 2: 1500 employment contracts for public service by 2017

The cumulative change in the number of CESP signed since 2012 (Ministère des Affaires sociales et de la Santé, 2014; Braichet & Schneider, 2014b):

2012: 353 contracts signed
 2013: 591 contracts signed
 2014: 881 contracts signed
 2017 (aim): 1500 contracts signed

Commitment 3: 200 territorial general practitioner (PTMG) contracts

200 PTMG contracts were offered in September 2013 and in four months, they were all claimed. Hence, the Ministry decided to introduce 200 new contracts in 2014. The cumulative change in the number of contracts PTMG (Touraine, 2014; Ministère des Affaires sociales et de la Santé, 2014; Braichet & Schneider, 2014b):

September 2013: 33 PTMG claimed
 October 2013: 63 PTMG claimed
 January 2010: 180 PTMG claimed
 September 2014: 246 PTMG claimed
 November 2014: 303 PTMG claimed

Commitment 5: develop teamwork

This reorganization is making great strides. In 2012, there were barely 170 'maisons de santé pluriprofessionnelles'. There are 370 in 2014, the number has doubled. These new structures are implanted throughout France, thanks to the efforts of professionals and elected officials. An example from the regions also shows this growth (Tourain, 2014):

Number of 'maisons de santé pluriprofessionnelles' in Bretagne
 2012: 21 maisons are functioning
 2013: 43 maisons are functioning

Commitment 5: develop teamwork

The number of Maisons de santé pluriprofessionnelles has been steadily increasing (Braichet & Schneider, 2014b):

2012: 174 MSP
 2013: 370 MSP
 2014: 600 MSP

Commitment 9: ensuring access to emergency care in less than 30 minutes by 2015

In 2012, 2 million French were more than thirty minutes of urgent care. At the end of this year, thanks to the actions that we have deployed, this number will be halved (Tourain, 2014). In 2012, there were 150 physicians SAMU (MCS) (doctors who provide first care on a voluntary bases in emergency situations in regions where access to urgent care is more than 30 minutes away), by the end of 2014 there will be 650, already in training (Tourain, 2014).

References

Braichet, J.M. & Schneider, N. (2014a). Telephone interview for the Recruitment and Retention study with national Department of Health 10-09-2014.

Braichet, J.M. & Schneider, N. (2014b). Interview during case site visit for the Recruitment and Retention study 09-12-2014.

Deschamps, A. and colleagues. (2015). Telephone interview for the Recruitment and Retention study with representatives of L'Agence Régionale de Santé du Centre 20-01-2015.

Direction générale de l'offre de soins (DGOS)(2013). Recruitment and retention problem: French documents and datas.

Ministere des Affaires sociales et de la Santé (2014). *Pacte territoire santé. Lutter contre les deserts médicaux et les inégalités d'accès aux soins: bilan 2013 et perspectives 2014.*

Touraine, M. (2014). Bilan du Pacte territoire santé. Intervention de Marisol Touraine. Lundi 10 février 2014. 11 February 2014.

Appendix 2.2. Case report 2.2

Topic 2. Attracting and retaining GPs to strengthen primary care in underserved areas

Case 2.2. The University of Queensland Rural Clinical School, Australia



Research methods applied:

Desk research: September 2014

Email interview: October 2014

1. Summary of the intervention – The University of Queensland Rural Clinical School, Australia

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Education
Professional group(s) targeted	Medical students
Level of intervention	Policy and organizational
Type of organisation	Educational institution; University of Queensland Rural Clinical School
Kind of services provided by organisation	The School of Medicine provides a four-year programme in which students undertake clinical training in years three and four. Students may elect to train in one of three clinical divisions, one of them being rural (Rural Clinical Division). There is also a four-week elective placement programme available for medical students in their first year.
Size of organisation	Large
Area covered	State of Queensland
Intervention period / duration of intervention	The Rural Clinical School at the University of Queensland was established in 2002. There is no expected end date.
Financial investment	Additional financing is required. The UQRCS is funded through the Australian Government. The UQRCS does not receive any other sources of funding.
Implementation strategy or processes used	The Australian Government has developed a number of parameters to guide implementation of the Programme and achieve the overall aims.
Personnel investment	No specific information was retrieved on this issue.
Outcome measures of the intervention	The UQRCS has an intake of up to 150 medical students who live and work at one of the major rural academic sites for at least the duration of an academic year. Studies demonstrate that a student who has had the RCS experience is 2.5 times more likely to work in a rural area.

2. Rich description of the intervention

Case under study

The Rural Clinical School of the University of Queensland.

Reasons for the establishment of Rural Clinical Schools across Australia

In 2000-2001 the Australian Commonwealth Department of Health and Ageing, under the Australian Government's Rural Medical Workforce Strategy, provided significant funding to Australian medical schools to develop a national network of 10 Rural Clinical Schools (RCS). The Rural Clinical Schools provide an opportunity for medical students to undertake their clinical training across a network of hospitals, general practice surgeries and community medical centres in rural/regional locations throughout Australia (Eley et al., 2006; 2012).

Establishment of Rural Clinical School at the University of Queensland

In response to the national Rural Clinical School initiative, the Rural Clinical School at the University of Queensland (UQ) was established in 2002, as the Rural Clinical Division (RCD) of the School of Medicine. The MB BS (Bachelor of Medicine, Bachelor of Surgery) at the School of Medicine provides a four-year programme in which students undertake clinical training in years three and four (Eley et al., 2006). Students may elect to train in one of three clinical divisions, namely central, southern (both based in Brisbane), or rural (Rural Clinical Division). The Rural Clinical Division consists of four main teaching sites within south west and central Queensland. These are located at Toowoomba, Hervey Bay-Maryborough, Rockhampton and Bundaberg.

Objective of the intervention

The nationwide Rural Clinical School programme was established as a workforce strategy to address the chronic shortage of rural doctors and to improve rural medical workforce recruitment and retention through a rurally based undergraduate clinical training experience (Australian Government, 2011; Eley et al., 2006; 2012; Nicholson, 2013).

The University of Queensland Rural Clinical School (UQRCS) has a mandate to address health workforce shortages, primarily in rural and regional Queensland. To achieve this mandate, UQRCS aims to lead and direct the rural health agenda through the highest quality education, training, research and community service (University of Queensland, 2014).

Type of intervention

The Rural Clinical School is an educational intervention, focused on providing hands-on experience for medical students in working in rural areas.

Professional group(s) targeted

Medical students of the University of Queensland. The MB BS (Bachelor of Medicine, Bachelor of Surgery) at the School of Medicine provides a four-year programme in which students undertake clinical training in years three and four. Students may elect to train in one of three clinical divisions, namely central, southern (both based in

Brisbane), or rural (Rural Clinical Division). The Rural Clinical Division consists of four main teaching sites within south west and central Queensland.

There are also shorter term (4 – 16 weeks) residential placement opportunities available for all other UQ medical students (Eley et al., 2006).

Level of the intervention

The intervention is conducted at organisational level; the University of Queensland Rural Clinical School.

Area covered

The University of Queensland Rural Clinical School envisions itself as a Clinical School for regional Queensland. The Programme activity is focussed on a number of distributed Academic Sites, currently (University of Queensland, 2014):

- Bundaberg and Hervey Bay in the Wide Bay-Burnett Region,
- Rockhampton in Central Queensland, and
- Toowoomba (Darling Downs, South-West Queensland).

Kind of services provided by University of Queensland Rural Clinical School

Training in third or fourth year

Students may elect to train in their third or fourth year in one of three clinical divisions, namely Central, Southern (both based in Brisbane) or Rural. In the Rural Clinical School they can train at one of four regional clinical teaching sites within central and southwest Queensland (Eley et al., 2006; 2012). The four clinical academic sites are (University of Queensland, 2014):

1. Bundaberg in the Wide Bay-Burnett Region

Clinical placements are available at the Bundaberg Hospital Mater Misericordiae Hospital and the Friendlies Hospital and in approved Teaching Practices. As well, community health services provide a range of distinctive learning opportunities.

2. Hervey Bay in the Wide Bay-Burnett Region

Clinical training is provided by a mix of public and private healthcare providers giving students exposure to the Hervey Bay and Maryborough Hospitals, St Stephen's Private Hospital, local General and Specialist consultants and a range of community-based health care providers

3. Rockhampton in Central Queensland

Rockhampton is a major referral centre for health care services in the Central Queensland region. In this regard, the clinical training programme includes opportunities and experiences in all the key discipline areas, and many sub-specialties such as Radiology, ENT, Urology and Ophthalmology.

4. Toowoomba (Darling Downs) in South-West Queensland

There is a diverse range of clinical training settings, including Queensland Health, private hospitals, GP's, specialist consultants and community based health professionals.

Four-week elective placement in first year

In addition, the University of Queensland Rural Clinical School works with the Rockhampton Hospital to offer a four-week elective placement programme for medical students in their first year. Students rotate through various Rockhampton Hospital departments including medicine, surgery, obstetrics and gynaecology, paediatrics and medical imaging. The programme also includes a series of skills-training workshops delivered through the UQ Rural Clinical School's clinical simulation and immersion unit in Rockhampton. The programme promotes a positive attitude towards living and training in Rockhampton with the UQ Rural Clinical School for Phase 2 (Years 3 and 4) of the MBBS, which focuses on clinical training (Morning Bulletin, 2013).

Running time of the intervention

The University of Queensland Rural Clinical School was established in 2002 (Eley et al 2006). There is no expected end date.

Organisational framework

Since 2009, the Rural Clinical School programme is part of the Australian Government Rural Clinical Training and Support (RCTS) Programme. The RHMT Programme supports a number of complementary initiatives facilitating education and training of medical, nursing and allied health students in rural and remote regions to encourage the recruitment and retention of rural and remote health professionals (Australian Government, 2011). Each Rural Clinical School operates within the framework of this programme as set by the Australian Department of Health (Eley, 2014).

The Australian Government has developed a number of parameters to guide implementation of the Programme and achieve the overall aims (Australian Government, 2011):

1. Delivering rural experiences to enhance the workforce: A number of Australian medical students equivalent to at least 25% of the University's Department of Education, Employment and Workplace Relations (DEEWR)-supported medical student allocation must undertake a minimum of one year of their clinical training in a rural area, defined by the Australian Standard Geographical Classification – Remote Areas (ASGC-RA) 2-5.
2. Ensuring high quality rural experiences
3. Supporting rural academics/teachers and building training capacity
4. Rural student recruitment: A number of Australian medical students equivalent to at least 25% of the University's DEEWR-supported medical student allocation must come from a rural background, defined as residency for at least 5 years since beginning primary school in an ASGC-RA 2-5 area.
5. Community engagement and collaboration
6. Progressing the rural health agenda (research, curriculum and student support)
7. Aboriginal and Torres Strait Islander health
8. Maintaining and progressing an evidence base
9. Maximise rural expenditure

The University of Queensland Rural Clinical School works closely with Queensland Health, local GPs and specialists to offer unique, patient centred learning experiences to students who undertake their clinical training in this area. It has purpose-designed

Clinical Skills and Simulation Facilities at all its sites which are readily available to our training partners, i.e. local doctors and health professionals, to undertake skill maintenance and professional development activities (Eley, 2014; School of Medicine, 2011).

Four-week elective placement

The University of Queensland Rural Clinical School works with the Rockhampton Hospital to offer a four-week elective placement programme for medical students in their first year. Students rotate through various Rockhampton Hospital departments including medicine, surgery, obstetrics and gynaecology, paediatrics and medical imaging. The programme also includes a series of skills-training workshops delivered through the UQ Rural Clinical School's clinical simulation and immersion unit in Rockhampton. The programme promotes a positive attitude towards living and training in Rockhampton with the UQ Rural Clinical School for Phase 2 (Years 3 and 4) of the MBBS, which focuses on clinical training (Morning Bulletin, 2013).

Implementation strategy

No specific information could be retrieved about how the Rural Clinical School was implemented.

Finances

The University of Queensland Rural Clinical School is funded through the Australian Government's Rural Clinical Training Support (RCTS) Programme (University of Queensland, 2014). The funding parameters as set out by this programme must be strictly adhered to secure future funding. The UQRCS does not receive any other sources of funding for its operational funding (Eley, 2014). All funding parameters of the RCTS programme were listed above. The first parameter is: delivering rural experiences to enhance the workforce, i.e. a number of Australian medical students equivalent to at least 25% of the University's Department of Education, Employment and Workplace Relations (DEEWR)-supported (ie "domestic") medical student allocation must undertake a minimum of one year of their clinical training in a rural area (Australian Government, 2011). The UQRCS consistently exceeds this target (Eley, 2014).

Funding levels for each participating university in the Rural Clinical Training Support Programme are determined by the Minister with advice from the Department. Funding levels for the RCS programme component are recommended to the Minister using a funding model. This model includes a base grant for each medical school of \$2.8 million per year, with additional funds allocated to each school based on student numbers and the level of remoteness of each school's training programme (Australian Government, 2011).

Reporting and accountability requirements are outlined in the Funding Agreement with each university. These include (Australian Government, 2011):

- Six-monthly performance reports;
- Six-monthly expenditure reports;
- Audited financial statements at specified times during the project period; and
- A final performance report at the end of the project period.

In 2011, the medical training capacity in Bundaberg and Hervey Bay (two distributed Academic Sites of the UQRCS) has been bolstered by the announcement of a 2,5 million dollar Australian Government grant to the Rural Clinical School. This was a one-time grant paid by the Department of Health under the Innovative Clinical Teaching and Training Grants (ICTTG) Programme (Eley, 2014). The money will be used to help fund the construction of two state-of-the-art Teaching and Learning Centres on the Hervey Bay and Bundaberg Hospital campuses. University of Queensland and Queensland Health have also committed funds for the new facilities (School of Medicine, 2011).

3. Results of the intervention

Rural workforce participation Rural Clinical School graduates – tracking system via alumni database

The University of Queensland Rural Clinical School graduates first entered the medical workforce in 2003. In 2006 a longitudinal study was designed to track workforce participation patterns since graduation. The first stage of the study reported primarily on intern location choices. The second stage entailed maintaining a UQRCS alumni database and track career pathways and vocational choices with follow-up data collections every 2 years (Eley et al., 2012). This tracking database was established in 2006.

In 2010, a total of 115 former RCS medical students out of 180 responded and answered questions about their current workplace. It was found that 40% of the respondents were working in a non-urban, rural & remote area. Eight per cent of all respondents had chosen 'rural medicine' as area of speciality.

Next to these database data, a qualitative study was undertaken and it was found that the primary drivers of and influences on early career decisions were personal/family reasons, positive rural exposure in the RCS and specialty training requirements (Eley et al., 2012).

Student enrolment numbers

The University of Queensland Rural Clinical School continues to grow and move towards its full potential. In the last seven years the full-time student number has increased by 50% (Nicholson, 2013). Currently, the Rural Clinical School has an intake of up to 150 medical students in the clinical phase of the medical programme who live and work at one of the major academic sites for at least the duration of an academic year (University of Queensland, 2014).

Higher interest to work in rural areas

Now in its second decade of operation, UQRCS is able to demonstrate a positive impact on the medical workforce in the regions in which it works (and elsewhere). Studies demonstrate that a student who has experienced the Rural Advantage via the Rural Clinical School is 2.5 times more likely to work in a rural area when compared with other University of Queensland medical graduates (Nicholson, 2013).

Evaluation of the programme by students

In 2005, 26 medical students at the University of Queensland completed their 4th year training with the Rural Clinical School. Via the 'Year 4 Exit Survey' their perceptions of their 4th year experience at the Rural Clinical School were evaluated. The results suggest high levels of student satisfaction with the programme. Over 80% of the students felt their time at the RCS encouraged their desire to pursue a rural or remote medical career (Eley et al., 2006). However, it was also noted that if the ultimate goal of improving the rural medical workforce is to be achieved, the positive rural training experience must be matched by a supportive clinical workplace environment (Eley et al., 2006).

References

Australian Government (2011). Rural Clinical Training and Support (RCTS) 2011-2014. Operational Framework. *Australian Government, Department of Health and Ageing*.

Eley, D. (2014). Personal communication.

Eley, D., & Baker, P. (2006). Does recruitment lead to retention? Rural Clinical School training experiences and subsequent intern choices. *Rural and Remote Health, 6*(1).

Eley, D. S., Synnott, R., Baker, P. G., & Chater, A. B. (2012). A decade of Australian Rural Clinical School graduates—where are they and why. *Rural Remote Health, 12*, 1937.

Morning Bulletin (2013). Practical approach works. *The Morning Bulletin*, 23 November 2013.

Nicholson, G. (2013). Newsletter: 2013 has been a great year!. December 2013.

School of Medicine, 2011. *The University of Queensland School of Medicine Report 2010/11*. University of Queensland: School of Medicine.

University of Queensland (2014). *Rural Clinical School*. <http://www.som.uq.edu.au/about/campuses-and-teaching-sites/clinical-schools/rural-clinical-school.aspx> (accessed: 06-10-2014).

Appendix 2.3. Case report 2.3

Topic 2. Attracting and retaining GPs to strengthen primary care in underserved areas

Case 2.3. Financial compensation for GPs to work in remote areas, Bulgaria



Research methods applied:

Desk research: September 2014 & February 2015

Email interview: September 2014

1. Summary of the intervention – Financial compensation for GPs to work in remote areas, Bulgaria

Dimension of interest	Categories/description
Objective of the intervention	Recruitment
Type of intervention	Financial incentives
Professional group(s) targeted	General practitioners
Level of intervention	Policy level
Type of organisation	National Health Insurance Fund, independent public institution
Kind of services provided by organisation	Healthcare in Bulgaria is provided by the National Health Insurance Fund. The NHIF spends the resources collected from mandatory health insurance contributions. Individuals who contribute to the NHIF receive a national health insurance card that must be presented to the doctor or dentist during each visit.
Size of organisation	Large
Area covered	Bulgaria
Intervention period / duration of intervention	The programme is (probably) running since 2008. No expected end date.
Key actions	Financial compensation for GPs to work in remote areas
Financial investment	Considerable additional financing is required, in this case provided by the Bulgarian government.
Implementation strategy or processes used	The Bulgarian Medical Association wrote a request to the National Health Insurance Fund regarding the financial compensation for GPs to settle in remote areas. They jointly prepared: <ul style="list-style-type: none"> - An updated list of settlements/practices with adverse working conditions for GPs in the district; - An updated list of the conditions that govern certain practices as unfavourable.
Day-to-day running of the intervention	Done by the NHIF.
Personnel investment	No additional HR is required when the programme is embedded in an existing organisation.

Outcome measures of the intervention	<p>Since 2005, the number of GPs has constantly been decreasing. In 2014, Bulgaria had 4515 GPs whereas at least 5374 are needed, i.e. 859 GPs were lacking, 16% of the total GPs needed. Financial incentives are considered too low to turn the tide.</p>

2. Rich description of the intervention

Introduction of financial compensation for GPs working in remote areas

Bulgaria is offering GPs financial compensation through the National Health Insurance Fund to work in remote areas. This programme was (probably) established in 2008 (Zahariev, 2014).

Reasons for the establishment of financial compensation for GPs working in remote areas

Compared to the average general practitioners coverage for the EU, which was 9.8 per 10,000 inhabitants in 2006, figures for Bulgaria are much lower with 6.7 GPs per 10,000 inhabitants. Moreover, the Bulgarian health workforce is severely disproportionally divided over the 28 Bulgarian regions. Especially the regions Kardzhali, Razgrad, Russe and Targovishte suffer from a severe lack of GPs (Adamov et al., 2010).

In 2011, it was estimated that almost 600.000 Bulgarians did not have adequate access to a GP, meaning that their GP is located in another settlement, far from where they live. Mr Zahariev explains: "When we say that a settlement without a GP is a problem we must bear in mind that many settlements are inhabited by elderly people who don't have cars. Many such settlements do not have public transport connections to nearby towns or the transport is irregular or inconvenient (e.g. one line in the morning and one back in the evening)." These settlements are often located in rural and mountainous areas and are often inhabited by Roma and Turkish population. In 2011, the district of Kardzhali located in the southern part of Bulgaria in a mountainous area and inhabited by a large Turkish population had the largest number of settlements without GP; 51. 9. Other districts had between 20 and 30 settlements without GP (Zahariev, 2014).

Objective of the intervention

To increase the number of GPs in underserved areas.

Type of intervention

This is a recruitment intervention that works via financial incentives.

Professional group(s) targeted

General practitioners.

Level of the intervention

The financial compensation for GPs who decide to settle in remote areas is provided through the National Health Insurance Fund. Hence, the intervention is situated at national policy level.

Area covered

The programme is executed at national level but focuses on remote areas in Bulgaria as defined in accordance with the so-called 'Map of Health Care Needs' which was prepared in 2011 (see figure 1). The map defines how many specialists are needed in concrete settlements in each of the 28 Bulgarian regions. The map was prepared by

the Bulgarian Ministry of health with input from their de-concentrated structures and probably with some input from municipalities. So it is based more on expert observations and perceived needs rather than on a thorough demographic and epidemiological research (Zahariev, 2014). In 2011, it was approved by the Bulgarian Cabinet that Bulgaria should have at least 5374 GPs to provide adequate primary health care to the population (Bulevard, 2015).

Figure 1: Map of settlements without GP across the 28 regions in Bulgaria (2011)



Key actions

This is a fairly straight forward intervention; the National Health Insurance Fund offers financial compensation for GPs who decide to settle in remote areas. Naturally, GPs need to fulfil a number of criteria which are listed below (under 'Organisational framework').

Running time of the intervention

The financial compensation through the National Health Insurance Fund was probably offered for the first time in 2008. There is no expected end date.

Implementation and organisational framework

Healthcare in Bulgaria is provided by the National Health Insurance Fund (NHIF). The NHIF spends the resources collected from mandatory health insurance contributions. The NHIF consists of a Central Office, 28 Regional Health Insurance Funds (one in each regional centre in the country) and 105 municipal offices. The structure built in this way is responsible for the 265 health regions coinciding with the municipalities in Bulgaria. On their part, the health regions encompass 5367 towns and villages (NHIF, 2014). The main functions of the NHIF include management of financial resources for

medical care in accordance with the Health Insurance Act and the National Framework Contract and to guarantee access to health care services for the insured population (Georgieva et al., 2007).

Planning functions are carried out through the design of Regional Health Maps (RHM). Through this, health establishments, doctors and specialists are planned and distributed by territorial principle on the basis of population needs for accessible and timely health care. The RHM describes the types, number, activities and distribution of health establishments/doctors/specialists within one region for inpatient, emergency and outpatient care. Based on the Regional Health Maps, a National Health Map is prepared (Georgieva et al., 2007).

The implementation of the compensation for GPs takes place at regional level based on the map of the regional health care needs (2011) and the funds are managed and disbursed by the Regional offices of the National Health Insurance Fund.

In 2003, the Bulgarian Medical Association wrote a request to the National Health Insurance Fund regarding the financial compensation for GPs to settle in remote areas. The NHIF in consultation with the Bulgarian Medical Association subsequently prepared:

- An updated list of settlements/practices with adverse working conditions for GPs in the district;
- An updated list of the conditions that govern certain practices as unfavourable.

GPs who want to receive the funding of the National Health Insurance Fund need to fulfil a number of criteria as set up by the NHIF. These need to be small settlements outside the major cities, which until now have not been served or are characterized by:

1. Large distance of the practice to other hospitals;
2. Access difficulties (alpine conditions, rough terrain, poor roads);
3. Dispersion of practice / clinic serving two or more cities;
4. Adverse conditions related to population served / adverse living conditions;
5. Other specific terms of the joint decision of the Bulgarian Medical Association and Regional Health Insurance Funds

Table 1: Criteria of the National Health Insurance Fund for financial compensation for GPs who decide to settle in remote areas

No	Adverse operating condition	Points	Criteria
1.1	Distance	1	Ambulatory with catchment area, farther than 15 kilometres away from another practice for primary outpatient care and center / branch for emergency medical help.
1.2	Distance	1	Ambulatory with catchment area, farther than twenty (20) kilometers from MTS or DCC
1.3	Distance	1	Ambulatory with catchment area, farther than thirty (30) kilometers from the hospital or contractor LZBP providing the highest level agreed CP within the area of the NHIF.
2.1	Difficult	2	III or IV class roads of settlements covered by

№	Adverse operating condition	Points	Criteria
	accessibility		the practice
2.2	Difficult accessibility	3	Intersection area of over 600 m. Altitude and presence of III or IV class roads
2.3	Difficult accessibility	4	Cross-country, situated above 1000 m. Altitude and presence of III or IV class roads
3.1	Dispersion	1	Practice serving two settlements and work schedule with no less than 2 hours per day for outpatient and home inspections in each village or providing hired nursing staff daily schedule in the settlements.
3.2	Dispersion	2	Practice serving three or four places and work schedule with no less than 8 hours per week for ambulatory and home inspections in each village or providing hired nursing staff daily schedule in the settlements.
3.3	Dispersion	3	Practice serving more than four settlements and work schedule with no less than 8 hours a week for outpatient and home inspections in each village or providing hired nursing staff daily schedule in the settlements.
4.1	Population served	1	Practice in which 50% of the registered population lives etc. and adverse living conditions.
4.2	Population served	2	Practice in a rural area that serves a population with a high unemployment rate
4.3	Population served	3	Practice that serves homes for medical and social care and those placed in special schools and homes for the upbringing of children deprived of parental care in homes for children with physical disabilities in institutions for mentally retarded children and children using residential care services
5.	Environmentally polluted area	1	Environmentally polluted area

In 2013, the Bulgarian Association of GPs proposed a number of changes in the National Frame contract for 2014 and the methodology for determining the monthly payment for work in areas with adverse working conditions.

Finances

The stimuli provided by the National Health Insurance Fund range from approximately €51 to €460 per month for a GP practice in an area with adverse working conditions, i.e. a remote area. In the North-West region of Vidin, for example, doctors are offered 500 Bulgarian Lev (comparable to €255,64) to open a practice in one of the settlements with poor access to medical care. This financial compensation is roughly equal to a minimum salary in Bulgaria (Zahariev, 2014). Doctors state that the money is not enough to be able to withstand. The main income of GPs is called "capitation", this is a monthly payment of frame for each patient enrolled. When a doctor has fewer patients, as GPs that serve smaller villages have, the total amount of money is still not enough to sustain their practice (Bulevard, 2015).

3. Results of the intervention

In January 2015, the National Health Insurance Fund published new data concerning the number of GPs working in Bulgaria. These data show that the number of GPs is below the required minimum for the country and continues to decline (see table 1).

Table 1 Number of GPs in Bulgaria (i.e. GPs who had a contract with the NHIF)

Year	N of GPs	N of GPs needed	N of GPs lacking	% GPs lacking
2005	5340	5374	34	0,6
2007	5001	5374	373	6,9
2011	4715	5374	659	12,3
2013	4565	5374	809	15,1
2014	4515	5374	859	16,0

Source: Bulevard, 2015

Since 2005, the number of GPs in Bulgaria has constantly been decreasing. In 2014, Bulgaria had 4515 GPs whereas the 'Map of Health Care Needs' as approved by the Bulgarian Cabinet in 2011 stated that Bulgaria should have at least 5374. This means that in 2014 859 GPs were lacking, 16% of the total GPs needed (Bulevard, 2015).

Moreover, the distribution of GPs over Bulgaria is suboptimal. The shortage of GPs is felt most acutely in small settlements. Fewer patients means less money for maintenance of medical practice. Especially practices with "adverse working conditions" (1088 in total) suffer from a lack of GPs. According to the Health Insurance Fund regions with acute shortage of general practitioners are Vidin, Kardzhali, Razgrad, Silistra, Smolyan and Yambol. In Kardzhali, for example, only 64 GPs are employed, whereas according to the National Health Map the minimum to ensure adequate access to treatment for Kardzhali is 123 GPs. Hence, there is a lack of 59 GPs, i.e. almost half the GPs needed are not available (Bulevard, 2015). Even though the National Health Insurance Fund provides these practices with "adverse working conditions" with additional funding, amounts ranging from 100 to over 900 lev per month (€51 to €460 per month) depending on the remoteness of the place, doctors state that the money is not enough to be able to withstand (Bulevard, 2015). Three GPs with long working experience in Pernik, an area with "adverse working conditions" explain:

- "You can pay your rent, but then there are costs for heating, electricity, water, and the biggest item is transport costs."
- "Winter is a survival test."
- "The funds which are given to us as "adverse practices" cannot cover the cost of travel. This is our biggest item - the journey - and then put your insurance, taxes, maintenance, etc."

References

Adamov, V., Kolev, K., Vrachovski, D., Zahariev, A., & Marcheua, A. (2010). Human resources of the health system in Republic of Bulgaria. *Cahiers de sociologie et de démographie médicales*, 50(1), 6.

Bulevard (2015). Все по-голям недостиг на лични лекари в България [Growing shortage of GPs in Bulgaria]. Available at: <http://bulevard.bg/news/vse-po-golyam-nedostig-na-lichni-lekari-v-balgariya-6767.html> (accessed: 09-02-2015).

Georgieva, L., Salchev, P., Dimitrova, R., Dimova, A., Avdeeva, O., & World Health Organization. (2007). Health systems in transition: Bulgaria: health system review.

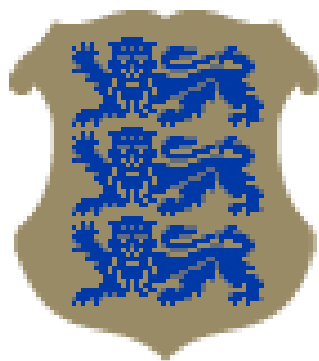
National Health Insurance Fund (2014). *Structure of the National health insurance fund*. <http://www.en.nhif.bg/web/guest/structure> (accessed: 19-09-2014)

Zahariev, B. (2014). Personal communication by email.

Appendix 2.4. Case report 2.4

Topic 2. Attracting and retaining GPs to strengthen primary care in underserved areas

Case 2.4. Financial support for young doctors, Estonia



SOTSIAALMINISTEERIUM

Research methods applied:
Desk research: September 2014
Email interview: September 2014

1. Summary of the intervention – Financial support for young doctors, Estonia

Dimension of interest	Categories/description
Objective of the intervention	Recruitment (into medical specialism)
Type of intervention	Financial incentives
Professional group(s) targeted	Physicians
Level of intervention	Policy
Type of organisation	Ministry of Social Affairs
Kind of services provided by organisation	The Ministry of Social Affairs is the steward of the Estonian health care system. The ministry has to develop the relevant regulations and strategies.
Size of organisation	Large
Area covered	Estonia
Intervention period / duration of intervention	The beginners' allowance was introduced in 2012. There is no expected end date.
Key actions	Beginner's allowance is a lump-sum allowance paid to a physician who commences work as a medical specialist
Financial investment	Each awarded beginner's allowance costs the Ministry €15.000 (excl. tax)
Implementation strategy or processes used	Introduced in law. The Ministry of Social Affairs is responsible for the execution of the programme.
Day-to-day running of the intervention	The beginner's allowance was introduced and is run and followed-up by the Ministry of Social Affairs.
Personnel investment	The personnel investment is low. No additional HR is required.
Outcome measures of the intervention	Since 2012, 10 medical specialists received the beginner's allowance. There are no results in terms of recruitment monitored.

2. Rich description of the intervention

Reasons for the establishment of the start-up grants for young doctors

In Estonia, the number of doctors fell by 24% during the 1990s and is expected to fall another 12% by 2010. Moreover, Estonia is facing an uneven distribution of specialist services around the country (WHO, 2004).

Objective of the intervention

The aim of the beginners allowance is to motivate and support the start-up of young doctors, including family physicians and medical specialists, in specialities in which recruiting has proven to be difficult (Saar, 2014a).

Type of intervention

This is a recruitment intervention that works with financial incentives.

Professional group(s) targeted

Young doctors, including family physicians and medical specialists.

Start-up grants can be applied for within three months of taking up professional work.

Requirements for the start-up grant are that physicians (Saar, 2014b):

1. Have graduated and completed a residency in anaesthesiology, emergency medicine, laboratory medicine, family medicine, radiology, internal medicine, or general surgery specialist (see Table 1);
2. Have to consent to work five years in the chosen area of work after receiving the grant;
3. Work at least 40 hours a week.

Table 1: Local-, general and central hospital specialties

Local Hospital	General Hospital	Central Hospital
Emergency medicine Internal medicine Anesthesiology Labouratory Medicine Radiology	Emergency medicine Internal medicine General Surgery Anesthesiology Labouratory Medicine Radiology	Emergency medicine Internal medicine Cardiology Neurology General Surgery Urology Orthopaedics Obstetrics and Gynecology Anesthesiology Physiotherapy
		Infectious diseases Psychiatry Pediatrics Labouratory Medicine Radiology Pathology

Level of the intervention

National policy level.

Area covered

Estonia.

The beginner's allowance as explained in the Health Services Organisation Act:

Chapter 4 Beginner's Allowance for Medical Specialists

[RT I, 21.12.2011, 2 - entry into force 01.06.2012]

§ 54¹. Beginner's allowance for medical specialists

(1) Beginner's allowance for medical specialists (hereafter beginner's allowance) is a lump-sum allowance paid to a physician who commences work as a medical specialist.
[RT I, 11.06.2013, 2 - entry into force 01.09.2013]

(2) The beginner's allowance may be applied for within three months after commencing work or practice in the acquired specialty by a physician who:

1. Has completed residency and acquired the specialty of family medicine or a specialty of medical care required for the provision of compulsory health services at a central, general or local hospital according to the requirements for types of hospitals established under subsection 22 (4) of this Act;
2. Commences work or practice in the acquired specialty as a medical specialist within five years as of completion of residency, and;
3. Works as a medical specialist with the work load of at least forty hours a week or works or practices as a family physician with a practice list.

(3) A physician having acquired a specialty specified in clause 2.1 of this section, except for family medicine, may apply for beginner's allowance if he or she commences work in the acquired specialty as a medical specialist with the work load specified in clause 2.3 of this section:

1. At an owner of a hospital who does not run a hospital in Tallinn or Tartu City;
2. At one or more central, general or local hospital(s) specified in the development plan of the hospital network established under subsection 55 (1) of this Act;
3. In a position the provision of health services in the corresponding specialty of which is compulsory for the hospital where the physician works according to the requirements for types of hospitals established under subsection 22 (4) of this Act, and;
4. In a position where the place of work of which is outside Tallinn or Tartu City.

[RT I, 11.06.2013, 2 - entry into force 01.09.2013]

(4) A physician having acquired the specialty of family medicine may apply for beginner's allowance if he or she commences practice as a family physician on the basis of a practice list and the practice list and service area of family physician are located outside of Tallinn, Tartu or surrounding areas.

[RT I, 21.12.2011, 2 - entry into force 01.06.2012]

(2) The grant of beginner's allowance shall be decided by the Ministry of Social Affairs within two months after the submission of an application. The beginner's allowance shall be paid to the physician's bank account within one month as of making the decision to grant beginner's allowance.

[RT I, 11.06.2013, 2 - entry into force 01.09.2013]

(3) The amount of beginner's allowance shall be 15 000 euros.

[RT I, 11.06.2013, 2 - entry into force 01.09.2013]

(5) A physician who has received the beginner's allowance is required to return the allowance paid to him or her if his or her continuous employment or practice on the conditions specified in subsections 54¹ (2)-(4) of this Act ends before five years have passed from the receipt of the allowance.

September 1, 2013 changes were implemented in the specialized medical dispatch support system, which amended the starting grant application, payment and recovery times (Saar, 2014a)

Running time of the intervention

The beginners' allowance was introduced in 2012. There is no expected end date.

Organisational framework

Start-up grants are regulated in the Health Services Organization Act (see above for relevant information in Health Services Organization Act). The Ministry of Social Affairs is responsible for the execution of the programme, i.e. in allocating the grants and in checking whether grants are being used lawfully. A physician who has received the beginners' allowance is required to inform the Ministry of Social affairs when stopping employment or practice before five years have passed from the receipt of the allowance. Furthermore, the employer will have obligation to inform the Ministry of Social affair if the physician who has received the beginners' allowance stopped employment (Saar, 2014a).

Finances

The amount of the beginner's allowance that medical specialists receive is usually €15.000. However, the beginner's allowance also includes income tax. The income tax withholding rate is 21%, but each individual medical specialist will receive €15.000. This means that the costs for the Government who provides the beginner's allowance are higher than €15.000 per medical specialist (Saar, 2014a).

In 2012, the State Budget scheduled payments of €150.000 for the beginner's allowance programme, but it was stated that the amount of the beginner's allowance depended on the number of applicants. Should there for example be 9 or 10 approved applications, the grant would be €15.000. However, should there be 15 approved applications; the individual grants would be €10.000 (Saar, 2014b).

Conditions for replicability

According to Ms Saar, who works at the Health Care Department of the Ministry of Social Affairs, introducing a regulation such as the beginners allowance asks for a

good media campaign and pre-introduction. It would be best to introduce the regulation to physicians who have just started medical specialist studies (medical residency) so that they will have sufficient time to decide which region they would like to work in after graduation (Saar, 2014a).

3. Results of the intervention

Since 2012, a total of 10 medical specialists have received the beginner's allowance. Table 2 breaks down the numbers per year.

Table 2: Number of beginner's allowances granted since 2012

	Total	General practitioner	Other medical specialists
2012	1		
2013	6	3	3
2014 (up to September)	4	1	3
<i>Expected in 2014</i>	7	3	

Source: Saar, 2014a

Results in terms of increased recruitment in underserved areas are not being monitored. Moreover, the numbers of the beginner's allowance are too low at this point to make a significant difference.

The Ministry of Social Affairs assumed that there would be at least 10 applicants yearly. However, the problem is that physicians on graduating usually already have families. This makes moving into another place of habitation complicated (Saar, 2014a).

References

Saar, P. (2014a). Answers received in response to email questions for the Recruitment and Retention study.

Saar, P. (2014b). Medical specialist beginners allowance.

WHO (2004). Health Care Systems in Transition Summary Estonia. WHO/ European Observatory on Health Systems and Policies.

Appendix 2.5. Case report 2.5

Topic 2. Attracting and retaining GPs to strengthen primary care in underserved areas

Case 2.5. Resident scholarship programme, Hungary



Research methods applied:

Desk research: August – September 2014

Email interview: September 2014

1. Summary of the intervention – Resident scholarship programme, Hungary

Dimension of interest	Categories/description
Objective of the intervention	Retention
Type of intervention	Financial incentives
Professional group(s) targeted	Young medical residents
Level of intervention	National policy
Type of organisation	Hungarian Government / Office of Health Authorisation and Administrative Procedures
Kind of services provided by organisation	In Hungary the social and welfare systems are managed and supervised by the Ministry of Health, Social and Family Affairs.
Size of organisation	Large
Area covered	Hungary
Intervention period / duration of intervention	The first Resident Scholarship programme started in 2011. There is no expected end date.
Key actions	After successful application, resident doctors can receive a tax-free scholarship if they agree to work for the Hungarian public healthcare system after specialisation training for the same number of years as their scholarship lasts.
Financial investment	Considerable additional financing is required. The Resident Scholarships are financed by the Hungarian Government. In 2014, the total budget for all four scholarships was €2.449.440.
Implementation strategy or processes used	No information could be retrieved.
Day-to-day running of the intervention	The programme is run by the Hungarian Government. The procedures surrounding the programme (including application, contracting, payment, monitoring) are coordinated by the Office of Health Authorisation and Administrative Procedures.
Personnel investment	No additional HR is required when the programme is embedded in an existing organisation(s).
Outcome measures of the	The programme is very popular. Every year,

intervention	the number of applicants is higher than the number of places available. Total number of participants up to 2014: 1692. No official evaluation criteria have been formulated for the Resident Scholarship programme in terms of recruitment and retention and no results can be reported yet.
--------------	--

2. Rich description of the intervention

The Resident Scholarship Programme

Since 2011, Hungary has established a resident scholarship programme. After a successful application procedure, resident doctors can receive a tax-free scholarship. For receiving the scholarship they have to agree that they will work for the Hungarian public healthcare system after specialisation training for the same number of years as their scholarship lasts (5 years in most cases). Moreover, they must agree not to accept any informal payments (Cserhádi, 2014).

Reasons for the establishment of the Resident Scholarship Programme

Retention of health professionals is one of the main problems that the Hungarian health system is facing. Hungary is highly affected by the mobility of health professionals. The international mobility of doctors has increased significantly since Hungary joined the European Union. One of the main triggers to move is that the wages in the Hungarian healthcare sector cannot compete with the wages in the western part of the European Union. One of the challenges is therefore to motivate graduates to enter into Hungarian residency training programmes.

Objective of the Resident Scholarship Programme

This is a retention intervention. The resident scholarship programme aims to support young medical doctors who participate in specialist training. By providing them with a Scholarship, the Hungarian government hopes to provide opportunities for many young trainee specialists to fulfil their talents and strengthen their commitment to contribute to the effective functioning of the Hungarian health care system. Moreover, the scholarship is also meant to create the necessary financial security for establishing a family and begin the construction of their livelihood (EEKH, 2014).

Type of intervention

Retention intervention that works with financial incentives.

Professional group(s) targeted

Young medical residents (divided over four different scholarships, see below).

Level of the intervention

National policy level.

Area covered

Hungary.

The Resident Scholarship programme

There are four different types of scholarships included under the Resident Scholarship programme (EEKH, 2014):

1. *Markusovszky Ösztöndíj scholarship*

This scholarship was awarded for the first time in 2011. It is targeted at resident doctors, including all young medical doctors who participate in specialisation training regardless of the type of speciality they are training in (EEKH, 2014; Cserhádi, 2014). The main conditions for receiving the scholarship are that resident doctors need to work in the public health care system after completing their specialisation training for the same amount of time that they received the scholarship (which is typically 5 years) and not accept informal payments.

2. *Than Károly Ösztöndíj scholarship*

This scholarship was awarded for the first time in 2011. It is targeted at resident hospital pharmacologists. There are many career pathways for pharmacists in Hungary, including pharmacies, pharmaceutical industry, research and the hospital sector. Hospital pharmacists have to obtain a specialisation in clinical hospital pharmacy. This training lasts 3 years. In the hospital sector, there is a shortage of pharmacists. The Than Károly Ösztöndíj Scholarship addresses this shortage (EEKH, 2014; Cserhádi, 2014).

The main conditions for receiving the scholarship are that resident hospital pharmacists need to work in the public health care system after completing their specialisation training for the same amount of time that they received the scholarship (which is typically 5 years) and not accept informal payments.

3. *Méhes Károly Ösztöndíj scholarship*

This scholarship was awarded for the first time in 2012. It is aimed at paediatrician residents who are willing to work in underserved areas in primary care, in long-term “unfilled” practices. After completing the specialisation training they have to accept the workplace where they are directed. Because of this, the grant sum is higher than for the *Markusovszky Ösztöndíj* and *Than Károly Ösztöndíj* scholarships (EEKH, 2014; Cserhádi, 2014).

The main conditions for receiving the scholarship are that paediatrician residents need to work as primary care paediatricians in shortage areas after completing the specialisation training for the same amount of time that they received the scholarship (which is typically 5 years) and not accept informal payments.

4. *Gábor Aurél Ösztöndíj scholarship*

This scholarship was awarded for the first time in 2013. It is aimed at emergency medicine residents. In Hungary, emergency medicine is a shortage area, especially for the ambulance services. The *Gábor Aurél Ösztöndíj* scholarship is applicable for emergency medicine residents if they agree to work for the Hungarian Ambulance Service after completing their specialisation. Moreover, the Hungarian Ambulance Service will choose their workplace. Because of this, the grant sum is higher than for the *Markusovszky Ösztöndíj* and *Than Károly Ösztöndíj* scholarships (EEKH, 2014; Cserhádi, 2014).

The main conditions for receiving the scholarship are that emergency medicine residents need to work in shortage areas at the Hungarian Ambulance Service after completing the specialisation training for the same amount of time that they received the scholarship (which is typically 5 years) and not accept informal payments.

Running time of the intervention

The resident scholarship programme was run for the first time in 2011. There is no expected end date.

Organisational framework

The resident scholarship programme was developed jointly by the Hungarian Government and the Hungarian Association of Resident Doctors. The programme is run and financed independently by the Hungarian Government. The procedures surrounding the programme (including application, contracting, payment, monitoring) are coordinated by the Office of Health Authorisation and Administrative Procedures (Egészségügyi Engedélyezési és Közigazgatási Hivatal, EEKH) (Cserhádi, 2014).

Implementation strategy

No information could be retrieved.

Finances

The scholarships are financed by the Hungarian Government (Cserhádi, 2014).

1. Markusovszky Ösztöndíj scholarship

The *Markusovszky Ösztöndíj* scholarship is 100.000 Hungarian forint (HUF) per month, approximately €324 per month. The payment only occurs under the condition that the resident fully complies with the demands of his/her training programme. In 2014, the total budget for this scholarship amounts HUF 660 million, approximately €2.138.400 (EEKH, 2014).

2. Than Károly Ösztöndíj scholarship

The *Than Károly Ösztöndíj* scholarship is 100.000 Hungarian forint (HUF) per month, approximately €324. The payment only occurs under the condition that the resident fully complies with the demands of his/her training programme. In 2014, the total budget for this scholarship amounts HUF 24 million, approximately € 77.760 (EEKH, 2014).

3. Méhes Károly Ösztöndíj scholarship

The *Méhes Károly Ösztöndíj* scholarship is 200.000 Hungarian forint (HUF) per month, approximately €648. The payment only occurs under the condition that the resident fully complies with the demands of his/her training programme. In 2014, the total budget for this scholarship amounts HUF 36 million, approximately € 116.640 (EEKH, 2014).

4. Gábor Aurél Ösztöndíj scholarship

The *Gábor Aurél Ösztöndíj* scholarship is 200.000 Hungarian forint (HUF) per month, approximately €648. The payment only occurs under the condition that the resident fully complies with the demands of his/her training programme. In 2014, the total budget for this scholarship amounts HUF 36 million, approximately € 116.640 (EEKH, 2014).

Conditions for replicability

According to Mr. Cserhádi (2014) the Resident Scholarship programme is popular among young doctors and hospitals. The involvement of the Hungarian Resident Doctors Association at the beginning was a key factor to the success of the

programme; it was important to set a sum for the grant that is attractive enough for young doctors.

According to Mr. Cserhádi (2014), the Hungarian programme could be complemented with a more specific focus on shortage areas, for example by differentiating the sum of the grant according to specialty areas. A first step in this direction has been made in 2012 and 2013 with the introduction of the *Méhes Károly Ösztöndíj* resp. *Gábor Aurél Ösztöndíj* scholarship.

3. Results of the intervention

Number of participants

The Resident Scholarship Programme is very popular. For each year that the programme was run there was a pre-determined budget for the scholarships, and in every year there were more applicants than places. The number of participants contracted per year (Cserhádi, 2014):

2011: 600

2012: 507

2013: 585

Total number of participants up to 2014: 1692

Mr. Cserhádi (2014) explained that 95% of all participants are participating in the Markusovszky Scholarship. This is because the *Markusovszky Ösztöndíj* programme is a general programme which is available for all medical doctor residents, regardless of their type of specialisation training. Hence, there has been over-application for the *Markusovszky Ösztöndíj* programme every year. The maximum number of available places is determined by the yearly budget and the numbers are announced for each programme when the application procedure starts.

Results related to recruitment and retention

No official evaluation criteria have been formulated for the Resident Scholarship programme. However, the number of doctors who entered the residency training, the number of doctors who completed specialisation and the number of doctors requesting verification certificate for working abroad are monitored every year. The link between these parameters and the scholarship programme was not examined yet, but these parameters can be taken into account when an evaluation process is implemented. Yet since an average medical specialisation training programme lasts for 5 years, and most of the participants are still receiving the grant, it is too early to draw conclusions. However, the number of doctors who requested a verification certificate for working abroad has slightly decreased since 2011, when the programme started, see table 1 (Cserhádi, 2014):

Table 1: Number of doctors requesting a verification certificate

Number of doctors requesting a verification certificate	2010	2011	2012	2013
All doctors	1111	1200	1108	955

Source: Office of Health Authorisation and Administrative Procedures

References

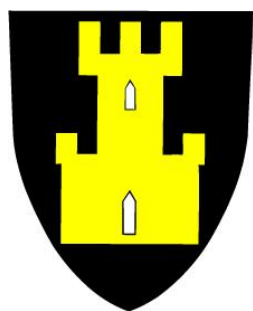
Cserháti, Z. (2014). Personal communication. Zoltán Cserháti, Head of the Department for Health Sector Human Resources Strategy, Ministry of Human Resources.

Egészségügyi Engedélyezési és Közigazgatási Hivatal, EEKH (2014). Meghirdetett ösztöndíjak. Available on: http://www.eekh.hu/index.php?option=com_content&task=view&id=358&Itemid=999999 (accessed: 26-10-2014)

Appendix 2.6. Case report 2.6

Topic 2. Attracting and retaining GPs to strengthen primary care in underserved areas

Case 2.6. Finnmark intern support project, Norway



Finnmark fylkeskommune
Finnmárkku fylkkagielda

Research methods applied:

Desk research: August – September 2014

Telephone interview: October 2014

1. Summary of the intervention – Finnmark intern support project, Norway

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Personal and professional support
Professional group(s) targeted	Medical interns
Level of intervention	Organisational
Type of organisation	The body who has taken a lot of responsibility for the recruitment and stabilization of GPs in Finnmark is the "County Medical Officer", which at present is Dr Karin Straume.
Kind of services provided by organisation	Primary health care
Size of organisation	Large
Area covered	The county of Finnmark, Norway
Intervention period / duration of intervention	The new primary care internship support project in Finnmark was launched in 1998. There is no expected end date.
Key actions	Interns are offered tutorials in groups and encouraged to discuss the challenges to their demanding roles and their potential solutions.
Financial investment	Additional financing is required. Since 1997, Finnmark is granted funds (approx. €119.190 annually) by the national Ministry of Health and group tutors are paid by the MoH.
Implementation strategy or processes used	There was no formal implementation strategy. In 1997, the then Chief County Medical Officer of Finnmark sent his worries about the health workforce crisis to the MoH. Then the MoH decided to supply Finnmark with funds to solve its recruitment crisis. Ms Straume developed the programme for the intern groups jointly with other tutors.
Personnel investment	Limited; group tutors who meet intern groups 3 times for 1-3 days during the 6-month period of their Primary Care internship.

<p>Outcome measures of the intervention</p>	<p>Significantly more interns than could be expected took their first fully licensed physician job in the north of Norway. Given that this improvement coincided with the introduction of supported internships, this was taken as indication that internship in the north promotes recruitment. Causality can't be proven.</p>
---	---

2. Rich description of the intervention

Establishment of the Finnmark intern support project

The primary care internship support project in Finnmark was launched in 1998. Interns were offered tutorials in groups, in addition to the day-to-day clinical supervision by their local GP, and encouraged to discuss the challenges to their demanding roles and their potential solutions. The meetings also provided opportunities to overcome professional and social isolation by networking with peers from neighbouring municipalities (Straume & Shaw, 2010a).

Reasons for the establishment of the Finnmark intern support project

The recruitment of sufficient health workers in rural and remote areas has been a constant challenge in Finnmark. Finnmark's health workforce crisis peaked in 1997. In the autumn of that year, 19 (23%) primary care physician posts were vacant and 12 (15%) others were occupied by physicians on long-term leave. Finnmark was granted funds by the Ministry of Health to address this crisis and as a result the intern support project was introduced (Straume & Shaw, 2010a).

Objective of the intervention

The aim of the intern support project is to provide adequate professional and social support for interns during their challenging service in Finnmark and help them overcome their worries and concerns. This is regarded as a prerequisite for retaining them for further service after finishing their internship (Straume, 2014; Straume & Shaw, 2010b).

It should be noted that the internship as such is not new. Internships have been a compulsory part of medical education in Norway since 1954 until very recently (Straume & Shaw, 2010b). What was new in 1998, when the support project was launched, was that the internship was explicitly used to recruit doctors for further work in Finnmark (Straume, 2014).

Type of intervention

The internship programme is a personal and professional support intervention. It is focused mainly on retention, but also on recruitment.

Professional group(s) targeted

Medical interns.

Level of the intervention

Organisational level.

Area covered

The county of Finnmark in Northern Norway.

Running time of the intervention

The new primary care internship support project in Finnmark was launched in 1998. There is no expected end date.

Implementation strategy

In 1997, the then Chief County Medical Officer of Finnmark sent his worries about the health workforce crisis in his county, e.g. the fact that one third of the positions for GPs were not covered, to the Ministry of Health. This was the moment that the MoH decided to supply Finnmark with the funds required to solve this recruitment crisis (Straume, 2014; Straume & Shaw, 2010b). No clear plans needed to be submitted to the Ministry of Health to obtain the funding.

Ms Straume had been a group tutor for GPs in Oslo for many years. When she moved to Finnmark, she was given the possibility to work with young doctors. She then came up with the idea to work with the interns and set up groups as a means to recruit and retain doctors in Finnmark. She led the first groups. The content of the programmes for the intern groups were developed jointly and were refined during the first years in collaboration with the tutors in the other counties. No other people or organisations were involved at this stage (Straume, 2014). Hence, there was no formal implementation strategy and the process was quite informal.

Even though a survey was conducted in 1998 to determine what the biggest problems for GPs in Finnmark were, funding for the internship support groups did not depend on the results of this survey. This would also have been impossible, as the survey was conducted a year later (Straume, 2014; Straume & Shaw, 2010b).

The primary care internship support project

The primary care internship support project offers interns tutorials in groups, in addition to the day-to-day clinical supervision by their local GP, and, and encourages them to discuss the challenges to their demanding roles and their potential solutions. The groups meet 3 times for 1-3 days during the 6-month period of their Primary Care internship, with the first meeting at approximately 1 month after the beginning of service (Straume & Shaw, 2010b). The meetings provide opportunities to overcome professional and social isolation by networking with peers from neighbouring municipalities (Straume, 2014).

Organisational framework

In Norway, since 1984, primary care and the recruitment and retention of health workers have been organized at the municipal level. Helse Finnmark [in English: Health Finnmark] has experienced recruitment and retention problems over the years, and is striving to solve persistent challenges due to staff turnover and frequent vacancies (Halvorsen et al., 2012). The body who has taken a lot of responsibility for the recruitment and stabilization of GPs in Finnmark is the State Fylkeslege ("County Medical Officer"), which at present is Dr Karin Straume.

In 1997, when the intern support project in Finnmark started, the then Chief County Medical Officer raised the funding and Ms Straume came up with the idea to work with the interns and led the groups. No other people or organisations were involved at this stage.

When at a later stage, Ms Straume wanted to evaluate the project (see Straume & Shaw, 2010a; 2010b) she got some advice from the research institute of the Norwegian Medical Association in how to set up an evaluation model for the project.

Currently, there are three intern groups in Finnmark, one in each part of the county. Each group is led by a different experienced GP who acts as a tutor for the group (Straume, 2014).

Finances

In 1997, Finnmark was granted funds by the national Ministry of Health and Care Services/ Directorate of Health to address the health workforce crisis in the county (Straume & Shaw, 2010b). The Chief County Medical Officer of Finnmark at that time had sent his worries to the Ministry of Health that one third of the positions for GPs in Finnmark were not covered. This was the moment that the MoH decided to supply Finnmark with the funds required to solve this recruitment crisis. Even though a survey was conducted in 1998 to determine what the biggest problems for GPs in the region were, funding for the internship and GP support groups did not depend on the results of this survey (as the survey was conducted a year later).

The Ministry of Health paid the salary of Ms Straume, who worked as group tutor at that time, and there was also money to refund the costs for the doctors that attended (e.g. travel costs etc.). Up to this day, the Finnmark intern support project is being funded in this way. This funding is non-conditional. No specific results need to be obtained to continue receiving funding. The support groups for interns are funded throughout the whole country of Norway (Straume, 2014).

In the first years of the programme, the funding was around 1 million Norwegian Krone (approx. €119.190) annually. The funding is somewhat higher now, because there are more interns (Straume, 2014).

Facilitators in the running of the intern support project

The most important reason that made the intern support project a success was the severe need for doctors in Finnmark. Because of this high need, municipalities were just glad they had an intern. They took very good care of their interns and would gladly let them go two days off to attend the support meetings if this increased the likelihood that the intern would apply for a job in Finnmark after finishing his/her internship. Another crucial success factor was the funding by the Ministry of Health. As Ms Straume states: 'we could not have done it without that' (Straume, 2014).

Barriers in the running of the intern support project

The main barriers in the running of the support groups were related to geographical issues and the climate in Finnmark. It was important to plan things well in advance and with safe time margins, so as to make sure that everyone was able to attend the meetings (Straume, 2014).

Conditions for replicability

The intern support project started in Finnmark in 1998. In the years thereafter, there was a recruitment crisis in the other Northern counties of Norway as well. Hence, the project was extended to these counties and additional tutors were recruited in the other counties. After some years, it was concluded that the groups were a good way of recruiting and that this result was not limited to remote areas. Hence, the project was extended again to recruit doctors into general practice all through the country of Norway. From 2004, the group tutorial has been an integrated element of internship training throughout the country (Straume & Shaw, 2010b). So what started as a specific recruitment project is now part of the internship for all medical doctors (Straume, 2014).

3. Results of the intervention

The intern support project was established in Finnmark in 1998. In the years that followed, from 15 January 1999 until 15 August 2006, data were collected from graduates who had conducted their primary care internship in Finnmark and an evaluation was conducted (Straume & Shaw, 2010b). However, since no baseline data were available, the results from Finnmark were compared with the results from interns in Nordland, the second most remote county in Norway. Of the 267 interns in Finnmark in this period, complete records were obtained for 233 (87.3%).

First official post in the rural North

One of the characteristics that were recorded was the place of first professional post after internship. It was found that significantly more interns than could be expected from their origin took their first fully licensed physician job in the north of Norway. Given that this improvement coincided with the introduction of supported internships in the north, this fact was interpreted by the researchers as an indication that internship in the north, when accompanied by adequate professional and social support does promote recruitment (Straume & Shaw, 2010b). However, causality cannot be proven.

General practice

Another finding of this study (Straume & Shaw, 2010b) was that 34% of the interns from Finnmark chose general practice as specialisation. This was significantly higher than the 15% national gain of new GPs during the same period ($p < 0.001$). Again, however, causality cannot be determined.

The results of the internship project have been reported annually to the Ministry of Health, although funding was not conditional upon obtained results. Apart from the above mentioned results, more recent data that specifically focus on this intervention are not available. Interns are not being monitored anymore because of a lack of time on behalf of the people conducting the intern support groups (Straume, 2014).

References

Halvorsen, P., Lilleaas, M., Vanem, M. (2012). *Recruitment and Retention of Health Care Providers in Remote Rural areas. Status report for Norway*. Recruit and Retain.

Straume, K. (2014). Telephone interview 16-10-2014.

Straume, K., & Shaw, D. M.P. (2010a). Effective physician retention strategies in Norway's northernmost county. *Bulletin of the World Health Organization*, 88(5), 390-394.

Straume, K., & Shaw, D. M. P. (2010b). Internship at the ends of the earth-a way to recruit physicians. *Rural and remote health*, 10(1366).

Appendix 2.7. Case report 2.7

Topic 2. Attracting and retaining GPs to strengthen primary care in underserved areas

Case 2.7. Framework Contract, financial incentives to attract GPs to work in deprived areas, Romania



Research methods applied:

Desk research: September – October 2014 & February 2015

Email interview: September 2014

1. Summary of the intervention – Framework Contract, Romania

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Financial incentives
Professional group(s) targeted	General practitioners
Level of intervention	Policy
Type of organisation	National public institution
Kind of services provided by organisation	National Health Insurance Fund is an autonomous public institution whose main activity is to ensure consistent and coordinated operation of the health insurance system in Romania.
Size of organisation	Large
Area covered	Underserved areas in Romania
Intervention period / duration of intervention	The financial incentives were introduced for the first time in 1999 in the Framework Contract.
Key actions	Granting of financial incentives to attract general practitioners to work in deprived areas.
Financial investment	Additional financing is required.
Implementation strategy or processes used	No information available.
Personnel investment	No additional HR is required when the program is embedded in an existing organisation.
Outcome measures of the intervention	The number of rural GPs in Romania remains fairly stable in absolute terms, but is decreasing in relative terms. Hence, the financial incentives appear to have little effect in attracting and/or retaining GPs. The number of GPs continues to decrease and the number of medical graduates entering family medicine residency is 'decreasing dramatically'.

2. Rich description of the intervention

Case under study

The financial incentives to attract general practitioners to work in deprived areas that are mentioned in the norms of implementation of the Romanian Framework Contract. The Framework Contract is a document which regulates the delivery of all types of healthcare services in Romania which are funded (totally or partially) by the National Health Insurance Fund (NHIF). Apart from the Contract, the NHIF also publishes a document with norms of implementation of the Framework Contract. According to this norms of implementation-document, depending on the conditions in which a primary care office is performing its activity, the total number of points based on which it receives pay per capita can be increased by up to 100%. Hence, it establishes some incentives to attract GPs to work in deprived areas – defined as a place where the district health authority has made several documented attempts to attract a general practitioner with no success (World Bank, 2011).

Reasons for the introduction of financial incentives to attract GPs to work in deprived areas

Romania faces difficulties in attracting GPs to rural areas and establishing (timely) access to primary care services for inhabitants of rural settings. In 2008, it was found that 16.1% of population in rural areas had no regular family doctor. This means that 153.904 inhabitants in 88 settlements were not covered by GP services. The number of uncovered inhabitants varied heavily by regions, being worst in the South-East and South regions of the country (Chanturidze, 2012).

In 2009, the number of physicians in rural areas was more than six times lower than in urban areas. On average, there were 379 physicians per 100.000 population in urban areas compared to only 58 in rural areas of Romania. The lowest coverage was in the least developed economic regions of Romania – the South (Muntenia), South-East, and North-East (World Bank, 2011).

More background information on general practices in Romania

General practice in Romania was recognized as a clinical specialty in 1990, with a 3 year vocational training postgraduate program. In 1999, general practice became known as family medicine, thus marking the primary health care reform in Romania - GPs/family doctors became independent professionals, self-employed and were no longer Government employees. Since 1999, GPs work under contract with the county branches of the National Health Insurance House (CNAS), receiving payment for the health services they provide to all those insured under the social health insurance scheme (SNMF, 2015b)

There are 11.400 GPs in Romania, the average list of registered patients is 1.600, with some practices caring for just 1.000 patients (minimum accepted limit for a contract with the CNAS) while about 20% of practices look after over 2.200 patients. GPs are a third of the total number of doctors in Romania. Most GPs work in single-handed practices, especially in rural areas. In urban areas there usually are larger primary care clinics, but GPs still work in solo practices, with at least one nurse for each GP (a requirement of the contract with the CNAS). Apart from GPs who own their own

practice, there are also salaried GPs who work for GPs with solo practices but with more than 2200 registered patients or for large private clinics (SNMF, 2015b). Most GP practices aren't open during weekends or after normal working hours. Out-of-hours care is assigned to dedicated centres with GPs, usually in rural areas. Some rural areas aren't covered by GPs, due to lack of involvement of the local authorities. An important percentage of practices, especially in rural areas, don't have ECGs, ultrasound or basic lab tests equipment (SNMF, 2015b).

Objective of the intervention

To attract general practitioners to work in deprived areas.

Type of intervention

Financial incentives.

Professional group(s) targeted

General practitioners.

Level of the intervention

National policy level.

Area covered

Underserved areas in Romania.

Running time of the intervention

The financial incentives were introduced for the first time in 1999 in the Framework Contract.

Criteria for financial incentives to attract general practitioners to work in deprived areas as stated in the Order no. 16393 of 18 February 2008

Issued by: Ministry of Public Health

Nr. 163 of 18 February 2008

National Health Insurance House (CNAS)

Nr. 93 of February 7, 2008

Published in the Official Gazette no. 177 of 7 March 2008

I. Conditions for the doctors' activity

- the source of drinkable water (the distance between the family doctor's office and closest source of water);
- whether the office uses solid fuel for heating;
- distance to the closest urban setting

Minimum 2 points Maximum 12 points

II. Conditions in which medical care is provided

- population density;
- the distance between the extreme points of the area;
- easiness to go to patients' homes;

Minimum 2 points Maximum 12 points

III. Support for medical care delivery

- the distance between the location of the office and the closest location with an emergency unit;

Minimum 2 points Maximum points 7

IV. Population's socio-economic level

- number of patients on the list, for whom the contribution to the healthcare fund is granted by the local budget;

Minimum 2 points Maximum points 6

V. Low number of insured people on the doctor's list

Minimum 5 points Maximum 20 points

For each of these criteria, the doctor receives a certain number of points, which in the end are totalled. Based on the total number of points, the increase in the percentage of **per capita** points is determined:

- a) from 51 to 57 points 82% - 100%
- b) between 41 and 50 points 62% - 80%
- c) between 31 and 40% points 42 - 60%
- d) between 21 and 30 points 22% - 40%
- e) between 10 and 20 points 10% - 20%

Hence, depending on the conditions in which a primary care office is performing its activity, the total number of points based on which it receives funding can be increased from 10% to up to 100%. Also, the primary care offices located in the Danube Delta benefit from a 100% increase of their number of points. It should be noted, however, that the Danube Delta is a Romanian County with an extremely difficult situation and a very small number of doctors. Almost no GP is willing to go there. The increase of 100% in this area only applies to 5 doctors, hence the impact is low. Moreover, it has been reported that the increase still doesn't even cover a minimum decent way of life there (SNMF, 2015a).

Organisational framework

The Framework Contract regulates the delivery of all types of healthcare services in Romania which are funded (totally or partially) by the National Health Insurance Fund (NHIF). The National Health Insurance Fund (in Romanian: Casa Nationala de Asigurari de Sanatate) is an autonomous public institution of national interest, with legal personality, whose main activity is to ensure consistent and coordinated operation of the health insurance system in Romania (Pharmaboardroom, 2014). The NHIF also publishes the norms of implementation of the Framework contract in which the financial incentives to attract GPs to underserved areas are mentioned as well.

Implementation strategy

No information available.

Finances

Only 3.6% of Romania's GDP is assigned by the Government to the healthcare system, while for other European countries this percentage lies around 6-12%. The Government collects money from the employee and the employer and from some retired people with pensions over a certain limit and creates the National Insurance Fund (FNUASS in Romanian). This is administered by the National Insurance House. Primary care receives for the 11.500 family medicine offices only about 6% from this

fund, while in other European countries primary care gets about 10-15% of the funding (SNMF, 2011).

Regarding payment, in 2010 a change in the per capita / pay-per-service system was made, and GPs received 50% of the income from pay-for-service and 50% for the patients registered with their practice (SNMF, 2015b). So the remuneration of GPs, most of whom are self-employed, consists of a mix of capitation fees and fees for services. Capitation fees are related to the number and age of registered people and can be higher depending on the location of the practice (urban, rural), the structure and profile of the population and hardship conditions (WHO, 2012). Hence, the financial incentives to attract more GPs to rural areas are directly related to the capitation fees; depending on the conditions in which a primary care office is performing its activity, the total number of points based on which it receives pay per capita can be increased by up to 100%.

The SNMF (2015a) informed us that a new version of the framework changes the ratio between pay per capita and pay-per-service system from 50% - 50% to respectively 20% - 80%. Considering the fact that the percentage of increase in funding for remote and isolated areas is directly related to the pay per capita, this means a significant decrease in the amount of funding.

3. Results of the intervention

The number of rural GPs in Romania is fluctuating (see tables 1 and 2). Hence, the financial incentives appear to have little effect in attracting and/or retaining GPs. This is consistent with anecdotal evidence received by the Romanian National Society of Family Doctors (SNMF), the main professional association of family doctors in Romania. The SNMF informed us that the number of rural GPs decreases and that the number of medical graduates entering family medicine residency is 'decreasing dramatically' (SNMF, 2015a). Young doctors prefer to emigrate (SNMF, 2011).

It should be noted that the total N of active GPs in Romania differ between tables 1 and 2. This is because different reporting standards are used at different places (some reports talk about General Practitioners, in Romania this includes every doctor who finished college, other reports talk about family doctors, those who complete exam and residency). Also, some doctors are working individually while others have employees, resulting in different numbers as well depending on whether the employees are included.

Table 1 Number of active GPs in Romania

Year	Total N of doctors	Total N of active GPs	% GPs
2010	52.204	11.170	21,4%
2011	52.541	11.211	21,4%
2012	53.681	11.151	20,8%
2013	51.993	11.179	21,5%

Source: SNMF, 2015a

Table 2 Number of rural active GPs in Romania

Year	Total N of active GPs	Rural	% rural GPs
2009	12.009	4.446	37%
2011	14.616	4.553	31,2%
2012	13.767	4.551	33,1%

Source: INSSE (2015)

In 2011, the World Bank already concluded that it is unclear whether the financial incentives provided through the Framework Contract are succeeding in alleviating the rural area shortage. It was stated that further analytical work is needed to explore which combination of incentives would be most cost-effective for increasing the recruitment and retention of physicians in rural areas (World Bank, 2011).

References

Chanturidze, T. (2012). *Technical Assistance for Project Management Unit APL 2, within the Ministry of Health of Romania, in order to develop a Strategy for Primary Health Care in Underserved Areas and the Related Action Plan. Contract N40. Final Report*. Oxford Policy Management.

INSSE (2015). *Activitatea Unitatilor Sanitare*. Available at: <http://www.insse.ro/cms/files/publicatii/san2009.pdf> (accessed: 03-03-2015)

Pharmaboardroom (2014). *National Health Insurance House of Romania (CNAS)*. Available at: <http://pharmaboardroom.com/companies/national-health-insurance-house-of-romania-cnas> (accessed: 01-12-2014).

SNMF (2011) - Primary Healthcare in Romania – The main problems we are facing.

SNMF (2015a). Answers received per email on questions Recruitment and Retention study.

SNMF (2015b). *Overview*. Available at: http://www.snmf.eu/en/GP_in_Romania.htm (accessed: 09-02-2015).

World Bank (2011). *Romania - Functional review : health sector*. Washington, DC: World Bank. <http://documents.worldbank.org/curated/en/2011/05/17056888/romania-functional-review-health-sector> (accessed: 02-03-2015).

World Health Organization (2012). *Evaluation of structure and provision of primary care in Romania: A survey-based project*. Available at: http://www.euro.who.int/__data/assets/pdf_file/0005/167576/Evaluation-of-structure-and-provision-of-primary-care-in-Romania.pdf?ua=1 (accessed: 02-03-2015).

Appendix 3.1. Case report 3.1

Topic 3. Providing training, education and research opportunities for a life-long career

Case 3.1. Professional training to Bachelor level for nurses and midwives via bridging courses, Poland



Research methods applied:

Desk research: December 2014 – January 2015

Email interview: January 2015

1. Summary of the intervention – Professional training to Bachelor level for nurses and midwives via bridging courses, Poland

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Education Financial incentives
Professional group(s) targeted	Nurses and midwives
Level of intervention	Policy and organisational
Type of organisation	European Social Fund, Polish Ministry of Health, educational institutions
Kind of services provided by organisation	Various
Size of organisation	Large
Area covered	Poland
Intervention period / duration of intervention	Bridging courses were offered for the first time in Poland in 2003. There is no expected end date. Between October 2008 – academic year 2013/2014, an ESF funded project financed many bridging course places.
Key actions	The duration of the bridging course for nurses/midwives depends on their prior education. Bridging courses have general course content.
Financial investment	Yes. For educational institutions to offer the bridging course, for participants there are fees involved. Between 2008 and 2013, the project “Professional training of nurses and midwives as part of bridging studies” was co-funded by the ESF.
Personnel investment	Team responsible for the realisation of the ESF funded project at Polish MoH is composed of 9 people. While additional HR in universities may be required, the new form of study certainly demands additional preparation of educational staff.
Outcome measures of the intervention	71 universities are offering the bridging course. Up to 2014, 30.577 nurses and midwives have graduated. Main results of

	the course are in increased professional qualifications and increased motivation for career development. Results in terms of professional and social advancement are moderate.
--	--

2. Rich description of the intervention

Case under study

The 'bridging courses', in operation since 2003, which offer Polish nurses and midwives who do not fulfil the requirements for permission to work in other EU countries the possibility to obtain a Bachelor degree and hence become eligible to work in other EU countries. It should be noted that this is not a compulsory course if people want to remain working in Poland.

Reasons for the introduction of bridging courses in Poland

On the 1st of May 2004, Poland joined the European Union. As the free movement of workers is a key right of EU citizenship, the European Commission developed common educational standards to which all EU Member States need to conform. In 2001, prior to the entrance of Poland to the EU, the Polish authorities and the European Commission negotiated the terms for the Accession Treaty. The European Commission proposed a three-tiered system for the recognition of qualifications of Polish nurses (Van Riemsdijk, 2013):

1. *Automatic recognition*: The Accession Treaty of April 2003 ensured that qualifications of nurses and midwives with university education would automatically be recognized within the EU after Poland's accession.
2. *Acquired rights*: The Accession Treaty permits certain acquired rights, as established in Annex II, 2.C. This means that Polish nurses whose training started before May 1, 2004 and who do not meet the minimum training requirements can use their professional experience for recognition purposes.
3. *Recognition under Directive 92/51/EEC*: Professionals who do not meet the requirements listed under regime 1 or 2 can seek recognition under the Second General System Directive (92/51/EEC) as health assistants (European Commission, 2005).

This system of recognition obstructed the transfer of qualifications of the majority of Polish nurses in EU Member States. Only Polish nurses with a master degree in nursing qualified for automatic recognition and this applied to only 2% of all Polish nurses. Only about 28% of Polish nurses fulfilled the requirements for acquired rights, leaving approximately 70% of Polish nurses allowed to work only as health assistants in other EU countries. To offer nurses who do not automatically fulfil the minimum requirements for permission to work in other EU countries the possibility to meet these requirements, 'bridging courses' have been offered since 2003 (Van Riemsdijk, 2013). As the nursing profession in Poland is underpaid and undervalued as a legacy of Poland's communist healthcare model, this results in poor motivation and morale. Around the time of introduction of the bridging courses, it was hoped that these issues would be addressed as well (Van Riemsdijk, 2013).

Objective of the intervention

The main goal of the bridging courses is to increase the professional qualifications of nurses and midwives to Bachelor level. These courses aimed to provide Polish nurses and midwives with better career opportunities and working conditions in Poland, and the opportunity to practice in other EU Member States (Van Riemsdijk, 2013). The bridging courses also aim to motivate nurses and midwives to further develop their

professional qualifications and professional career, as well as to increase the professional and social prestige of nurses and midwives (Ministry of Health, 2015).

Type of intervention

Educational intervention with strong financial incentives (as since 2008 there were many fully subsidized bridging course places for nurses and midwives).

Professional group(s) targeted

Nurses and midwives who hold a baccalaureate certificate and have graduated from either five year medical secondary schools, two year medical vocational schools, two and a half year and three year medical vocational schools (Ministry of Health, 2015).

Level of the intervention

Policy and organisational level

Area covered

Poland

Running time of the intervention

Bridging courses were offered for the first time in Poland in 2003. There is no expected end date.

Since October 2008, the European Social Fund has co-financed the project "Professional training of nurses and midwives as part of bridging studies" and financed bridging course places. However, the last recruitment session in the context of this project took place for the academic year 2013/2014 (Studiapomostowe, 2015).

Bridging course

The duration of the bridging course for individual nurses/midwives depends on the professional education they received. Initially, the duration of bridging courses ranged from two to five semesters:

Bridging course for nurses:

- Path A – graduates of medical high school (3 semesters)
- Path B – graduates of 2 year study on medical secondary school (5 semesters)
- Path C – graduates of 2.5 year study on medical secondary school (3 semesters)
- Path D – graduates of 3 year study on medical secondary school (2 semesters)

Bridging course for midwives:

- Path B – graduates of 2.5 year study on medical secondary school (2 semesters)

By virtue of a decision of the European Commission of the 19th of November 2009, the bridging courses were shortened from five and three to two semesters for graduates of medical secondary school (Studiapomostowe, 2015). Hence, the new path duration is:

Bridging course for nurses:

- Path A – graduates of 5 year medical high school (2 semesters- 1150 hours)
- Path B – graduates of 2 year study on medical secondary school (3 semesters)

- Path C – graduates of 2.5 year study on medical secondary school (2 semesters)
- Path D – graduates of 3 year study on medical secondary school (2 semesters)

Bridging course for midwives:

- Path B – graduates of 2.5 year study on medical secondary school (2 semesters)

The content of the course is determined by the individual educational institutions and approved by the Polish Ministry of Health. All bridging courses for nurses roughly cover the following subjects (Zarzycka, 2014):

- Physical Examination
- Specialized Nursing
- Research in Nursing
- Health Promotion and Health Education

For example, the course subjects for path A & B of the bridging course at at the State Higher Vocational School in Nowym Sączu are the following (PWSZ, 2015):

- Elements of anatomy physiology
- Biochemistry and biophysics
- Microbiology and parasitology
- Pharmacology
- Radiology
- Philosophy and ethics of the profession
- Psychology
- Education
- Right
- Public Health
- Physical examination
- Research in Nursing
- Dietetics
- Fundamentals of Nursing
- Primary Health
- Health Promotion
- Nosocomial infections
- Anaesthesiology and Nursing at the risk of life
- Surgery and Nursing Surgical
- Internal and Nursing internist
- Geriatrics and Nursing geriatric
- Neurology and Nursing Neurological
- Palliative care
- Pediatrics and Nursing Pediatrics
- Emergency medical services
- Psychiatry and Nursing Psychiatric
- Rehabilitation and nurturing Disabled

After successfully finishing the bridging course, a graduate obtains the title Bachelor (Zarzycka, 2014).

Implementation strategy and organisational framework

The Polish Ministry of Health – Department of Nurses and Midwives is responsible for the implementation and realisation of the '*Vocational training system project for nurses and midwives in the context of bridging studies*'. The project is co-funded by the European Union as part of the European Social Fund, Priority II: Measure 2.3 Sub-Measure 2.3.2 of the Human Capital Operational Programme 2007-2013 (Studiapomostowe, 2015). The project's co-financing system was placed in the Department of Structural Funds and Assistance Programmes in the Polish Ministry of Health in April 2008. The team responsible for the realisation of the project at the Ministry of Health is composed of 9 people (Cholewka, 2014).

Universities

The contractors in this project are the universities. They are selected via open tender procedures (in accordance with the public procurement procedure) for carrying out the courses of the Bridging Project, i.e. the bridging courses for nurses and midwives (Studiapomostowe, 2015). In 2014, bridging courses were being offered by 71 universities accredited by the Ministry of Health to do so (Studiapomostowe, 2015). The responsibilities that universities carry in terms of the Bridging Project are:

- Recruitment of bridging course participants
- Selection of bridging course participants
- Gathering of potential course participants' required documentation

Bridging course participants

Eligible for participation in bridging courses are nurses and midwives as depicted in the Nurses and Midwives Act of 15 July 2011 (Act of 15.07.2011r. Ustawa o zawodach pielęgniarstwa i położnej, Journal of Laws 2011, No. 174, item 1039).

To participate in the project nurses and midwives must (PMWSZ, 2015):

- Have completed high school (i.e. hold a so-called 'certificate of maturity')
- Be graduates from either: five-year medical lyceum, two-year medical vocational school, two and a half year- medical vocational school and three-year medical vocational school
- Have the right to practice
- Be employed as nurse or midwife (unemployed nurses and midwives are excluded)
- Meet the required conditions for participation that have been determined by the University

Barriers in the running of the intervention

The bridging courses cost approximately two months of a nursing salary and take a considerable amount of time to complete, based on the prior qualifications of the nurse or midwife. This made it difficult for many nurses to follow the bridging course (Van Riemsdijk, 2013). The ESF funding has taken away many of these financial constraints.

For universities, there were quite a number of barriers when the bridging courses were introduced and needed to be run for the first time. These mainly related to administrative and regulative barriers. They were overcome by development of national regulations, appropriate standards and curricula and development of rules for students' recruitment. In addition, the new bridging courses demanded additional

preparation of university's educational staff and restructuring of organizational objectives (Jagiellonian University, 2015).

Facilitators in the running of the intervention

Few facilitating factors have been reported. At Jagiellonian University, facilitating factors in the running of the bridging course were the increasing professional experience of nurses and their motivation to continue studying (Jagiellonian University, 2015).

Example from practice: the bridging course at Jagiellonian University

Since 2004, Jagiellonian University has been offering the 'bridging course' for nurses and midwives who want to obtain a Bachelor degree. The entry requirements for nurses as well as the duration of the bridging courses were all determined by the general requirements drafted for bridging courses all over Poland (as explained above). Facilitating factors in the running of the bridging course at Jagiellonian University were the increasing professional experience of nurses and their motivation to continue studying. Barriers were related to the heavy work burden and intensive programme for the students (part time study from Friday to Sunday) and their need to combine work, study and personal life. It was also difficult to select the course subjects to be taught, based on the different knowledge fields of nurses (Jagiellonian University, 2015).

The bridging course at Jagiellonian University was evaluated with the survey audit as requested by the Ministry of Health. However, internal assessments were also performed within the university based on its own criteria (student surveys, satisfaction rating scales, class evaluation, further evaluation and career of the graduates). Jagiellonian University reports that this has shown that bridging course graduates have greater job satisfaction, more professional confidence, value the opportunity to continue learning and that the bridging course increases the quality of care provision (Jagiellonian University, 2015). For universities, there were quite a number of barriers when the bridging courses were introduced and needed to be run for the first time. These mainly related to administrative and regulative barriers. They were overcome by development of national regulations, appropriate standards and curricula and development of rules for students' recruitment. In addition, the new bridging courses demanded additional preparation of university's educational staff and restructuring of organizational objectives (Jagiellonian University, 2015).

Finances

The fee for the bridging course is about 1900 Polish Zloty (€441,27) per semester (PWSZ, 2015). Nurses and midwives either cover the costs of this study on a private basis or they had the opportunity (at least over the last years) to follow the course free of charge because fees were covered by the European Social Fund.

Universities that have obtained grants in the framework of the project "Vocational training of nurses and midwives in the context of bridging studies", co-financed by the European Social Fund under the Human Capital Operational Programme, and under an agreement with the Polish Ministry of Health, have committed to not charge any fees from course participants for the entire period of the bridging course. In accordance with the provisions of this agreement, the ESF grants universities funds based on the costs for one semester for one participant times the number of course participants.

Hence, the exact amount of the grant depends on the number of bridging course student places agreed upon between the University and the Ministry of Health. Additionally, the ESF grant provides funding for administrative support, etc. In view of this, universities are not allowed to charge any additional fees from students (Studiapomostowe, 2015).

However, should bridging course participants abandon the bridging course for unjustified reasons, the participant is obliged to return the funds intended for his/her education to the University. This does not apply to participants who for reasons beyond their control (e.g. health problems) dropped out of the bridging course (PMWSZ, 2015)

The total budget for the project "Vocational training of nurses and midwives in the context of bridging studies", co-funded by the European Social Fund (Priority II: Measure 2.3 Sub-Measure 2.3.2 of the Human Capital Operational Programme 2007-2013) is approximately 193 million PLN (Studiapomostowe, 2015). Table 1 shows that most of the money in the project is spent on the education itself, whereas a much smaller amount is spent on necessary promotion and information about the free bridging courses.

Table 1 Expenditures Project "Vocational training of nurses and midwives in the context of bridging studies"

Type of expenditure	Spent (status May 2014)	% of spending	Remains to be spend
Further training nurses and midwives	146.562.294 PLN (€34.038.359)	82%	3.182.400 PLN (€739.096)
Promotion and information	4.918.885 PLN (€1.142.386)	75%	1.676.385 PLN (€389.332)
Remaining expenses	6.034.624 PLN (€1.401.511)	78%	1.720.115 PLN (€399.488)
Total	157.515.803 PLN (€36.582.257)	82%	35.578.902 PLN (€8.263.022)

Source: Cholewka, 2014

3. Results of the intervention

Number of participating universities and course participants

The number of participating universities has been increasing since the ESF started financing the bridging course project (see table 2). At present the project is being realised by 71 universities accredited by the Ministry of Health in the aspect of providing nursing and midwifery training (Studiapomostowe, 2015).

Table 2 Number of universities selected via tender to provide bridging course

Year	Season	Nr of universities selected via tender	Nr of starting nurses and midwives
2008	Autumn	32	2935
2009	Spring	9	365
2009	Autumn	45	5152
2010	Spring	17	N/A
2010	Autumn	56	N/A
2011	Autumn	47	N/A
2012	Spring	9	N/A
2012	Autumn	68	N/A
2013	Autumn	64	N/A
2014	Spring	64	N/A

Source: Cholewka, 2014

Before the ESF started funding the bridging courses in 2008, roughly 12000 nurses and midwives already completed a bridging course. The expectation was that with the ESF funding, this number would increase with 40 thousand to 52339 (Cholewka, 2014). Since the onset of the Project until June 2014, a total of 30577 nurses and midwives have graduated from the programme, including 27894 nurses and 2683 midwives. Of the 30577 graduates, 8556 students are pursuing further education (Cholewka, 2014).

Results of graduate surveys

The MoH- Department of Nurses and Midwives is responsible for the task that all educational institutions let their bridging course graduates, who received funding through the ESF, fill out a survey. These surveys are used for assessing the implementation of the project. Students must fill out a questionnaire within two weeks from the date of completion of training (Studiapomostowe, 2015).

In 2010, 1804 bridging course graduates filled in the survey. These were:

Nursing graduates (98.3% of the respondents):

Path A - 67.2%

Path B - 1.2%

Path C - 23.2%

Path D - 6.8%

Midwifery graduates (1.7% of the respondents): Path B

Table 3 Results survey graduates bridging course

	Yes	No	Do not know
Did the bridging course expand your knowledge in the field of nursing/midwifery?	97.7%	0.4%	1.9%
Did the bridging course increase your motivation for career development?	89.9%	3.8%	6.3%
Did the bridging course raise your professional confidence?	92.7%	3.1%	4.2%
Did the bridging course raise the social esteem for your job?	88.7%	4.9%	6.4%
Did the bridging course created the possibility of career advancement?	45.4%	46.5%	8.1%
Did the bridging course created the possibility of social advancement?	40.1%	51.3%	8.6%

Source: Studiapomostowe, 2015

In 2013, benefits for graduates from the bridging course were comparable to the ones reported in 2010. Survey research showed that for 95.5% of the graduates the main advantage is their increase in professional qualifications. 85.4% of the graduates had increased motivation for career development and further development of his/her professional qualifications. Again, scores were lowest for the possibilities that graduating the bridging course had brought in terms of professional and social advancement (32.3%) (Cholewska, 2014).

Additional information

- Information about bridging studies financed by the EU within the framework of the ESF has been effectively disseminated in the environment of professional nurses and midwives.
- 11 information and training conferences were organised, attended by a total of 1.065 persons from universities and other stakeholders.
- 38.850 starter packages have been prepared for students for the purposes of information provision and promotion of the project.
- 471.383 promotional and information campaign materials have been developed

References

Cholewka, B. (2014). Projekt Systemowy pn. *Kształcenie zawodowe pielęgniarek i położnych w ramach studio pomostowych współfinansowany przez Unie Europejska w ramach EFS. Na finiszu*. Presentation at Information and Training Conference in Warsaw, 16-17 June 2014.

Jagiellonian University (2015). Answers to questions sent by email for Recruitment & Retention study.

Ministry of Health (2015). *About project*. Available at: <http://www.studiapomostowe.mz.gov.pl/index.php/en/?Itemid=809> (accessed on 20-01-2015).

Państwowa Wyższa Szkoła Zawodowa w Nowym Sączu [State Higher Vocational School in Nowym Sączu] (2015) <http://www.pwsz-gnieszno.edu.pl/index.php/karty-opisu-przedmiotow/821-pielgniarstwo-niestacjonarne-pomostowe>

Panstwowa Medyczna Wyzsza Szkoła Zawodowa w Opolu [Public Higher Medical Professional School in Opolu] (2015). Projekt systemowy: Kształcenie zawodowe pielęgniarek i położnych w ramach studiów pomostowych. Available at: <http://www.wsm.opole.pl/16/projekt-systemowy-ksztalcenie-zawodowe-pielgniarek-i-polozonych-w-ramach-studiow-pomostowych.html> (accessed: 21-01-2015).

Studiapomostowe (2015). *Projekt systemowy Kształcenie zawodowe pielęgniarek i położnych w ramach studiów pomostowyc [Vocational training system project for nurses and midwives in the context of bridging studies]*. Available at: <http://www.studiapomostowe.mz.gov.pl/index.php> (accessed: 19-01-2015)

Zarzycka, D. (2014). *Kształcenie "pomostowe" pielęgniarek w Rumunii – doświadczenia własne*. Presentation at Information and Training Conference in Warsaw, 16-17 June 2014.

Appendix 3.2. Case report 3.2

Topic 3. Providing training, education and research opportunities for a life-long career

Case 3.2. Graduate Nurse Programme, Calvary Health Care ACT, Australia



Research methods applied:
Desk research: August 2014

1. Summary of the intervention – Graduate Nurse Programme, Calvary Health Care ACT, Australia

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Education Personal and professional support
Professional group(s) targeted	Graduate nurses who make the transition into clinical practice
Level of intervention	Organisational
Type of organisation	Calvary Health Care ACT is a not-for-profit hospital
Kind of services provided by organisation	Calvary Health Care ACT provides public and private hospital services
Size of organisation	Large (334 beds)
Area covered	Australian Capital Territory
Intervention period / duration of intervention	Calvary Health Care ACT already had a Graduate Nurse Programme, but in 2008, a new improved GNP was introduced which is running two times a year.
Key actions	Graduate Nurse Programme provides education, support and socialization for newly graduated RNs.
Financial investment	Additional financing is required, but limited. Calvary Health ACT funded a new Graduate Nurse Coordinator on an on-going basis.
Implementation strategy or processes used	A first step in the redevelopment of the GNP was conducting a focus group with 13 RNs, then a Graduate Nurse Coordinator was employed and an extensive literature review of other GNPs was undertaken. On the basis of this input, the new GNP was developed.
Day-to-day running of the intervention	Predominantly through the Graduate Nurse Coordinator.
Personnel investment	Additional HR is required. In January 2008, a Graduate Nurse Coordinator was employed and in 2009, in addition, a Graduate Facilitator position was trialled.

Outcome measures of the intervention	Since the introduction of the new GNP, there has been a significant improvement in retention rates.
--------------------------------------	---

2. Rich description of the intervention

Case under study

The Graduate Nurse Programme at Calvary Health Care ACT, Australia.

Establishment of new Graduate Nurse Programme

Calvary Health Care ACT already had a Graduate Nurse Programme in place. However, a 2007 hospital-wide staff satisfaction survey showed that there was dissatisfaction with the programme. In 2008, a new improved Graduate Nurse Programme was introduced (Cubit & Ryan, 2011).

Reasons for the establishment of the new improved Graduate Nurse Programme

Australia is facing a nursing shortage. Moreover, since the early 1990s, the clinical preparedness of nursing graduates has been a continuous problem across Australia. As the costs of replacing a graduate nurse are high, the development and retention of graduate nurses is considered a vital recruitment initiative (Cubit & Ryan, 2011).

In 2007 a hospital-wide staff satisfaction survey was conducted at Calvary Health Care ACT. This survey identified a need to expand Learning and Development (L&D) across the organisation. Approval to fund a Learning and Development project was granted in October 2007 which included redeveloping the existing GNP (Cubit & Ryan, 2011).

Objective of the intervention

To improve retention rates of graduate nurses within Calvary Health Care ACT and increase recruitment of new graduates.

Type of intervention

The Graduate Nurse Programme provides education, support and socialisation (Cubit & Ryan, 2011).

Professional group(s) targeted

Graduate nurses.

Level of the intervention

Organisational level.

Area covered and kind of services provided

Calvary Health Care ACT is a not-for-profit hospital that provides public and private hospital services within the Australian Capital Territory (Cubit & Ryan, 2011). The GN programme focuses on graduate nurses within Calvary Health Care ACT.

Running time of the intervention

The new improved Graduate Nurse Programme at Calvary Health Carer ACT was run for the first time in 2008. There are currently 2 graduate programmes per year. There is no expected end date (Calvary Health Care ACT, 2011).

Calvary Health Care ACT Graduate Nurse Programme

Calvary Health Care ACT runs a comprehensive, supportive, caring and fun programme for graduate nurses. The Calvary Health Care ACT Graduate Nurse Programme consists of the following elements (Calvary Health Care ACT, 2011):

- Specific graduate orientation day.
- 3 day hospital and nursing orientation.
- 2 - 3 induction days at the beginning of each rotation.
- Clinical support structure including Clinical Development Nurses, Graduate Coordinator, Graduate Facilitators and Preceptors.
- Regular meetings and de-briefings with the Graduate Coordinator, Graduate Facilitators, Clinical Development Nurses and Preceptors.
- Weekly skills based workshops designed specifically for Graduates Nurses. Topics include:
 - o Preparing a patient for OR
 - o Aseptic Technique
 - o Insulin Infusions
 - o ECGs
 - o Drains
 - o Bladder Irrigation
 - o IDC insertion
 - o PCA/Epidurals
 - o CVC dressings
 - o NG/PEG/TPN
 - o Wound Vacs
 - o Trachy care
 - o Latex allergy
 - o IM injections
- Six study days throughout the year. These days encompass a wide variety of clinical and non clinical topics, such as:
 - o Team Building
 - o Reality Shock
 - o Adjustment
 - o Facing Death
 - o Beyond the Biomedical Paradigm
 - o Wound Care
 - o Bowel Care
 - o Clinical case studies
 - o Stoma care
 - o Chest pain
 - o Areas of preventable harm
 - o Inter-professional learning sessions
- Team building exercises
- Informal drop-in lunch time meetings with the Graduate Nurse Coordinator
- Graduation: after all the hard work you've put in over the first year of your nursing career, we like to mark your achievement with a graduation celebration.

- Clinical Rotations & Streaming: we offer a number of different rotation options at Calvary Public Hospital; either 4 months, 6 months or 12 months depending on your chosen specialty.

Implementation strategy

After the 2007 hospital-wide staff satisfaction survey showed a need to expand Learning and Development (L&D) across Calvary Health Care ACT, a L&D project was set up which included the redevelopment of the existing Graduate Nurse Programme.

A first step in the redevelopment of the GNP was conducting a focus group with 13 registered nurses who were part of the existing 2007 Graduate Nurse Programme. The results of the focus group identified several issues including a lack of orientation and induction days, and dissatisfaction with study day content (Cubit & Ryan, 2011).

In January 2008, a Graduate Nurse Coordinator (GNC) was employed to redevelop the GNP. Together with the Learning & Development Project Manager the GNC undertook an extensive literature review and analysis of other local and national GNP. The intent was to identify key best practice aspects of GNP which could be incorporated into the new programme (Cubit & Ryan, 2011).

Based on these efforts, the new Graduate Nurse Programme was developed and implemented.

Organisational framework

No further information concerning the organisational framework could be retrieved.

Finances

After the 2007 hospital-wide staff satisfaction survey showed a need to expand Learning and Development (L&D) across Calvary Health Care ACT, an L&D project was funded which included the redevelopment of the existing Graduate Nurse Programme. As part of the L&D project, a highly motivated Graduate Nurse Coordinator (GNC) was employed in January 2008 to redevelop the

GNP. In 2009, funding for an on-going Graduate Coordinator was secured. Additionally in 2009, a Graduate Facilitator position was trialled to overcome some of the assessment and feedback issues identified by the 2008 graduate nurses (Cubit & Ryan, 2011).

3. Results of the intervention

Results on recruitment and retention

Important measures of the success of the new graduate nurse programme are recruitment and retention rates. Table 1 shows the retention rates for the old programme and the new programme. There has been a significant improvement in retention rates of graduate nurses (Cubit & Ryan, 2011).

Table 1: Retention rates Calvary Health Care ACT GNP

			Retention rate
2007	old	GN programme	64%
2008	new	GN programme	88%

Source: Cubit & Ryan, 2011

Proxy measures

Calvary Health Care ACT also conducted an evaluation of the new GNP. In 2009, following the completion of the programme all GN who completed the 2008 GNP were invited to participate in focus groups. GNs reported that the best aspects of the GNP were being supported, encouraged and accepted as a team member (Cubit & Ryan, 2011).

References

Calvary Health Care ACT (2011). Graduate Nurse Programme Booklet.

Cubit, K.A. & Ryan, B. (2011). Tailoring a Graduate Nurse Programme to meet the needs of our next generation nurses. *Nurse Education Today*, 31, 65–71.

Appendix 3.3. Case report 3.3

Topic 3. Providing training, education and research opportunities for a life-long career

Case 3.3. The opportunity to perform research as a form of Continuing Professional Development, Sweden



Research methods applied:

Desk research: August- September 2014

Telephone interview: August 2014

1. Summary of the intervention – The opportunity to perform research as a form of Continuing Professional Development, Sweden

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Education Regulation
Professional group(s) targeted	Healthcare staff, in particular physicians
Level of intervention	Policy and organisational
Type of organisations	Universities, hospitals, county councils and the Swedish government (in this report: Örebro University, Uppsala University, Skåne University Hospital Karolinska Institutet)
Kind of services provided by organisations	Various
Size of organisations	Large
Area covered	Country of Sweden
Intervention period / duration of intervention	We weren't able to establish a clear starting point for this incentive to recruit and/or retain staff.
Key actions	The offering of positions in which staff are able to spend time on research and further professional development.
Financial investment	Additional financing is required for this intervention and is mainly provided by the Swedish government. Other external and internal grants provide additional funding.
Day-to-day running of the intervention	Varies per healthcare institution and university.
Personnel investment	No extra HR is required to introduce this intervention.
Outcome measures of the intervention	None of the universities or hospitals involved was able to produce numbers of the effects of being able to offer healthcare staff the opportunity to conduct research on recruitment and retention numbers. However, this is generally considered a good way to attract staff.

2. Rich description of the intervention

Case under study

The offering of positions in which healthcare staff, in particular physicians, are able to spend time on research and further professional development as an incentive to retain or recruit healthcare professionals.

Reasons for the introduction of this measure

Sweden faces a shortage of nurses with work experience, although the situation does differ throughout Sweden. The ageing population is expected to create an increased demand, especially within the care of the elderly and the shortage will probably culminate in 2020.

The demand for physicians is also expected to rise as a result of the growing and ageing population in Sweden. The number of newly graduated physicians is predicted not to be enough to satisfy the demand for physicians (Svensson et al., 2011). Hence, innovative ways are being sought to retain and recruit healthcare professionals.

Objective of the intervention

To recruit and/or retain healthcare staff.

Type of intervention

Educational intervention.

Professional group(s) targeted

All healthcare staff. The particular type of staff depends on every county's demand for health professionals (Svensson et al., 2011).

Level of the intervention

Predominantly organisational level.

Area covered

Sweden.

Running time of the intervention

We weren't able to establish a clear starting point for the incentive to recruit and/or retain staff.

Organisational framework

Sweden is divided into 20 counties (in Swedish: län), these are the first level administrative and political subdivisions of Sweden. The counties are responsible for healthcare in the region, including academic care. The responsibility for (bio)medical research, however, is divided between on the one hand the universities and on the other hand, the county councils.

Örebro county

For example, in the case of Örebro county, responsibilities for research are divided between Örebro University and Örebro county council. Örebro University is responsible for the research that it conducts itself, while the County Council is responsible for the clinical research that is being conducted within the University Hospital. So even though the research that is being conducted within the University Hospital may be (and often is) linked to the University (most researchers employed by the University Hospital have a formal affiliation to the University), it is nonetheless independent research of the University Hospital for which the county council bears responsibility (Brummer, 2014).

This division of responsibilities means that if the University Hospital (that falls under the responsibility of the County Council) is trying to recruit a doctor or a nurse, it can offer a job, which includes both healthcare and research (as the County Council is responsible for both of these issues). This is an attractive strategy to recruit personnel.

At the same time, the University is able to recruit candidates by offering them the opportunity to carry out part of their appointment at the University Hospital. This is because the University and University Hospital work together closely (Brummer, 2014). The University calls this an 'attractive construction' to recruit people, because the University can offer candidates the possibility to work an x percentage of their time in the University Hospital and vice versa.

Moreover, everyone who actively conducts research at the University Hospital automatically receives an 'affiliation' with the University. This means that they are not employed by the University but nonetheless are able to utilize a number of University facilities and services, as the University is much better equipped to assist with research specific issues, such as finding grants (Brummer, 2014).

Uppsala county

In Uppsala, physicians are offered the opportunity to spend time on research. This is actively being used as a way to attract and retain hospital staff (Uppsala University, 2014). Again, as in Örebro, this is mainly done through parallel employment of staff in Uppsala University and the University Hospital Uppsala. The framework agreement is with Uppsala county council, as the responsibility for healthcare lies with the county. There is a framework agreement between the State (who runs university education) and the county councils (who run the hospitals) in financing the clinical research of physicians. This is called the ALF agreement. The ALF funds are the government's way of remunerating the university hospitals for training doctors and for clinical research. This means that most clinical research is paid for by the state, even in the council-run hospitals (Uppsala University, 2014).

Skåne County

Skåne University Hospital has established a programme in which physicians and/or other hospital staff can spend time on research. This programme is run in partnership with Lund University and Malmö Högskola (Skåne University Hospital, 2014).

Stockholm county

In Stockholm county, the Karolinska University Hospital has established a programme in which physicians and/or other hospital staff can spend time on research in

partnership with the Karolinska Institute (Medical University). This was not explicitly introduced as recruitment and retention (Karolinska University Hospital, 2014).

Barriers in the running of the intervention

This close cooperation between University and University Hospitals is a strong recruitment strategy but it can be improved. As professor Brummer of Örebro University explained: in general, a person's career structure is determined by the organisation in which he/she is employed. So even though a physician may work 70% of his time at the University Hospital and 30% of his time at the University, if he is employed by the University Hospital than his career structure will be formed by the 'rules' of the University Hospital, as this employer is responsible for it. In practice, this means that for young doctors, there are advantages to only do clinical work instead of combining this with research. Because if you want to make a career in the hospital, you are 'judged' by the amount of clinical work you perform. So doing research, to put it very strongly, is detrimental to your monthly salary. Because if your salary is dependent upon your clinical knowledge and skills and you can rise in rank (and get paid more) by doing five year clinical work, then why would you do research? The University and University Hospital need to have a better alignment to solve this issue. Because this leads to people leaving or not entering an academic career (Brummer, 2014).

Finances

In Sweden, there is a framework agreement between the State (who runs university education) and the county councils (who run the hospitals) in financing the clinical research of physicians. This is called the ALF agreement. The ALF funds are the government's way of remunerating the university hospitals for training doctors and for clinical research. This means that most clinical research is paid for by the state, even in the council-run hospitals. So for example in Stockholm county, Stockholm County Council is paying for the time that the Karolinska University Hospital is providing to healthcare staff to conduct research (Karolinska University Hospital, 2014).

In addition to financing through the ALF-agreement, many researchers receive grants through internal and external funds that provide money to allow them to "pay themselves" time for research (Karolinska University Hospital, 2014; Skåne University Hospital, 2014).

Conditions for replicability

One of the most important things for hospitals that want to offer their staff the possibility to conduct research is to have a cooperation agreement with nearby universities. Formal cooperation agreements facilitate the exchange of knowledge and can be beneficial for both institutions.

3. Results of the intervention

None of the universities or hospitals involved was able to produce numbers of the effects of being able to offer healthcare staff the opportunity to conduct research on recruitment and retention numbers. It should be noted that this is a fairly difficult thing to do, considering the many confounding factors and especially the fact that there is no clear 'before' and 'after' with this kind of intervention.

However, professor Brumner of Örebro University explained to us that the fact that University Hospitals can offer potential candidates the opportunity to combine their clinical work with research, is a good way to attract young doctors for example from non-University hospitals. It is an attractive recruitment construction, because the University can offer candidates the possibility to work an x percentage of their time in the University Hospital and vice versa (Brumner, 2014).

Uppsala University also informed us that being able to offer healthcare staff the opportunity to perform research has been an important measure with regard to staff recruitment. The pull factor of the nearby Stockholms region is great, and research opportunities are a good way to keep and attract staff to Uppsala University and Hospital.

References

Brumner, R. (2014). Telephone interview for the Recruitment and Retention study. 27 August 2014.

Karolinska University Hospital (2014). Answers received on email questions Recruitment & Retention study. 5 September 2014. 25 August 2014.

Skåne University Hospital (2014). Answers received on email questions Recruitment & Retention study. 5 September 2014. 8 September 2014.

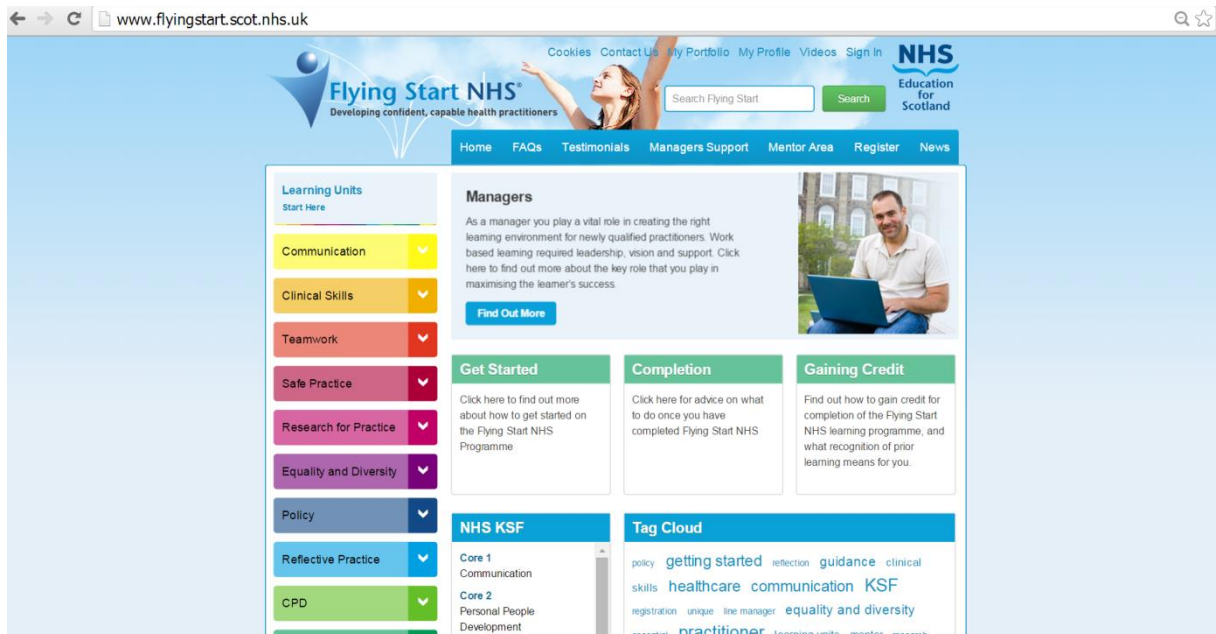
Svensson, P.G., Gustafsson, M.R., Kaplan, D. (2011). *Sweden, Mobility of Health Professionals*. Bonn: WIAD - Scientific Institute of the Medical Association of German Doctors.

Uppsala University (2014). Answers received on email questions Recruitment & Retention study. 5 September 2014.

Appendix 3.4. Case report 3.4

Topic 3. Providing training, education and research opportunities for a life-long career

Case 3.4. Flying Start NHS, Scotland, United Kingdom



Research methods applied:
 Desk research: July-August 2014
 Email interview: November 2014

1. Summary of the intervention – Flying Start NHS, Scotland, United Kingdom

Dimension of interest	Categories/description
Objective of the intervention	Retention
Type of intervention	Education Personal and professional support
Professional group(s) targeted	Newly qualified nurses, midwives and allied health professionals
Level of intervention	Organisational
Type of organisation	The <i>Flying Start NHS</i> programme is offered by NHS Education for Scotland, a special health board.
Kind of services provided by organisation	NHS Education for Scotland develops and delivers education and training for those who work in NHS Scotland.
Size of organisation	Large
Area covered	Scotland
Intervention period / duration of intervention	Launched in January 2006. No expected end date.
Key actions	Supporting new staff through a structured programme of online work packages and an associated mentoring scheme
Financial investment	Additional financing is required. The Scottish government provides the funding for Flying Start NHS
Implementation strategy or processes used	NHS Education for Scotland, NHS Scotland and the Higher Education Institutions developed the programme. Implementation is the responsibility of NHS Boards. In 2006, funding was provided to Boards to support them with this and they are free in how to do this.
Day-to-day running of the intervention	The day-to-day running of the programme is the responsibility of the individual NHS Boards across Scotland. There is no guiding framework for this, hence there is variation across the Boards in how and the extent in which the Programme is used.

Personnel investment	Additional HR is required in implementing the programme. In the day to day running, this depends on the way a Board uses the programme.
Outcome measures of the intervention	The effects of the programme on recruitment and retention are currently not measured. In 2010, a 2-year evaluation was finished. Despite considerable efforts, data of adequate quality to enable a statistical analysis of recruitment and retention patterns were not available.

2. Rich description of the intervention

Case under study

Flying Start NHS® is a national web-based development programme for newly qualified nurses, midwives and allied health professionals (NMAHP) entering employment with NHS Scotland (Upton et al., 2012).

Establishment of Flying Start NHS

Flying Start NHS was launched by NHS Education for Scotland in 2006 (Upton et al., 2012).

Reasons for the establishment of Flying Start NHS

Early career development and support for newly qualified health practitioners (newly qualified practitioners) has been high on the Scottish agenda with a view to decreasing both student and post-registration attrition rates (Banks et al., 2011). To support newly qualified health practitioners in their transition from student to autonomous practitioner, the Scottish Executive Health Department in 2005 commissioned National Health Service (NHS) Education Scotland to develop a web-based educational resource to support the transition from student to qualified practitioner for all newly qualified health practitioners. Subsequently, the Delivering for Health agenda in Scotland was published in 2006 and also stated the need for a well-developed workforce to ensure patient care and services are delivered effectively and efficiently. It recognised that an individual's first experience of working with NHS Scotland is likely to have a big influence on future career plans and hence recognised the need to provide support during initial employment within the NHS. Flying Start was promoted as a means of helping NMAHPs develop into confident and competent practitioners (Banks et al., 2011; Scottish Executive, 2006; Upton et al., 2012).

Objective of the intervention

Flying Start NHS® aims to support new staff in their transition from student to effective practitioner (Upton et al., 2012). It aims to support the individual's progression, build his or her confidence, and assist him or her in making choices about career development through a structured programme of online work packages and an associated mentoring scheme (Scottish Executive, 2006; Upton et al., 2012; Flying Start NHS, 2014).

Type of intervention

Flying Start NHS is aimed at retaining newly qualified nurses, midwives and allied health professionals through education and professional and personal support.

Professional group(s) targeted

All newly qualified nurses, midwives and allied health professionals who join NHS Scotland, working in any NHS setting. Staff on NHS banks and employed within care home settings, independent hospitals and within the armed forces are also able to register onto Flying Start NHS (Flying Start NHS, 2014).

Level of the intervention

Organisational level.

Area covered

Flying start NHS is available to all newly qualified nurses, midwives and allied health professionals across Scotland who join NHS Scotland (Flying Start NHS, 2014).

Running time of the intervention

Flying Start NHS® was launched in Scotland in 2006 (Upton et al., 2012). There is no expected end date.

Implementation strategy

NHS Education for Scotland, in partnership with NHS Scotland and the Higher Education Institutions (HEIs), developed the Flying Start NHS programme but is not responsible for its implementation. This is the responsibility of the individual NHS Boards across Scotland (Cowan & Hall, 2014; NHS Forth Valley, 2014). In 2006, funding was provided to Scottish NHS Boards to support the implementation of Flying Start NHS (Banks et al., 2011). While NHS Education for Scotland provides guidance to individual Boards when requested, it does not monitor the implementation by the Boards nor does it automatically provide guidance by itself (Cowan & hall, 2014).

The extent to which Flying Start has been adopted and promoted varies across the country. Few NHS

Boards have actually adopted a policy relating to Flying Start, although many have developed guides and information about how Flying Start should be approached. Only a few Boards developed and implemented a Flying Start *policy*, to ensure that the programme was integrated into their Mandatory Training Policy (Banks et al., 2012). Because the responsibility for the implementation of the Flying Start NHS programme lies with the individual Boards, variation can also be observed as to whether participation in the programme is mandatory for new staff or not (Cowan & hall, 2014).

The Flying Start NHS® programme

The Flying Start NHS programme is delivered through a dedicated website. On entering employment, all newly qualified practitioners are expected to register and access the Flying Start NHS programme (Banks et al., 2011). The website is constantly reviewed to ensure it is kept dynamic and contemporary (NHS Education for Scotland, 2012). Newly qualified staff can register by visiting the website www.flyingstart.scot.nhs.uk. They must enter their details there following the launch. They should also consult their line manager/mentor to arrange for appropriate time/support to complete the programme (Flying Start NHS, 2014). Moreover, they need to confirm with their line manager who their named mentor will be, meet with their mentor as soon as possible to agree how they will work together, locate computers and other educational resources that can be accessed on a regular basis and access protected learning time in their work schedule wherever possible (Banks et al., 2011).

The Flying Start NHS® programme comprises 10 learning units, along with learner guides which assist the newly qualified staff in navigating the system, which reflect current priorities and expectations in health and healthcare (Flying Start NHS, 2014):

1. Communication
2. Clinical skills
3. Teamwork
4. Safe practice
5. Research for practice
6. Equality and diversity
7. Policy
8. Reflective practice
9. CPD
10. Careers

Each learning unit has sub-sections with specific learning activities. Newly qualified practitioners undertaking the programme decide which activities fulfil their individual learning needs and learning style. Thus they are not required to undertake all activities; however, each learning unit has a concluding activity, which must be completed (Banks et al., 2011). Moreover, participants are expected to construct a portfolio of evidence of how they have achieved the ten learning outcomes upon which Flying Start NHS is based. It will normally require participants twelve months to complete the programme (Flying Start NHS, 2014).

Support for those undertaking the Flying Start NHS® programme is provided by mentors, whose role is to offer a light-touch approach to guide new entrants through the programme and lead them to completion (Upton et al., 2012). Participants will also work with peers and multi-disciplinary team colleagues (Flying Start NHS, 2014).

Link with NHS Knowledge and Skills Framework

Flying Start NHS® is integrated into the NHS Knowledge and Skills Framework, and designed to assist with building a portfolio of experience to support the existing development review cycle. The KSF provides a single, comprehensive framework on which reviews and development for all NHS staff are based. All the learning activities in each module in Flying Start are linked to the appropriate core dimension of the KSF on the Flying Start website, and as such the Flying Start portfolio is designed to feed into the evidence base required for the 6 month and 12 month reviews under KSF, rather than being seen as a duplication of effort (Upton et al., 2012).

Organisational framework

Flying Start NHS has been developed by NHS Education for Scotland, in partnership with NHS Scotland and the Higher Education Institutions (HEIs) (NHS Forth Valley, 2014). The implementation and day-to-day running of the programme is the responsibility of the individual NHS Boards across Scotland.

Cooperation with other organisations

Since its development in 2006, the Flying Start programme has received considerable attention from other organisations. Since 2010, the words 'Flying Start NHS' and the related logo are registered trademarks of NHS Education for Scotland (Flying Start NHS, 2014). In 2010, Flying Start was purchased by NHS England and in 2011, a

licensing agreement was established between Queensland Health (Australia) and NHS Education for Scotland for use of the Flying Start programme. According to NHS Education for Scotland, it has not been difficult for NES to produce these contracts (Cowan & Hall, 2014).

NHS England – Flying Start England

In 2010, Flying Start was purchased for use in all NHS Trusts in England to support preceptorship for newly qualified nurses and midwives (NHS Education for Scotland, 2012). NHS England paid a licensing agreement with NHS Education for Scotland for this (Cowan & Hall, 2014). However, the Flying Start England programme has now closed.

The Flying Start England programme was similar to the Flying Start NHS programme. It was available to all qualified nurses, midwives, and allied health professionals (AHPs) across England. The overall aim of the programme was to enable newly registered nurses, midwives, and AHPs to experience a meaningful structured programme that facilitated their transition from being a student to a fully autonomous, competent and confident practitioner (Locally Healthy, 2011).

Flying Start England contained 10 learning programmes, which corresponded to that of Flying Start NHS:

- communication
- clinical skills
- teamwork
- safe practice
- research for practice
- equality and diversity
- policy
- reflective practice
- professional development
- career pathways.

The content of Flying Start England was overseen by a National Editorial Board that met on a quarterly basis. It was made up of preceptorship experts, practitioners and Higher Education Institution academics from across England (Locally Healthy, 2011).

Queensland Health – Flying Start Queensland Health

More information about the development of Flying Start Queensland Health, the implementation process, the cooperation between NHS Education for Scotland and Queensland Health and the licensing agreement can be found in the case study report on Flying Start Queensland Health (see case report 3.5, appendix 3.5).

Finances

Flying Start NHS is financed by the Scottish Government. In 2005, the Scottish Executive Health Department commissioned National Health Service (NHS) Education Scotland to develop the programme and in 2006 short-term funding was provided to Scottish NHS Boards to support them in implementing Flying Start NHS (Banks et al., 2011).

In 2010 the intellectual property rights of the programme were protected which resulted in the successful branding of Flying Start NHS®. The purchase of a licensing agreement to use the Flying Start programme by NHS England (in 2010) and

Queensland Health (in 2011) yielded considerable benefits for NHS Education for Scotland, although all parties involved are reluctant to make the amounts publicly available.

Conditions for replicability

See case report 3.5, appendix 3.5).

3. Results of the intervention

Effects on recruitment and retention

There is on-going evaluation of the Flying Start programme by NHS Education for Scotland and NHS Education for Scotland reports registration figures to the Scottish Government. However, the effects of the Flying Start programme on recruitment and retention of newly qualified staff within the NHS are currently not fully measured (Cowan & Hall, 2014).

In 2010, a two-year evaluation of the programme by Banks et al. (2010) was finished which focussed on the impact and effectiveness of Flying Start NHS in supporting the recruitment, confidence and skills development of newly qualified nurses, midwives and allied health professionals within NHS Scotland. As part of the evaluation the research team undertook to carry out a scoping exercise to identify available baseline data from associated bodies concerning current recruitment and retention of newly qualified staff within the NHS. The aim was to examine the impact of Flying Start NHS by tracking changes in recruitment and retention by year following implementation of Flying Start. Despite considerable efforts to identify databases which would enable a statistical analysis of recruitment and retention patterns over the period since the introduction of Flying Start NHS, data of adequate quality were not available (Banks et al., 2010).

The research team also conducted interviews and asked participants on their views concerning Flying Start's influence on recruitment and retention. A large majority of participants indicated that there was no evidence that Flying Start had had an impact on recruitment. However, final year students stressed the importance of feeling valued and indicated that their 'ideal' employer would have a reputation for supporting newly graduates and that the provision of support to undertake Flying Start would be one way of gauging potential employers' commitment to supporting their future career development (Banks et al., 2010).

Proxy measures

In November 2009 an email inviting participation was sent to newly qualified practitioners registered to undertake Flying Start NHS. When asked if Flying Start NHS had helped them to understand their future career options, just over one in 10 newly qualified practitioners (n = 65, 11,9%) indicated that it had; 173 newly qualified practitioners (31,6%) reported that it had not helped.

Findings from the survey also indicated that most newly qualified professionals found participation in the scheme to be a positive experience, particularly in relation to clinical skills development and confidence. However, the evaluation also found that difficulties in completing the programme were experienced due to competing pressures within work time, the technicalities of the system, and the need for further support. While respondents reported that they theoretically had protected time to enable them to complete Flying Start NHS, four out of five were not always able to take it (Banks et al., 2011).

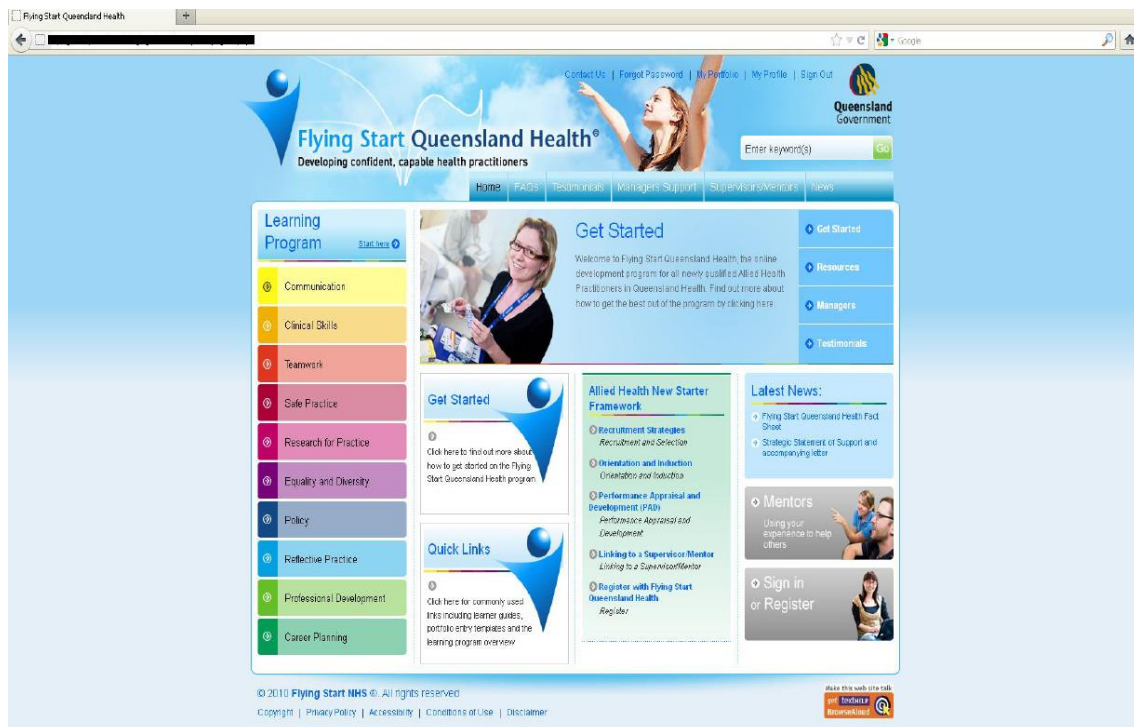
References

- Banks, P., Kane, H., Roxburgh, M., Lauder, W., Jones, M., Kydd, A., Atkinson, J. (2010). Evaluation of Flying Start NHS. Final report. February 2010. University of the West of Scotland.
- Banks, P., Roxburgh, M., Kane, H., Lauder, W., Jones, M., Kydd, A., & Atkinson, J. (2011). Flying Start NHS™: easing the transition from student to registered health professional. *Journal of clinical nursing*, 20(23-24), 3567-3576.
- Cowan, N. & Hall, A. (2014). Answers per email to questions Recruitment & Retention study. November 20, 2014.
- Flying Start NHS (2014). *Frequently Asked Questions*.
<http://www.flyingstart.scot.nhs.uk/faqs/> (accessed: 03-10-2014)
- Locally Healthy (2011). Flying Start England. Available at:
<http://www.locallyhealthy.co.uk/story/flying-start-england> (accessed: 21-11-2014).
- NHS Education for Scotland (NES) (2012). Flying Start NHS® goes 'down under'. Media Release 21 June 2012. NHS Education for Scotland.
- NHS Forth Valley (2014). *Flying Start Policy*. NHS Forth Valley.
- Scottish Executive (2006). *Delivering Care, Enabling Health*. Edinburgh: Scottish Executive.
- Upton, D., Upton, P., Erol, R. (2012). *Evaluation of the Key Characteristics Which Support Completion of Flying Start NHS® in NHS Scotland*. Project Report. NHS Education for Scotland.

Appendix 3.5. Case report 3.5

Topic 3. Providing training, education and research opportunities for a life-long career

Case 3.5. Flying Start Queensland Health, Australia



Research methods applied:
Desk research: July-August 2014
Telephone interview: September 2014

1. Summary of the intervention – Flying Start Queensland Health, Australia

Dimension of interest	Categories/description
Objective of the intervention	Retention
Type of intervention	Education Personal and professional support
Professional group(s) targeted	Newly qualified allied health professionals
Level of intervention	Organisational
Type of organisation	The <i>Flying Start Queensland Health</i> programme is offered by the Cunningham Centre, a Registered Training Organisation (RTO) for Queensland Health
Kind of services provided by organisation	The Cunningham Centre provides state-wide training and education, provision of post-graduate clinical upskilling, support for clinical and non-clinical staff and partnering with other stakeholders in the industry.
Size of organisation	Medium to large
Area covered	State of Queensland; all local Hospital and Health Services (HHSs)
Intervention period / duration of intervention	Launched on June 18, 2012. No expected end date.
Key actions	Building a progressive portfolio of professional development through reflective learning units, modules and activities.
Financial investment	Financing is required for the use/licensing of the programme itself, the website hosting company and human resources. For Queensland, financing is provided by Queensland Health.
Implementation strategy or processes used	A professional support policy had been released within Queensland, which was helpful for the implementation of Flying Start. There were lead contacts in local institutions for disseminating information. After the official launch, Cunningham Centre Staff provided workshops about the programme.

Day-to-day running of the intervention	There is a clear division of responsibilities in the running of Flying Start Queensland Health between the Cunningham Centre, the website hosting and support contractor and the local health services.
Personnel investment	After implementation phase, fairly limited.
Outcome measures of the intervention	Retention, although important, is not a key measure for the Cunningham Centre as the number of confounding variables is too high.

2. Rich description of the intervention

Case under study

Flying Start Queensland Health, hosted by the Cunningham Centre, is a web-based programme designed to increase the confidence and competence of new starter allied health professionals. The resource has been developed to complement professional support practices such as supervision and mentoring (Queensland Health, 2014).

Establishment of Flying Start Queensland Health

Flying Start Queensland Health was developed to complement professional support practices such as supervision and mentoring (Cunningham Centre, 2013). During consultation with allied health professional groups, it became clear that more support was needed for new starters. Hence, Flying Start Queensland Health was implemented to help maximize the performance and support of new allied health professionals once they are aboard, so as to maximize their efficiency and effectiveness in the early years of their careers (Fuelling, 2014a).

Reasons for the establishment of Flying Start Queensland Health

In line with recommendations from the 2007 Ministerial Taskforce on Clinical Education and Training, Queensland Health in 2009 undertook a training needs-analysis across the allied health disciplines to assist in determining current and emerging gaps in clinical education and training. Support for new starters, including new graduates was identified as a need across most discipline (Fuelling & Tosh, 2013). In response to this identified need, Flying Start Queensland Health was developed to complement professional support practices such as supervision and mentoring (Cunningham Centre, 2013).

Objective of the intervention

Flying Start Queensland Health was implemented to help maximize the performance and support of new allied health professionals once they are aboard, so as to maximize their efficiency and effectiveness in the early years of their careers. The resource aims to help professionals in the mentoring process that occurs between senior staff and early career allied health professionals (Fuelling, 2014a).

Type of intervention

Flying Start Queensland Health is aimed at retaining newly qualified allied health professionals through education and professional and personal support.

Professional group(s) targeted

Flying Start Queensland Health is targeted at newly qualified allied health professionals (NHS Education for Scotland, 2012).

Level of the intervention

Organisational level.

Area covered

The Flying Start Queensland Health website is available to all local Hospital and Health Services (HHSs) in the state of Queensland, Australia.

Choice for Flying Start NHS programme

After identifying the need for more structured support for new starter allied health professionals, Queensland Health considered a number of options to address this need. This included the choice between developing an own support programme or utilising existing programmes (Fuelling, 2014b). An investigation into existing new starter/orientation/induction programmes and related resources relevant to Allied Health was conducted and revealed Flying Start NHS as an option (Cunningham Centre, 2012). Flying Start NHS stood out as a structured, inter-professional education package that provided support for both new starters and their supervisors or mentors (Fuelling, 2014b). Moreover, the resource had been developed, trialled and evaluated (NHS Education for Scotland, 2012).

In addition to these advantages that the existing Flying Start NHS programme had for Queensland Health, historically there have been staff from NHS Scotland and England who have come to work in the Queensland context. These staff members were already familiar with the Flying Start NHS programme which was introduced in Scotland in January 2006 (Fuelling, 2014a).

Cooperation between NHS Scotland and Queensland Health concerning the Flying Start programme

Once Queensland Health had decided that the Flying Start programme would fulfil the needs that Queensland was facing, the Allied Health Professions' Office of Queensland contacted the education unit of NHS Scotland, NHS Education for Scotland. The initial reaction of NHS Education for Scotland to transfer the Flying Start programme to Queensland was positive and a plan was made to investigate the opportunity of doing this (Fuelling, 2014a). Once the two organisations decided that the Flying Start programme would be transferred to Queensland, they started drafting a license agreement to secure their cooperation. This process took much longer than initially anticipated. It proved to be very difficult to negotiate a contract or a license agreement to meet the legislative needs of both the Queensland Government and the NHS Scotland, i.e. the Scottish Government. This took a very long time mainly because there was no precedence for an agreement to be established between these two bodies. Starting from scratch and making an agreement that met the legislative requirements in both jurisdictions proved to be difficult. Moreover, neither organisation was well set-up to share, license or sell intellectual property. Both organisations usually develop their own intellectual property without selling it. So the drafting of the license agreement meant a significant departure from the normal processes for both organisations (Fuelling, 2014a).

The licensing agreement

In 2011, Queensland Health and NHS Education for Scotland established a licensing agreement, meaning that Queensland Health is licensed to use the Flying Start resource, but hasn't bought it from the NHS. The resource remains the intellectual property of the NHS Scotland. The licensing agreement involves a licensing fee and a range of obligations for both the NHS Scotland and Queensland, including making

available potentially relevant updates on the resource, reporting back from Queensland to NHS Scotland on the usage and uptake of the resource, and so on. The licensing agreement also contains a commitment on behalf of Queensland Health to maintain the look and feel of the website, so that it can be identified as a version of the original site. Hence, there is an obligation on the part of Queensland Health that all significant changes made to the resource need to be agreed by NHS Scotland. The initial license that Queensland Health bought from NHS Education for Scotland was three years, with two options for two-year extensions. Queensland Health is now (2014) in the first period of these extensions (Fuelling, 2014a).

Advantages and disadvantages for Queensland Health of adjusting an existing resource to local needs

To be able to acquire and contextualise an existing programme like Flying Start made a significant difference in the time and resources required to develop the programme. Another big difference has been the benefits gained from the shared experience with NHS. A number of programme improvements in the promotion and reporting of the programme have been incorporated in response to the NHS experience. The efficiencies created by acquiring a developed resource along with the benefits of applying system enhancements used by NHS has meant it has been a successful partnership (Fuelling, 2014b).

According to the Cunningham Centre, it was relatively straight forward to adjust Flying Start NHS Scotland to the local Queensland context. NHS Scotland provided the content and the Cunningham Centre had the opportunity to use a reference group to contextualise that content to its local Queensland environment. What was very difficult was negotiating a contract or a license agreement that would meet both the legislative needs of Queensland Government and the NHS Scotland or Scottish Government. This took considerable time.

Overall, the Cunningham Centre feels that even though it took a long time and there were many challenges, the actual costs of the licensing agreement are relatively cheap compared to the costs of employing people to develop (the content) of such a resource themselves. Together with the licensing agreement with NHS Scotland, Queensland Health also entered into a contract with the hosting and support company 'Storm ID' (the same company used by NHS Scotland). This means that the Cunningham Centre got the content, the website design and functions. Even though the combination of these two different contracts were difficult to negotiate, it did save a significant amount of time and resources compared to building that resource from scratch. "So despite the challenges, it was probably worth it."

The Cunningham Centre would advise other organisations that are also thinking about introducing the Flying Start programme or a different existing resource to look into the possibilities and compare it with the costs of designing one on your own (Fuelling, 2014a).

Implementation strategy of Flying Start Queensland Health

Just before the implementation of Flying Start Queensland Health, a professional support policy had been released within Queensland. This meant that for the first time, a standardized approach for allied health professionals to receive professional supervision or mentoring was available. This was an enabling factor in the implementation of Flying Start Queensland Health, as people were in the process of

establishing mentoring arrangements and needed resources to use in these arrangements (Fuelling, 2014a).

Up to the official launch of Flying Start Queensland Health, the Cunningham Centre staff had been working with lead contacts in each of the 16 local hospitals and health services throughout the state, to work out a strategy of promotion and rollout in each area (NES, 2012a). During the implementation phase, these contacts were key points for disseminating information and collecting feedback. The key champions at local level were either directors of allied health or team leaders, i.e. they were usually in senior or management position (Fuelling, 2014a).

After the official launch in June 2012, the Cunningham Centre Staff provided workshops to target staff, mainly those who mentor and support new starters (NES, 2012a). In the initial phase of resource implementation face to face workshops were held in many locations state-wide that aimed at raising awareness of Flying Start Queensland Health and demonstrating its application to practice (Cunningham Centre, 2013). Workshops gave a guided tour through the website and a simulated activity of applying flying start during mentoring (NES, 2012a). These workshops were rated as highly relevant by participants. During the later phases of implementation these workshops were delivered online via teleconference and WebEx. A total of 42 face-to-face and online workshops were organised with a total number of 339 participants. The workshop content is now available in online video screencasts creating sustainable access to on-going training in resource use state-wide (Cunningham Centre, 2013).

Apart from the website itself, no additional new infrastructure was needed to implement the Flying Start Queensland Health programme. Some local institutions increased the number of computer stations available for allied health staff, but this fell outside the scope of the Flying Start project (Fuelling, 2014a).

Kind of services provided by Flying Start Queensland Health

Flying Start Queensland Health is a web-based programme designed to increase the confidence and competence of new starter allied health professionals. It is learner-directed, with an emphasis on building a progressive portfolio of professional development evidence through reflective learning activities (Fuelling & Tosh, 2013). It requires high level management and workplace support.

The Flying Start Queensland Health learning programme consists of 10 learning units, which are:

1. Communication
2. Clinical skills
3. Team work
4. Safe practice
5. Research for practice
6. Quality and diversity
7. Policy
8. Reflective practice
9. Professional development
10. Career planning

Each learning unit contains a variety of learning modules and activities. Moreover, each unit has a specific aim and a number of learning outcomes to guide the learners

and their supervisor in choosing appropriate activities. Learners are not required to complete every activity; it is highly recommended that newly commencing staff perform activities that are relevant to their needs and that are sufficient to demonstrate that they have met the learning outcomes. The learner can also create an online portfolio, creating evidence of their continuing professional development. The website also includes different learner guides, tailored to the amount of time that a learner has been in position. These learner guides recommend the learner in which units to undertake.

Finally, the website also contains resources to support mentors in their supervisory role (NHS Education for Scotland, 2012a).

Running time of the intervention

The Flying Start Queensland Health website was launched on 18 June 2012 (Cunningham Centre, 2013). There is no expected end date.

Organisational framework

There is a clear division of responsibilities in the running of Flying Start Queensland Health between the Cunningham Centre, the website hosting and support contractor and the local health services.

The Cunningham Centre is responsible for update of the content of the website. It is also responsible for the reporting on the usage and managing relationship with the NHS Scotland.

Storm ID Ltd hosts the website on their server and they manage the on-going IT-requirements for the site. For example, they work on enhancing the reporting functions of the website.

The administration and coordination of the programme is up to the local health services and supervisors in those areas (Fuelling, 2014a). The Cunningham Centre undertook a significant amount of promotion of the programme during the year 2012-2013. However, ongoing promotion of Flying Start has since then been at the discretion of individual Hospital and Health Services and the activity has varied widely between regions (Cunningham Centre, 2014).

Finances

In 2010 the intellectual property rights of the Flying Start NHS programme were protected which resulted in the successful branding of Flying Start NHS® (NHS Education for Scotland, 2012). To be allowed to use the programme, Queensland Health paid a license fee to NHS Education for Scotland for the first three years of licensing. Subsequently, each two-year extension involved an additional license fee.

The main other costs that Queensland Health needed to make relate to the contract with the website hosting and support contractor Storm ID Ltd. This involved an initial set-up fee and each two year extension period incurred an additional fee (Fuelling, 2014a).

The other costs involved concern Human Resources. These costs were situated mainly at the start-up of the programme, as later on the Cunningham Centre devolved some of the responsibilities for the promoting the programme to the individual local levels (Fuelling, 2014a).

Conditions for replicability

- Something that organisations that are also thinking about introducing the Flying Start resource should take into consideration is their economy of scale. For example, in the NHS there are about 100.000 users of the site, because of the sheer number of allied health professionals and nurses in that area. Whereas in Queensland, there are much less users. Moreover, Queensland has got a lower population than Scotland. This means that the economy of scale for both programmes isn't comparable (Fuelling, 2014a)
- It takes considerable time to negotiate a contract or a license agreement between two organisations. For Queensland Health and the NHS Scotland or Scottish government, it took considerable time as the legislative needs of both organisations needed to be met.
- It was relatively straight forward to adjust Flying Start NHS Scotland to the local Queensland context. NHS Scotland provided the content and the Cunningham Centre had the opportunity to use a reference group to contextualise that content to its local Queensland environment.
- The Cunningham Centre would advise other organisations that are also thinking about introducing the Flying Start programme or a different existing resource to look into the possibilities and compare it with the costs of designing one on your own (Fuelling, 2014a). Overall, the Cunningham Centre feels that for itself, even though it took a long time and there were many challenges, the actual costs of the licensing agreement are relatively cheap compared to the costs of employing people to develop (the content) of such a resource themselves (Fuelling, 2014a).

3. Results of the intervention

Results of the intervention in terms of retention

According to Peter Fuelling from the Cunningham Centre, retention was never a key measure for the Cunningham Centre. Even though it is an important measure, the number of confounding variables in establishing whether Flying Start Queensland Health has contributed to retention is too high. Moreover, the industrial changes and the changes to funding arrangements that took place in Queensland over the last years have probably been the greatest influence on staff remaining in- or leaving their positions. So it would be hard to detect the influence of Flying Start in the context of those movements, according to Mr Fuelling (Fuelling, 2014a).

Number of Flying Start Queensland Health users

Flying Start Queensland Health has experienced a progressive uptake of registered users in the first twelve months that the programme was run. During the first six months of the programme, supervisor/mentor registered users outnumbered new starter registered users by a proportion of approximately 2:1. After one year, this proportion was approximately 3:2, representing a trend toward increased uptake by new starters. This was consistent with the focus of promoting and raising awareness among supervisors/mentors that occurred during the implementation period (Cunningham Centre, 2013).

Registrations up to 30 June 2013 totalled 1173 users, categorised as 500 new starters (42.6%) and 673 supervisors/mentors/managers (57.4%) (Cunningham Centre, 2013). Table 1 provides an overview of all the 'new starters' up to 30 June 2013 (n= 500) categorised according to time in their role.

Table 1: Registered 'new starters' up to 30 June 2013, time in role

	<12 months	1-2 years	2-5 years	5+ years
Count	358	78	42	22
%	71,6	15,6	8,4	4,4

Source: Cunningham Centre, 2013

Of the 500 new starters that registered in the 2012-2013 year only 39 (8%) returned to the site in the 2013-14 year while there were 264 new starters that registered for the first time. This indicates that while Flying Start continues to attract new starters to the site, the typical period of use is less than 12 months (Cunningham Centre, 2014). Over 2013-2014, Flying Start had been taken up by 250 new starters and 120 supervisors and mentors (Queensland Health, 2014). During the 2013-14 year a total of 453 new and returning users accessed the site. This is considerably lower than the 1173 users during the previous 12 months of operation. This decrease was anticipated though, as there had been a significant amount of resource promotion undertaken by the Cunningham Centre in the 2012-13 year (Cunningham Centre, 2014).

Evaluation of the Flying Start Queensland Health programme

The programme is constantly being monitored and evaluated. While the ease of use of the Flying Start Queensland Health website was rated high (5.2/7), the perceived usefulness rated more moderately (3.5/7). The most prevalent themes in user

comments regarding the most useful aspects of Flying Start Queensland Health were access to resources, ease of use and support for supervision practices. The most prevalent themes in user comments regarding the least useful aspects of Flying Start Queensland Health were insufficient time to use the resource, absence of supervision in the workplace and non-specific nature of content (Cunningham Centre, 2013).

References

Cunningham Centre (2012). *Queensland Health Allied Health. Off to a Flying Start*. Cairns: Cunningham Centre.

Cunningham Centre (2013). *Flying Start Queensland Health State-wide report. Usage period: April 2012 to June 2013*. Cairns: Cunningham Centre.

Cunningham Centre (2014). *Flying Start Queensland Health State-wide report. Usage period: 1 July 2013 – 30 June 2014*. Cairns: Cunningham Centre.

Fuelling, P. & Tosh, R. (2013). *Purpose fit or fit for purpose: development resources for rural allied health*. Adelaide: 12th National Rural Health Conference. 7-10 April 2013.

Fuelling, P. (2014a). Telephone interview for the Recruitment & Retention study.

Fuelling, P. (2014b). Answers for the Recruitment & Retention study to questions sent by email.

NHS Education for Scotland (NES) (2012). Flying Start NHS® goes 'down under'. Media Release 21 June 2012. NHS Education for Scotland.

NHS Education for Scotland (NES) (2012a). State-wide-Launch-of-Flying-Start-Queensland-Health. <http://vimeo.com/45634828>

Queensland Health (2014). *Clinical education and training in allied health 2013-14 report. Allied Health Professions' Office of Queensland*. Fortitude Valley: State of Queensland (Queensland Health).

Appendix 4.1. Case report 4.1

Topic 4. Attracting and retaining nurses through the extension of practice and development of advanced roles

Case 4.1. *Huhtasuo Haltuun*-project, Finland



Research methods applied:

Desk research: October – November 2014

Email interview: November 2014

Case site visit: January 2015

1. Summary of the intervention – Huhtasuo Haltuun-project, Finland

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Mix/other (change of personnel build-up, change in care provision)
Professional group(s) targeted	Nurses and GPs
Level of intervention	Organisational
Type of organisation	Health centre
Kind of services provided by organisation	Primary care, maternity and dental services
Size of organisation	Medium
Area covered	Huhtasuo area in the city centre of Jyväskylä, Finland
Intervention period / duration of intervention	The Huhtasuo Haltuun- project was developed from October 1, 2012 until September 30, 2014. The new way of working was continued afterwards. There is no expected end date.
Key actions	Hire 4 nurses instead of 2 GPs and make the way of working in the Centre nurse-oriented.
Financial investment	No additional financial resources were needed, as the money which was 'saved' by the two unfulfilled GP vacancies was used to hire the four additional nurses. However, employer paid for additional nurse prescribing courses.
Implementation strategy or processes used	Staff of the Huhtasuo health centre had pleaded for years already to hire more nurses. It took a long time to convince political decision makers of the merits of this idea, which happened in 2012. The health centre started planning the project in May 2012 and started in October 2012. Staff would come up with ideas, based on a 'problem tree'.
Personnel investment	Mainly a change in staff build-up: hiring 4 nurses instead of 2 GPs. HuHa project also incorporated additional staff (specialized nurses).
Outcome measures of the intervention	No specific R&R outcomes were identified.

	<p>Patient perception is that services improved. Nursing staff feel in a better position to influence the course of daily work, which contributes to job satisfaction. Patient outcomes have improved, especially for chronic care.</p>
--	---

2. Rich description of the intervention

Case under study

The Huhtasuo Haltuun- project [in English: Huhtasuo Take-over- project], which started on the 1st of October 2012, in which the Huhtasuo Health Centre hired 4 RNs instead of 2 GPs (for which it was unable to fill up vacancies) and became nurse-led. Moreover, changes were made in the way patients were cared for. This was a development project conducted by the staff of the Health Centre. After the project ended, the new way of working was continued.

Reasons for the establishment of the Huhtasuo Haltuun- project

The Huhtasuo health centre, offering primary care and dental services in the city centre of Jyväskylä, has had a shortage of doctors for over a decade already, while the number of nurses was also too few (Jyväskylä municipality, 2014). This is because Huhtasuo is a difficult place to work; it is an area which houses people from many different cultural/ethnic backgrounds, often with social and economic problems (Mutka, 2014). The resulting understaffing put a lot of work pressure on the staff that was present and for years the Centre had been unable to meet the needs of the patient population. In 2012, the situation became so critical that the municipality of Jyväskylä was thinking about shutting down the health centre. There were 2.7 doctors instead of the 7 permanent doctors required (6,5 vacancies) and there were only 3 practice nurses and 3,5 office nurses. At that moment, there were two options: shutting down the centre or continue running the health centre by working in a new system which would enable the health centre to take care of all patients (Pekkilä et al., 2015).

Staff of the Huhtasuo health centre had pleaded for years already to hire more nurses to fill the gaps that existed because the centre wasn't able to attract more doctors. It should be noted that nurses that are working in Huhtasuo Health Centre are rather highly educated; many of them hold a Master's Degree. However, the Centre wasn't allowed to take on more nurses because the money available was meant to hire more GPs. Hence, it took a long time to convince political decision makers of the merits of this idea. This is because in Finland, the 'cultural' idea that doctors should provide all care is very strong. Moreover, policy makers are often not aware of all the tasks that nurses can perform and how extensive their knowledge is. But finally in 2012, the municipality (in the person of the Deputy Mayor) agreed to use the money of two GP vacancies (which the health centre was unable to fill) to hire four additional nurses instead. There was no extra money available, but this money could be used in a different way than originally planned. The centre then became 'nurse-oriented'. Tehy (Union of Health and Social Care Professionals) was very supportive of this project as well. So it was decided that the Huhtasuo health centre would try this new way of working for two years, and then it would be decided if and how to continue (Pekkilä et al., 2015).

Objective of the Huhtasuo Haltuun- project

Recruiting new nursing staff (and indirectly new GP staff) and retaining existing nursing and GP staff. The nurse-oriented care model that the HuHa project introduces focuses on the utilisation of multi-professional expertise and clarifies the division of

tasks between doctors and other healthcare professionals at the Huhtasuo health centre.

On a patient level, the aim of the HuHa-project is to ensure due implementation of the assessment of the local population's need for care and access to the right type of professional care based on such assessment (JYTE, 2015).

Type of intervention

This intervention changes the personnel build-up of the health centre and includes task-substitution.

Professional group(s) targeted

Nurses (by hiring new nurses and reducing the workload of existing nursing staff) and to a lesser degree GPs (by reducing their workload).

Level of the intervention

Organisational level.

Area covered

The Huhtasuo area in the city centre of Jyväskylä, Finland.

Kind of services provided by Huhtasuo Health Centre

The Huhtasuo Health Centre provides primary care and maternity and dental services (HuHa project focused only on primary care services).

Running time of the intervention

The Huhtasuo Haltuun- project ran from the 1st of October 2012 until the 30th of September 2014. This means that the new way of working was developed, implemented and adjusted during this time. However, because of its success, the new way of working was continued afterwards. There is no expected end date (Mutka, 2014).

Huhtasuo Haltuun-project

Between the 1st of October 2012 until the 30th of September 2014, the Huhtasuo Health Centre used the amount of money that they would have used to hire two GPs (which they were unable to hire) to employ four nurses (Jyväskylä municipality, 2014). But at the same time, additional staff was hired as well (some of this additional staff was new, others already worked at the health centre but their working hours were increased). Hence, the change in personal structure at the start of the HuHa-project was (Pekkilä et al., 2015):

- 4 additional RNs were hired (3 practice nurses and one office nurse)
- A social worker (½) was newly added to the staff
- A substance abuse nurse (⅔) was newly added to the staff
- Depression nurse: working time increased
- 'Half' a physiotherapist was added to the staff (bringing the total number of physiotherapists to 1 ½)

This brought the total amount of staff at the Huhtasuo health centre after the HuHa project started to:

- 6 RNs (practice nurses)
- 4 ½ office nurses (who make appointments, assist doctors, etc.) (these are also RNs, but some of them are not so highly educated as the 6 practice nurses)
- 1 archive employee
- 4 ½ doctors/GPs
- 1 ½ physiotherapists
- 1 psychologist
- ¾ depression nurse
- ⅔ substance abuse nurse
- ½ social worker

Inhabitants of Huhtasuo have many problems with mental health, substance abuse, etc. many immigrants, so the additional professionals were very welcome for this area. It should be noted that currently (January 2015) the Huhtasuo health centre is still facing a lack of doctors. Therefore, it has to hire two extra doctors from the private sector, who cost a lot more money (almost double the costs compared to a permanent doctor) (Pekkilä et al., 2015).

Project case management

The social worker came up with the idea to use the 'Problem Tree / Solution Tree' to develop the Huhtasuo Haltuun project. The problem tree provides an overview of all the known causes and effects to an identified problem. The main problem is depicted by the tree, while the roots are the causes of the problem. The smaller details in the roots contained the things that the staff of the Huhtasuo health centre needed to develop and they chose four to focus on. This was developed by the staff, which were given all freedom to do so. The project had an executive team which was informed on how the project proceeded, and the management level was supportive throughout (Pekkilä et al., 2015).

The four details which the staff chose to develop were:

1. Assessment of the need of care
2. Development of nurse appointments for chronic patients
3. Multi-professional cooperation
4. Self-care support

1. Assessment of the need of care

Accurate assessment of the need for treatment of the patient during the first contact is made by phone or on-site at the health centre. In performing the assessment procedure for a patient's need of care, use is made of care charting tools, non-labouratory tests and instructive diagrams describing the work of the various professionals involved. The assessment of the need of care is made by registered nurses who have undergone extensive training. At the same time, those making the assessment are in a position to easily consult other medical professionals.

This is an important starting point in the patient process. If a patient calls the healthcare centre, does the patient need to come to the health centre or can he take care of himself at home? If the patient needs to come to the health centre; when and which healthcare professional should he see? Which pre-examinations need to be

done, etc.? The Huhtasuo health centre tried to make the patient process as clear and straight as possible (Pekkilä et al., 2015).

As part of the assessment of the need of care, and the fact that patients can sometimes take care of themselves, the Huhtasuo health centre developed care instructions in 12 different languages (spoken in the Huhtasuo area) as part of the HuHa project. They are used as guidance for the patient if they do not need professional care, because many of the problems can be treated at home. However, this requires a change in patients' thinking, as especially people from different cultural environments are used to always seeing the doctor. The Huhtasuo health centre tries to teach them that it is not always necessary to see the nurse or doctor (Pekkilä et al., 2015).

2. Development of nurse appointments for chronic patients

All chronic patients are now guided to a nurse for their first contact. Nurses have one hour for patients, whereas doctors only have 20 or 30 minutes. The nurse will evaluate if and when the patient needs to see a doctor. The main principle is that the nurse will guide patients as far as she can, and she consults the doctor only when needed. The more patients visit the nurse, the less they have to see the doctor. This means that most chronic patients now only see nurses and meet the doctor when necessary (Pekkilä et al., 2015).

It should also be noted that four of the six nurses at Huhtasuo health centre have prescriptive authority. It is the dream of the nursing manager that one day, all nurses will have prescriptive authority, at least the practice nurses (Pekkilä et al., 2015).

For diabetes care, this new way of working results in a big improvement. Prior, people did not see a doctor nor a nurse and their disease got worse. When they finally would come to see a doctor, problems had already grown quite big. Now, people can come to see the nurse and problems can be solved at an early stage. Moreover, they manage their diseases better, because they get more information on how to treat themselves. Nurses ask advice from doctors when needed. But most chronically ill people only need a nurse (Pekkilä et al., 2015).

The nurse also develops a health & care plan for each patient, which include diagnosis, medicines, next appointment, etc. This is an important guidance for patients.

Another important pillar of nurses' appointments with patients is to develop patients' self-care. Patients are motivated to think "I must do something" instead of "something must be done". However, this is a change that takes a long time. Patients are still waiting for the nurses to treat them and are not yet used to thinking for themselves.

At Huhtasuo health centre, nurses use the Chronic Care Model (CCM) as guideline in their work. This CCM learns to think of patients as a whole and takes into consideration the patient's whole life (Pekkilä et al., 2015).

3. Multi-professional cooperation

Aside from doctors and nurses, as explained above, the care team includes a psychologist, depression nurse, substance abuse nurse, physiotherapists and a social worker. In the care team model, specialists offer local services that meet the needs of people living in the Huhtasuo area.

The goal of Huhtasuo health centre was to develop low standard consulting procedures between the different professionals in the healthcare centre. While multi-professional cooperation is being stimulated in the health centre, there are no structural multiprofessional consultations between them. If it is needed, the nurse organises a multi-professional meeting, but this does not take place on a regular basis (Pekkilä et al., 2015).

Huhtasuo health centre also aimed to develop a new model for multi-professional appointments (i.e. an appointment in which the patients at the same time meets with multiple healthcare professionals). This doesn't happen very often yet, but sometimes it does and it saves a lot of time. The nurses have a coordinating role in this for patients (Pekkilä et al., 2015).

4. Self-care support

The goal of Huhtasuo health centre was to:

- Motivate people to take care of themselves
- Enable third sector activities in the healthcare centre (associations, federations, experience experts, etc. For example the heart foundation)
- Simplify the finding of information for self-support, for example by developing "health care at home guides" for patients in foreign languages.

The Huhtasuo health centre furnished an empty room specifically for these purposes. In the so-called "Health stop-room" patients can find all sorts of information; medical guides, computer with internet, blood pressure monitor, etc. Every Wednesday afternoon, an outside visitor comes for almost two hours. He/she will provide information on a certain disease, for example about asthma. These visitors give advice and refer patients to information sources and tell about their own organisations (Pekkilä et al., 2015).

Implementation strategy

Staff of the Huhtasuo health centre had pleaded for years already to hire more nurses to fill the gaps that existed because the centre wasn't able to attract more doctors. But as explained before, it took a long time to convince political decision makers of the merits of this idea. This is because in Finland, the 'cultural' idea that doctors should provide all care is very strong. In 2012, the municipality (in the person of the Deputy Mayor) agreed to use the money of two GP vacancies (which the health centre was unable to fill) to hire four additional nurses instead.

The Huhtasuo Haltuun project started on the 1st of October 2012. The Huhtasuo health centre started planning the introduction of the project in May 2012. Staff would come up with ideas, based on a 'problem tree'. They did this next to their regular work at the health centre. There was also a guiding group/executive team involved, but they were only informed about the project.

Because Huhtasuo health centre already employed experienced nurses, they did not need much additional skills to start working in the new nurse-oriented way in the HuHa project. However, management decided to offer nurses prescribing education because this could be helpful. The employer paid for the education (€5.000) and also reimbursed 20 school days (i.e. nurses continued receiving salary) (Pekkilä et al., 2015).

In the beginning, there was some resistance against the HuHa project. But because there had been a lack of doctors for such a long time already, this resistance soon ceased to exist. The situation was critical; the centre had to become nurse-oriented. In the health centre itself, there is no doctor who is against the project and cooperation runs smoothly (Pekkilä et al., 2015).

Organisational framework

Ever since the Huhtasuo Haltuun project started, the team at the Huhtasuo Health Centre consists of doctors and highly educated nurses and additionally a psychologist, a depression nurse, substance abuse nurse, physiotherapists and social director. The multi-professional co-operation enables patients to make one multi-professional visit instead of a number of separate office visits. Close co-operation between professionals, the collective expertise and the knowledge of each other's work provide the patient with comprehensive and customer-oriented encounters (Jyväskylä municipality, 2014).

Barriers in the running of the intervention

In the beginning, there was some resistance against the HuHa project. But because there had been a lack of doctors for such a long time already, this resistance soon ceased to exist (Pekkilä et al., 2015).

However, staff at Huhtasuo health centre makes clear that it would be very difficult to spread this way of working to other health centres. Because of the good results at Huhtasuo, politicians want to introduce the nurse-oriented care model in other health centres in Jyväskylä as well. But because the need for such a way of working is less critical there, discussions will be more complicated and resistance will be higher (Pekkilä et al., 2015).

Facilitators in the running of the intervention

There are a few main factors which have contributed to the success of the HuHa project (Pekkilä et al., 2015):

- The fact that the nurses at the healthcare centre are experienced nurses. This is a very important prerequisite to make such a project work, according to the health centre.
- The fact that the nurses at the healthcare centre are well-educated (i.e. have followed some further education after basic nursing training).
- The united understanding of- and sharing of the vision of the project, and the good working atmosphere in the organisation.
- The fact that the project was developed bottom-up; it was an idea from the staff and nothing was top-down imposed. If that would have been the case, there doubtlessly would have been resistance.
- Prescriptive authority for nurses and especially their knowledge of how to examine patients. That gives a lot of information about how to treat the patient.

Finances

The Huhtasuo Haltuun project was conducted by the staff of the Huhtasuo Health Centre and there was no extra money available to support the project (Mutka, 2014). The four additional nurses were paid with the money which was 'saved' by the two

unfulfilled GP vacancies. Their additional education – prescribing course – was paid (€5.000) by the employer who also reimbursed 20 school days (i.e. nurses continued receiving salary) (Pekkilä et al., 2015). So, a relatively small amount of extra money was spent by the Health Centre.

Naturally, the additional staff that was hired required extra money as well. However, this money was not paid for by Huhtasuo health centre but came from other sources. At the same time when the HuHa-project started, a social development project took place. The project was interested in how to develop this role and gave the Huhtasuo health centre extra money for the social worker.

Also at the same time, a psychiatric ward at the Central Hospital was shut down. Because of this, a project was developed which replaced substance abuse nurses in health care centres and one of the substance abuse nurses was placed in Huhtasuo.

The physiotherapist and psychologist already worked at the health centre. The Huhtasuo health centre is paid from the municipal budget for outpatient clinics. There are also budgets for the hospital system and there are budgets for example for medical equipment, specialised workers, etc. The physiotherapists and psychologists are such type of specialised workers and have their own budgets (Pekkilä et al., 2015).

Conditions for replicability

There are some critical conditions which need to be fulfilled for such a project to be successful:

- Nurses need to be experienced
- Nurses need to be well-educated
- There needs to be a united understanding of- and sharing of the vision of the project, and a good working atmosphere in the organisation.

Staff at Huhtasuo health centre emphasised that it would be very difficult to spread this way of working to other health centres. Because of the good results at Huhtasuo, politicians in Finland want to introduce the nurse-oriented care model in other health centres in Jyväskylä as well. But because the need for such a way of working is less critical there, discussions will be more complicated and resistance will be higher (Pekkilä et al., 2015).

3. Results of the intervention

The Huhtasuo Health Centre has tried to measure the results of the Huhtasuo Haltuun-project in several ways (Mutka, 2014):

- By asking feedback:
 - o From patients
 - o From staff
- By measuring a whole range of process- and patient outcomes

Customer point of view

From the customer point of view, the HuHa project was evaluated in terms of the following objectives:

1. The local residents in Huhtasuo perceive that they have equal access to comprehensive healthcare services
2. Patients are committed to looking after their own health, self-care.

Data was obtained through repeated customer satisfaction surveys, feedback from the resident's panel, from the feedback forms available at the Health Desk, etc.

The overall perception was that the services had improved; care plans were prepared more frequently than before. Satisfaction with the service received at the nurse's practice improved: in 2013, 97% of the respondents were very satisfied with the service provided (as compared to 80% in 2012) (JYTE, 2015).

Staff point of view

From the staff point of view, the HuHa project was evaluated in terms of the following objectives:

1. Nurses and doctors are able to manage their work better and job satisfaction improves
2. The perception of the health station as an attractive workplace increases

Data for the staff-oriented evaluation was obtained via job satisfaction surveys, among others.

Work at the health centre is felt to be important and meaningful, even if challenging and at times exhausting. The nurses' skills and capabilities are being utilised 100% and they are in a better position to influence the course of daily work, which contributes to job satisfaction. Staff members are still enthusiastic about development efforts, there are still ideas worth considering and developments efforts are regarded as part and parcel of daily work (JYTE, 2015).

Cost-effectiveness and financial results

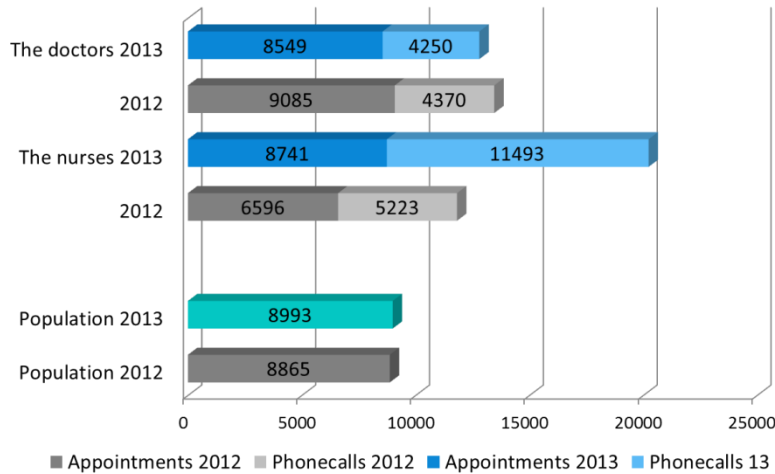
The financial approach was used to assess the economy and cost-efficiency of the activities as a whole. The evaluation criteria included the budget and adherence to it, number of appointments with doctors and nurses, and use of on-call services in the evenings/at night. As a rule, the results of financial monitoring are not obtained until later but it is safe to say at this stage (December 2014) that use of evening/night-time on-call services by the local residents in Huhtasuo area has decreased significantly and generated savings for the organisation (JYTE, 2015).

The shortage of doctors remains a problem in that it has not been possible to recruit doctors to fill the current vacancies in addition to the two permanent doctors. As a

result, it has been necessary to rely on private service providers to fill the gap (2-3 doctors). Since the payroll costs of these rental doctors are higher than those of permanent staff doctors, the budget was exceeded. The lowest cost incurred by the organisation was that of appointment of a nurse (JYTE, 2015).

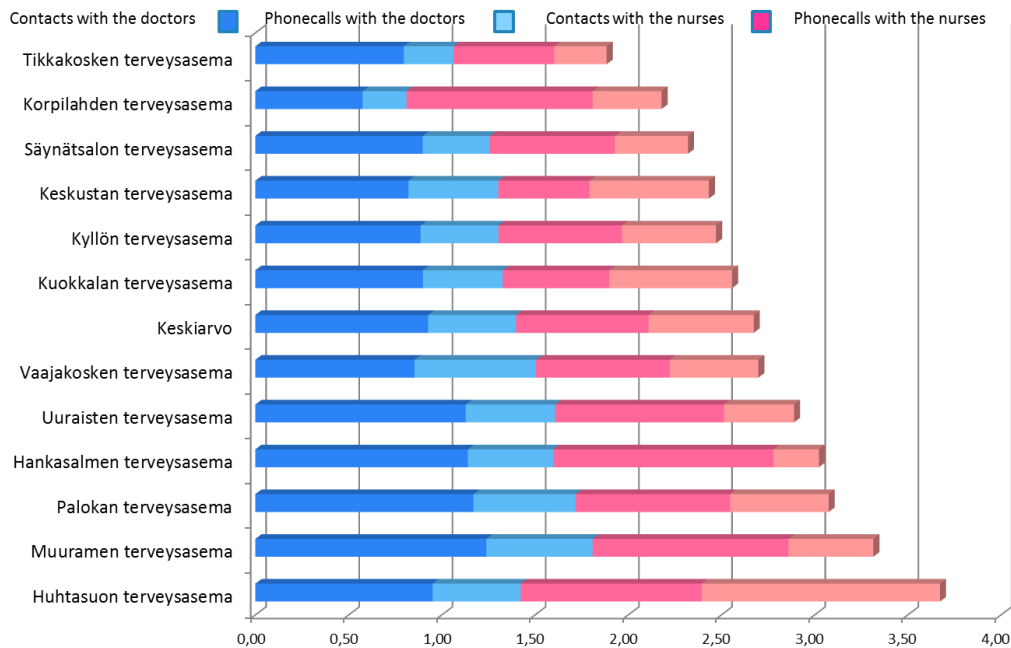
Patient results

Total patient contacts of doctors and nurses in 2012 and 2013



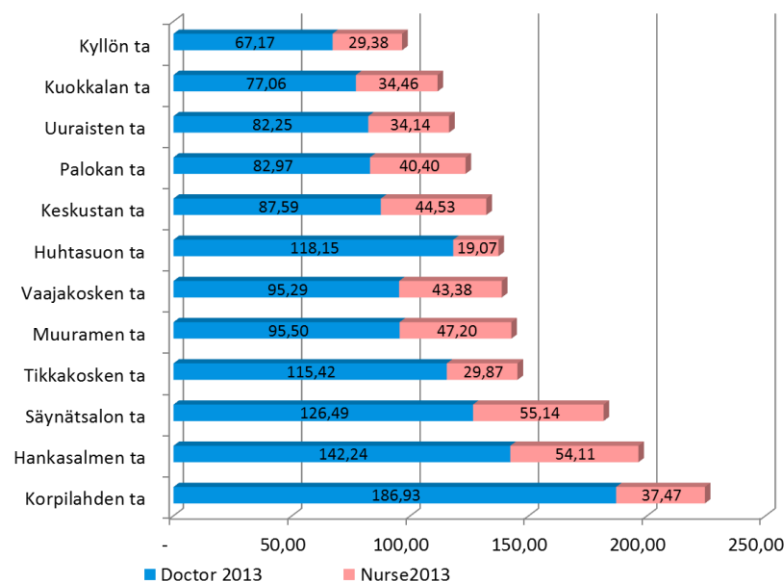
The above diagram shows the results of the first year after the HuHa project started. It becomes clear that compared to 2012, in 2013 there were much more patient contacts. The increase is caused by the high increase in patient contacts with nurses (especially phone calls). This is a positive thing, as many care questions do not require a visit to the health centre (for example to receive the results of blood sugar levels). Moreover, this results in time savings for the staff of the health centre. Doctors receive a bit less patients and have fewer phone calls, but because of the additional nursing staff they now have more time for their patients and can treat the more complex patients while nurses take care of the 'simpler' patients.

Average numbers of contacts and phone calls of doctors and nurses in 2013 (in relation to population size)



The above diagram shows that patients in the Huhtasuo area (the most socially deprived area of Jyväskylä) on average had the most contact and phone calls with doctors and nurses (especially the average number of phone calls with a nurse is remarkable and a clear effect of the HuHa project). Patients who had the second most contacts with doctors and nurses at their health centre were from Muuramen municipality, which is the richest area in Jyväskylä (Jyväskylä is the Jyväskylä co-operation area in health care), where there are also much more nurses and doctors employed. Important to note is that this diagram doesn't include the visits with other healthcare professionals (such as the substance abuse nurse, etc.).

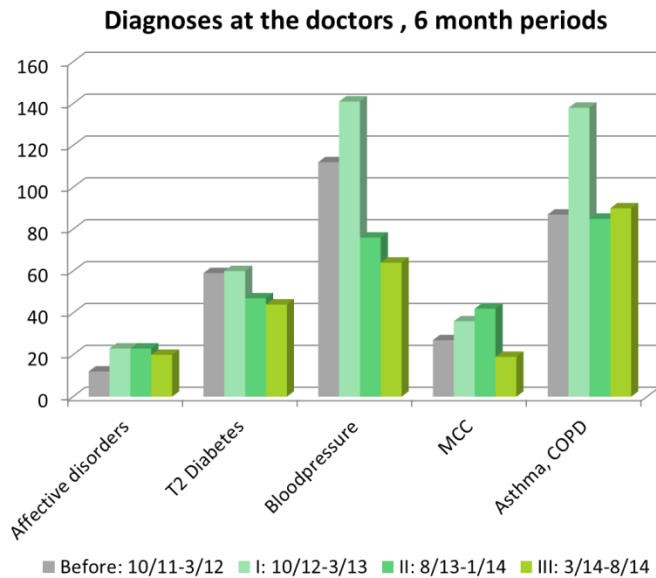
Average price of appointment time (only physical appointments) in health care centres in Jyväskylä



Directorate-General for Health and Food Safety
Recruitment and Retention of the Health Workforce

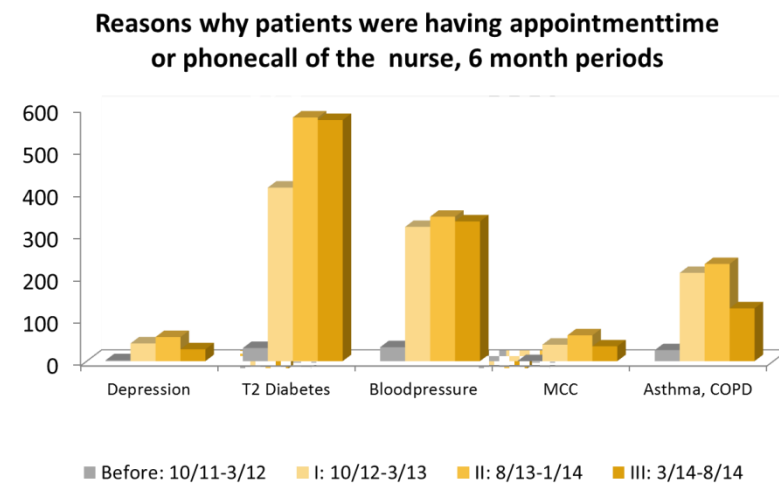
This picture shows that nurses' appointments in Huhtasuo are by far the cheapest in all Jyväskylä. The doctors score average, this is because they now see more complex patients (which takes more time) and because the health centre was forced to hire a number of doctors from the private sector (which are more expensive) to compensate for the lack of permanent doctors in the health centre.

Patients with chronic diseases



The grey bar depicts the situation before the start of the HuHa- project. When the project started, nurses got hold of these patients. So for example, for blood pressure, nurses detected patients who needed treatment for blood pressure and referred them to doctors who made the diagnosis. So prior to the HuHa-project, these patients would not visit the health centre at all. But now, in the new project, they are able to visit the nurse and hence the number of diagnoses for blood pressure increases.

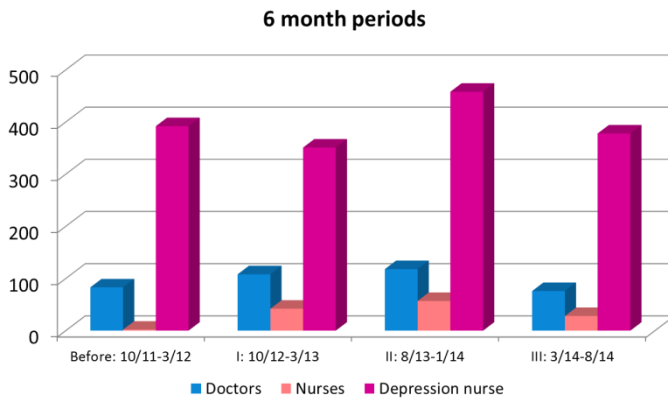
Patients with chronic diseases (but now for the nurses)



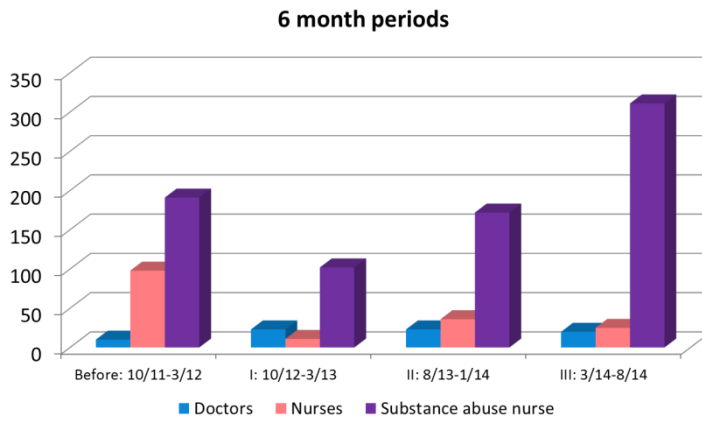
The grey bar depicts the situation before the start of the HuHa- project. So this means the patients didn't get help at all, anywhere. Now with the nurses who have their own

practices, patients do get the care they need. Moreover, the group appointments (for example for patients with high blood pressure) also increase the numbers in this chart. During these joint nurse appointments, a nurse sees 5 to 7 patients at the same time and gives them general guidance on how to treat their hypertension (diet advice, etc.).

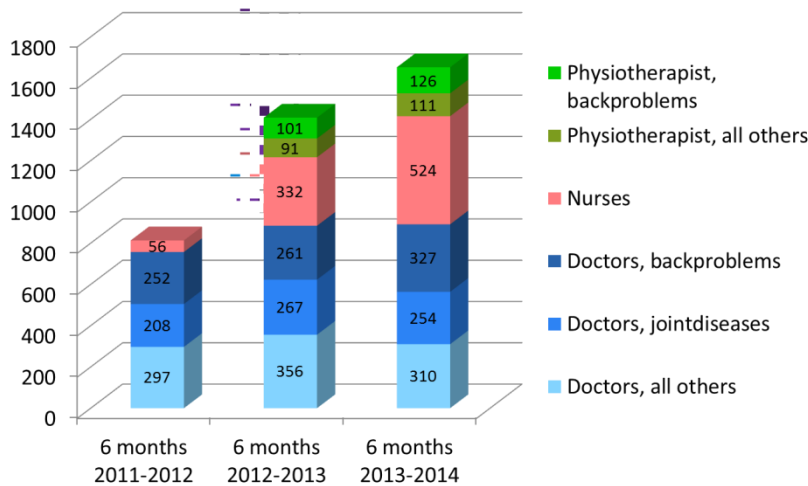
Patients with depression problems per different professionals



Patients with alcohol problems per different professionals

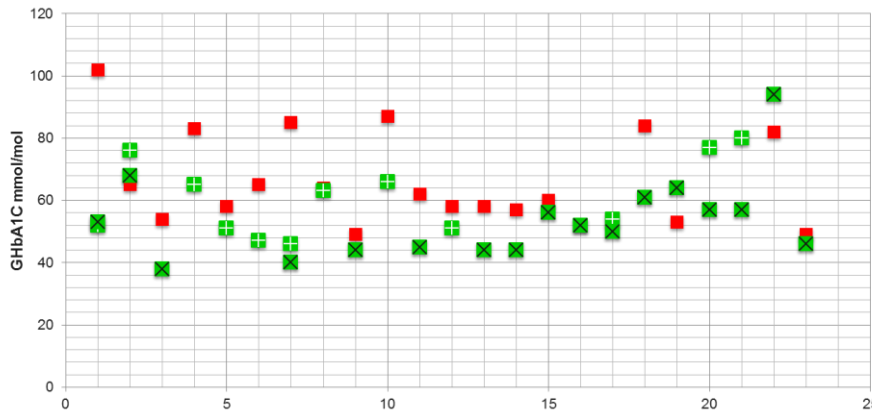


Patients with orthopaedic problems



The above diagrams show that people in Huhtasuo area received the care that they needed. It was somewhat surprising to see that nurses still treated a lot of the patients with orthopaedic problems, as it was expected that they would mostly see the physiotherapist directly. A likely explanation for this is that nurses take many telephone calls and if the problem is not acute or very big, they can give patients guidance for treatment at home (take a painkiller, some rest etc). Also a surprise was that the amount of patients that visited the doctor didn't go down. However, these are perhaps the patients with more complex problems (not merely physiotherapy).

Balance of long term blood sugar levels



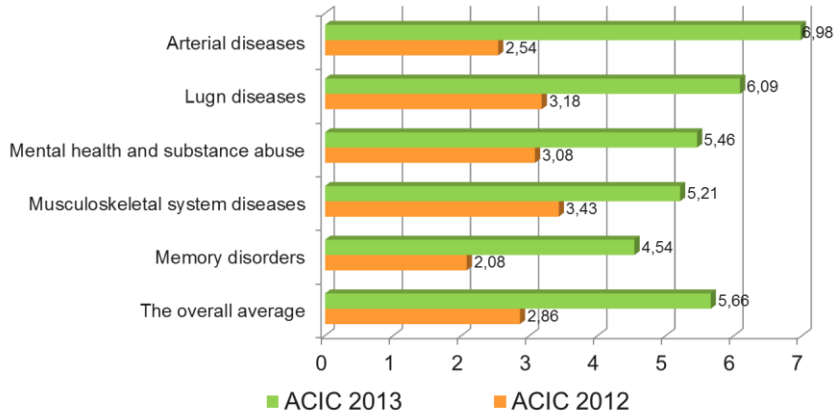
Red= years before 2009-2012, light green = in the beginning of 2013, dark green = end of 2013

In the above plot, each green and red dot on the same point of the horizontal axis denotes a single patient (so two or three measurements for the same patient). Because people get better care than before (through the nurses), almost all patients have made remarkable progress. For almost all patients, there is a decrease in blood sugar level visible. This is also because before they didn't get any treatment, now they have the nurse who takes care of them.

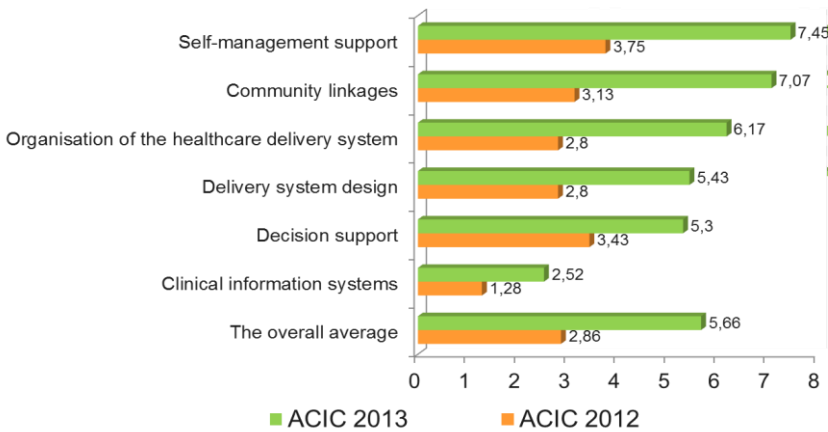
ACIC evaluation

The Assessment of Chronic Illness Care (ACIC) is a tool to that addresses the basic elements for improving chronic illness care at the community, organization, practice and patient level. Moreover, preliminary data indicate the ACIC is responsive to changes healthcare teams make in their care systems. Hence, the Huhtasuo health centre used the ACIC evaluation in 2012 and 2013 to evaluate improvements in the treatment of chronic patients since the start of the HuHa project.

ACIC – evaluation summary 2012 ja 2013 in different disease groups

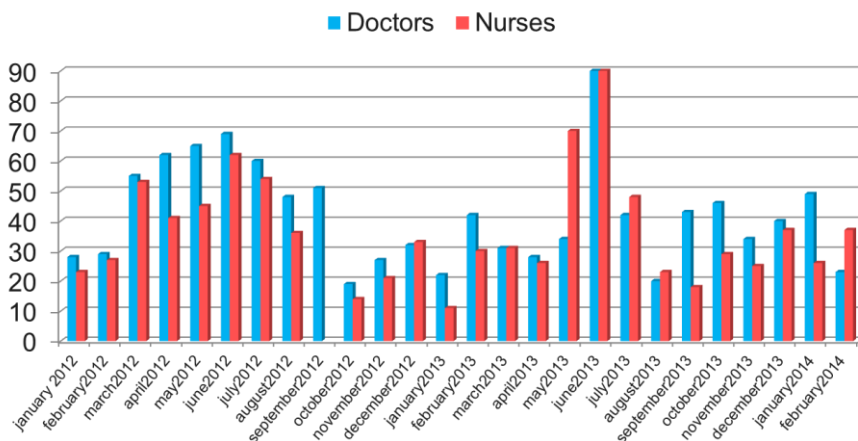


ACIC – evaluation summary 2012 ja 2013 in sections



The above diagrams show that in all areas, large improvements have been obtained since the HuHa project started. This is for a large part explained by the time that nurses have available for chronic patients, they have time to think with the patient. Scores on the ACIC run from 0 (lowest) to 11 (highest). The ACIC evaluation for the HuHa project was done by an outsider.

Waiting time for non-acute care



After the project started, waiting times for both doctors and nurses decreased.

Satisfaction with the service

In a patient satisfaction survey conducted in 2013 (n=91), it was shown that 90% of the patients at Huhtasuo are (extremely) satisfied with the service they receive at the health centre.

The Health Centre also received good feedback from the central hospital. The amount of Huhtasuo patients in emergency care is very low, even in the night time. And that saves the hospital money. And it's better for the patient that they don't have to go there.

References

JYTE (2015). Operation of the care team model at the Huhtasuo Health Station. Document obtained during case site visit 13 January 2015.

Jyväskylä municipality (2014). *Huhtasuo Haltuun -hanke*. Available at: <http://www.jyvaskyla.fi/terveys/terveysasemat/huhtasuo/huhtasuohaltuun> (accessed: 08-12-2014).

Mutka, A. (2014). Answers received per email on questions Recruitment and Retention study.

Pekkilä, J., Kasari, S., Kiuru, A., Mutka, A. & Peltonen, P. (2015). Interviews during case site visit to Jyvaskyla for the Recruitment & Retention study, January 2015.

Appendix 4.2. Case report 4.2

Topic 4. Attracting and retaining nurses through the extension of practice and development of advanced roles

Case 4.2. Extension of nurses' roles and functions, Australia



Research methods applied:

Desk research: August – September 2014

1. Summary of the intervention – Extension of nurses’ roles and functions, Australia

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Education Regulation Personal and professional support
Professional group(s) targeted	Registered nurses
Level of intervention	Policy and organisational
Type of organisation	State Ministries of Health, hospitals
Kind of services provided by organisation	Various
Size of organisation	Large, medium and small
Area covered	Most interventions take place at state level (e.g. New South Wales, Victoria), others are situated at organizational or ward level.
Intervention period / duration of intervention	Extension of nurses’ roles as a way of recruitment and retention gained momentum in Australia in the early 2000s.
Key actions	In New South Wales, the DoH has developed protocols to allow enrolled nurses to do tasks previously performed by RNs, such as the sterilisation of surgical instruments and the administration of certain drugs. Moreover, individual public hospitals have redesigned how nurses provide care and have established new roles. In New South Wales and Victoria, RNs are (financially) being encouraged to pursue postgraduate studies. Victoria also introduced NP roles.
Financial investment	No information could be retrieved.
Implementation strategy or processes used	No information could be retrieved.
Personnel investment	No additional HR is required in implementing the measures. Additional HR is sometimes required when RNs take up postgraduate study and (temporarily) need to be replaced.
Outcome measures of the intervention	It is difficult to establish R & R effects. Monitoring or evaluation barely seems to take place. However, the New South Wales Department of Health has reduced the nurse resignation rate and recruited more nurses.

	Yet the Department recognises it is too early to judge whether the measures taken will ensure that the nursing workforce in public hospitals will be adequate in the future.
--	--

2. Rich description of the intervention

Reasons for the extension of nurses' roles and functions

In 2004, a national Australian review of the nursing workforce predicted that the demand for nurses in Australia would increase by over two per cent a year due to expected increases in hospital admissions and the large number of nurses nearing retirement (NSW Audit Office, 2006). In Australia, state governments are responsible for healthcare. Hence, many states developed interventions related to extending nurses' roles, tasks and functions to recruit and retain more professionals for the nursing workforce.

New South Wales

As the New South Wales Department of Health is responsible for managing nurse supply in New South Wales, it identified and developed ways to attract, retain and best manage nurses working in public hospitals. One of the ways has been by providing nurses greater access to professional development, by changes in work practices and by freeing up registered nurses for more complex tasks (NSW Audit Office, 2006).

Victoria

In Victoria there is a public and private acute care hospital system, as well as both public and private aged and community care systems. The state of Victoria has taken a number of initiatives over the past decade to attract, recruit and retain nurses and midwives. One of them being the granting of scholarships to support nurses working in the public health service in postgraduate study (ANMF Vic Branch, 2014). Also, in 1998 the state of Victoria set up a task group on Advanced Nursing Practice. In 2002, the first NP in the state was endorsed (Kendall, 2013).

Objective of the extension of nurses' roles and functions

Attracting and retaining registered nurses through identifying career pathways and structures.

Type of intervention

This intervention is broad and includes aspects of education, regulation and professional support.

Professional group(s) targeted

Registered nurses.

Level of the intervention

Policy and organisational level.

Area covered

Several states of Australia, including New South Wales and Victoria.

Extension of nurses' roles and tasks

New South Wales

In New South Wales, the Department of Health has developed protocols to allow enrolled nurses to do tasks previously performed by registered nurses, such as the sterilisation of surgical instruments and the administration of certain drugs. Moreover, individual public hospitals have redesigned how nurses provide care. Locally developed initiatives have been publicised across the public hospital sector through the Models of Care Roadshow. This Roadshow was funded and organised by the NSW Nursing and Midwifery Office, an agency of the NSW Ministry for Health, to showcase existing examples of innovation and engage the profession in debate around the way in which nursing and midwifery care is practised and delivered and the current and future roles of nurses and midwives. For example individual wards:

- Allocate patients to a team of registered, enrolled and other nurses who provide a continuum of care under appropriate supervision. This contrasts to traditional models of care that allocate patients to a registered nurse.
- Have established new roles including shift coordinators responsible for coordinating daily admissions, ensuring discharges are organised and effective and mentoring and supporting new, casual and inexperienced staff members.

These initiatives have helped free up registered nurses to provide more complex clinical care. In addition, all public hospitals within New South Wales are supporting nurses to study to further develop their professional skills (NSW Audit Office, 2006).

Victoria

In Victoria, nurses working in public health service may be eligible for a scholarship to support them in postgraduate study. Postgraduate Nursing Scholarships are targeted to areas of clinical practice that employers determine as important to their health service. What Victorian health services deem as important is determined quite ad hoc and often coincides with the release of state government funding known to get projects started. There are also scholarships for mental health nursing and for becoming a nurse practitioner, with advanced practice status (AMNF Vic Branch, 2014).

In Victoria, one of the NP roles that were introduced was the Palliative Care NP role in the Grampians region. The Palliative Care NP performs advanced nursing practice and is able to prescribe medications, order diagnostics and pathology. Apart from the clinical work, the NP acts as a regional representative, has organisational responsibilities and acts as a clinical mentor (Kendall, 2013).

Running time of the intervention

In New South Wales, efforts have gained momentum after the 2004 publication on the expected shortage of nurses in Australia. In Victoria, developments have been taken place since the early 2000s.

Implementation strategy

No information could be retrieved.

Organisational framework

The initiatives that have been taken take place at several levels, but always involve a reciprocal interplay between policy and organisational level. In New South Wales, the Department of Health developed protocols, which had to be implemented by individual institutions and organisations to take effect. At the same time, individual public

hospitals have also redesigned how nurses provide care, within the realms of what the law allows.

Finances

No information could be retrieved.

3. Results of the intervention

As these interventions are not part of one coherent package and take place at different levels (from policy level to organisational level to ward level), it has proven to be very difficult to establish the effects of the interventions in terms of recruitment and retention rates. Moreover, monitoring or evaluation barely seems to take place.

New South Wales

The New South Wales Department of Health has reduced the nurse resignation rate and recruited more nurses. The annual rate of resignations fell from 16 per cent in 2001-02 to 14 per cent in 2005-06. The number of nurse vacancies fell by 13 per cent between 2001-02 and 2005-06. Between 2001-02 and 2005-06 the average number of permanent nurses employed increased to 39,804. This was a net gain of 5,588 nurses and represents an annual increase of four per cent. However, nearly half the nurses work part-time and the department is not able to quantify the gain in nursing resources or assess whether it is adequate to meet demand. The Department itself recognises that it is too early to judge whether the measures taken will ensure that the nursing workforce in public hospitals will be adequate in the future (NSW Audit Office, 2006).

References

Australian Nursing and Midwifery Federation, Victorian Branch (2014). Email interview.

New South Wales. Audit Office. (2006). *Performance audit: attracting, retaining and managing nurses in hospitals: NSW Health*. Sydney NSW: Audit Office of New South Wales.

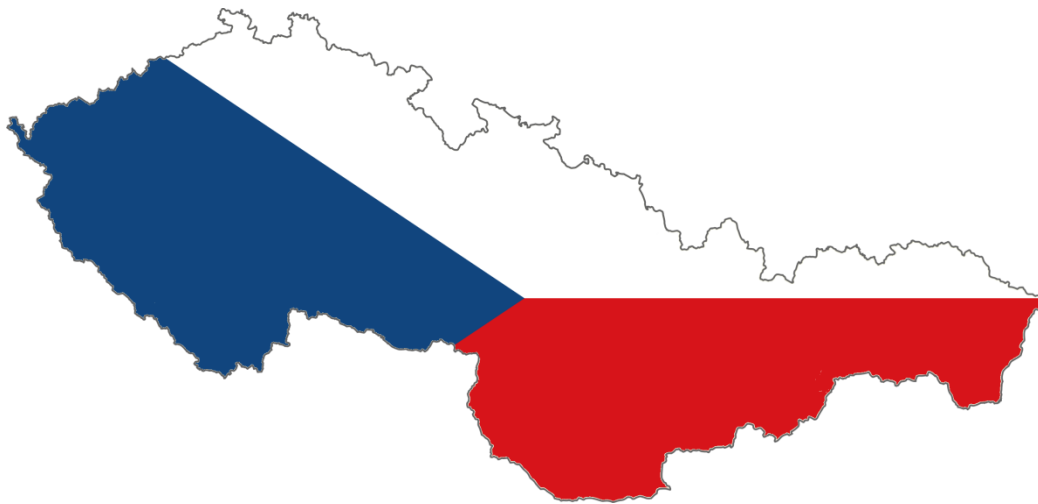
Kendall, R. (2013). Nurse Practitioners in Regional Victoria.

Kendall, R. (2014). Email interview.

Appendix 4.3. Case report 4.3

Topic 4. Attracting and retaining nurses through the extension of practice and development of advanced roles

Case 4.3. Subsidized education for nurse specialists, Czech Republic



Research methods applied:

Desk research: August – September 2014

Case site visit: September 2014

1. Summary of the intervention – Subsidized education for nurse specialists, Czech Republic

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Education Financial incentives
Professional group(s) targeted	RNs
Level of intervention	National policy level
Type of organisation	Czech Ministry of Health.
Kind of services provided by organisation	Various
Size of organisation	Large
Area covered	Czech Republic
Intervention period / duration of intervention	The subsidizing programme has run since 2009. There is no foreseen end-date.
Key actions	Educational courses, subsidized by the Ministry of Health through employers, for RNs to become nurse specialists.
Financial investment	Additional financing is required. The programme is subsidized by the Czech Republic.
Implementation strategy or processes used	The members of the Czech parliament suggested introducing a subsidized programme for doctors. The MoH decided to include other health care professionals as well. In 2008, the MoH conducted a study evaluating the need amongst all of the specialist areas. Based on this, the first round of the subsidized educational courses for nurses ran in 2009.
Day-to-day running of the intervention	Subsidy is the responsibility of the MoH, who employ one person for this. Employers apply at the MoH for the financial resources. The external administrator (IPVZ; Institute of Postgraduate Medical Education) processes the applications. The institute for health care education (NCONZO National centre of nursing and non-medical health care) controls whether the health care professional fulfils all requirements.
Personnel investment	Additional HR is required, but relatively

	limited.
Outcome measures of the intervention	Since 2009, between 485 and 694 specialist education course places have been approved by the MoH on an annual basis. There are no follow-up data available about the recipients, so it is not clear how many of them actually stay in the nursing profession.

2. Rich description of the intervention

Case under study

Educational courses, subsidized by the Ministry of Health through employers, for RNs to become nurse specialists (Di Cara, 2014).

Reasons for the establishment of subsidized courses for RNs to become nurse specialists

In 2008, the Czech Republic faced a shortage of nurses because of the change in RNs' education transfer of the basic nursing education (qualification) from a high school programme (4 years, general and professional education taught together, graduating at the age of 18-19) to tertiary level. That year, the Ministry of Health conducted a study to identify the need and the priority amongst all nurse specialist areas, which ones should be supported the most. In 2009, as a reaction to nursing shortage in different fields, the Czech government decided to subsidize a number of education courses for nurse specialists (Di Cara, 2014; Di Cara et al., 2014).

Objective of the intervention

The aim of subsidizing the specialist nursing courses for RNs was to train more specialist nurses in the fields where they were most needed (e.g. intensive care) and retain them in nursing (Di Cara et al., 2014).

Type of intervention

This is an educational intervention with financial incentives; it offers fully subsidized educational courses to become specialist nurses.

Professional group(s) targeted

All nurses in the Czech Republic can participate in this programme through their employers. There are 7 specialist courses for nurses (e.g. intensive care, intensive care in paediatrics, perioperative care, nursing care in paediatrics, nursing care in psychiatry, community nursing care, organization and management of health services).

Level of the intervention

National policy level.

Area covered

Czech Republic

Running time of the intervention

The subsidizing programme has run since 2009. There is no foreseen end-date for the programme and it is expected that it will run in the future as well (Di Cara et al., 2014).

Implementation strategy

The members of the Czech parliament suggested introducing a subsidized programme for doctors. The Ministry of Health then decided to include other health care

professionals as well. After an intense negotiation, this was accepted by the parliament (Di Cara et al., 2014).

Subsequently, in 2008 the MoH conducted a study evaluating the need and the priority amongst all of the specialist areas, which ones should be supported the most. Based on this evaluation, the first round of the subsidized educational courses for nurses ran in 2009 (Di Cara et al., 2014).

Organisational framework

The subsidy for the specialized education is the responsibility of the Ministry of Health. However, a number of actors are involved in the day-to-day running of the programme.

Employers (usually health care facilities) apply at the MoH for the extra financial resources to train more specialist nurses.

The MoH employs one person who is responsible for distributing the finances, checking the data and organizing the meetings of an expert group which decides how to and where to allocate the available finances. There is an annual negotiation at the MoH about which professions, how many places and in which specialist fields will be subsidized. This is compared with the received applications from the employers and subsequently the numbers are adjusted to satisfy the current need (for example in 2014, the MoH suggested 150 places for intensive care nurses, received 278 applications and approved 240 places). The director of the Department of non-medical health care professions at the Ministry of Health has to approve all decisions (Di Cara et al., 2014).

After the requested number of places is approved by the MoH, employers have to announce the opportunities to their employees and they can sign up.

The external administrator (IPVZ; Institute of Postgraduate Medical Education) processes the applications of the facilities for a subsidy and performs other daily administrative tasks.

The institute for health care education (institute called NCONZO National centre of nursing and non-medical health care) controls whether the individual health care professional is fulfilling the requirements of her/his specialist education.

The Czech Nurses Association is not involved in running this programme (Di Cara et al., 2014).

Nurse specialist courses – entry requirements

'Nurse specialist' is an official title in the Czech Republic that is awarded to general care nurses (RNs) who have successfully completed specialist education in their field. To be admitted to the specialist education programme, RNs must have substantial clinical experience. Nurse specialists have deeper knowledge of the nursing and medical aspects of the field in which they have specialized than RNs. Moreover, they are allowed to perform certain tasks (e.g. defibrillation, insertion of a Foley catheter) which RNs are not allowed to perform (Di Cara, 2014).

There are no strict entry requirements or eligibility criteria for RNs to be admitted to specialized education. The only requirement that the Ministry of Health sets for granting the subsidy is that the individual RN was accepted in a course for accredited specialization education. As soon as the MoH has this information, it will start reimbursing the costs of the RN's education.

Naturally, a RN's employer needs to approve of his/her RN following a certain course and educational institutions have certain conditions to include a nurse into their education as well (e.g. registration). But these are general conditions which hold no relation to the subsidy (Di Cara et al., 2014).

Facilitators in the running of the intervention

It is good to have a programme like this described in the law, as it then becomes a mandatory item of the state budget.

Barriers in the running of the intervention

At the start of the programme, there were some administrative barriers in the running of the programme such as not enough time and not enough personnel to fully process it. Later, the daily operation was transferred to an external subject to manage the normal agenda (Di Cara et al., 2014).

At this moment, there is an unnecessarily high administrative workload; the amount of related documents which need to be circulated between the MoH, the administrator and the recipient could be decreased. Moreover, modern technologies, software and programmes could be used for the remaining agenda.

Also, the evaluation of the programme could be improved (Di Cara et al., 2014).

Finances

The subsidiary programme is a general programme available to all healthcare professionals. In 2014 there were 600 places available for all non-medical health care professionals with a total budget of about €2.200.000. 300 of these places are allocated for nurses (Di Cara et al., 2014). The programme is dependent on the amount of finances released from the state budget every year. In 2014, the budget was larger than in 2013 (Di Cara et al., 2014).

Employers can use the subsidy they receive per individual nurse for covering the following costs: the cost of the specialist course (teachers, rooms, equipment, administration), the wages of the participating nurses and their travel costs and food, wages for extra personnel, if the employer needs to hire more nurses, because some are in school (Di Cara et al., 2014).

Conditions for replicability

Key requirements and conditions for replicating a similar programme are political goodwill, probably driven by a serious need for more health care workforce, success in negotiating this, and some financial resources (Di Cara et al., 2014).

3. Results of the intervention

Tables 1 to 6 present an overview of the specialist education courses for RNs which have been subsidized by the Czech government since 2009. Since 2009, between 485 and 694 places have been approved on an annual basis. Unfortunately, there are no follow-up data available about the recipients of the subsidies, so it is not clear how many of them actually stay in the nursing profession (Di Cara, 2014). The last columns of the tables show the number of applicants who apply and are approved places.

Table 1: Specialist education courses for nurses subsidized by the Czech government, 2009

Name of field	Fields of specialized education	Plan of MoH	Assigned places	Approved places
General nurse	Nursing care in anaesthesiology and intensive care	730	358	Data not available
	Perioperative care	150	70	
	Nursing care in pediatrics	390	70	
	Nursing care for patients in selected clinical specialties	200	65	
	Nursing Care for Mental Health	45	5	
	Total	1515	568	

Source: Di Cara, 2014

Table 2: Specialist education courses for nurses subsidized by the Czech government, 2010

Name of field	Fields of specialized education	Plan of MoH	Assigned places	Approved places
General nurse	Nursing care in anaesthesiology and intensive care	450	386	283
	Perioperative care	100	61	47
	Nursing care in pediatrics	150	137	81
	Community nursing care	10	1	1
	Nursing care for patients in selected clinical specialties	200	101	78
	Nursing Care for Mental Health	30	8	8
	Total	940	694	498

Source: Di Cara, 2014

Table 3: Specialist education courses for nurses subsidized by the Czech government, 2011

Name of field	Fields of specialized education	Plan of MoH	Assigned places	Approved places
General nurse	Intensive care	310	305	254
	Perioperative care	90	35	33
	Nursing care in pediatrics	80	50	38
	Community nursing care	50	4	1
	Nursing care in internal medicine	70	62	47
	Nursing care surgeon. fields	70	66	50
	Nursing Care in Psychiatry	30	2	2
	Total	700	524	425

Source: Di Cara, 2014

Table 4: Specialist education courses for nurses subsidized by the Czech government, 2012

Name of field	Fields of specialized education	Plan of MoH	Requested places	Approved places
General nurse	Intensive care	150	292	190
	Intensive care in pediatrics	20	27	18
	Perioperative care	20	43	19
	Nursing care in pediatrics	30	49	26
	Nursing care in internal medicine	20	79	18
	Nursing care surgeon. fields	20	61	17
	Nursing Care in Psychiatry	10	12	9
	Total	270	563	297

Source: Di Cara, 2014

Table 5: Specialist education courses for nurses subsidized by the Czech government, 2013

Name of field	Fields of specialized education	Plan of MoH	Requested places	Approved places
General nurse	Intensive care	250	312	272
	Intensive care in pediatrics	21	28	34
	Perioperative care	30	63	52
	Nursing care in pediatrics	80	70	67
	Nursing Care in Psychiatry	60	12	11
	Total	441	485	463

Source: Di Cara, 2014

Table 6: Numbers of available fields for RNs and the number of places available for 2014

Name of field	Fields of specialized education	Plan of MoH	Requested places	Admission RM	Total duration in months	Monthly allowance
General nurse	Intensive care	150	278	240	24	5.000 Kč (€181)
	Intensive care in pediatrics	15	34	27	24	5.000 Kč (€181)
	Perioperative care	30	43	37	24	5.000 Kč (€181)
	Nursing care in pediatrics	50	58	58	24	3.750 Kč (€135)
	Nursing Care in Psychiatry	40	13	13	24	3.750 Kč (€135)
	Community nursing care	10	1	0	24	3.750 K (€135)č
	The organization and management of health services	10	43	10	24	3.750 Kč (€135)
	Total	305	470	385		

Source: Di Cara, 2014

References

Di Cara, V. (2014). Email interview for the Recruitment & Retention study.

Di Cara, V., Prošková, E., Smidova, A., Moravek, J. (2014). Email interview for the Recruitment & Retention study. The Czech Nurses Association, Union of the Employers' Association of the Czech Republic, Czech Ministry of Health.

Appendix 4.4. Case report 4.4

Topic 4. Attracting and retaining nurses through the extension of practice and development of advanced roles

Case 4.4. Advanced Nursing Practice in relation to recruitment and retention, France



Research methods applied:

Desk research: September 2014

Telephone interview: September 2014

1. Summary of the intervention – Advanced Nursing Practice in relation to recruitment and retention, France

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Education and regulation
Professional group(s) targeted	Nurses and to a lesser degree doctors (indirectly other healthcare professionals are involved as well, because of the task substitution taking place).
Level of intervention	Policy
Type of organisation	National Ministry of Health, Regional Health Authorities (ARS) and educational institutions.
Kind of services provided by organisation	Various
Size of organisation	Large
Area covered	France
Intervention period / duration of intervention	Berland report was published in 2003. Subsequently, pilot projects were conducted on task substitution and advanced nursing practice. July 2009, article 51 was introduced in the Law "Hôpital, patients, santé et territoires". In October 2009, the Clinical Nursing Science Master's degree was developed by the University of Aix-Marseille and EHESP.
Key actions	Include article 51 in the law "Hôpital, patients, santé et territoires" which allows task substitution in healthcare via 'protocoles de coopération' and introducing the Master's degree in Clinical Nursing Science.
Financial investment	Additional financing is required.
Implementation strategy or processes used	Careful stepwise process, working from recommendations from the Berland report (2003) through pilot projects to article 51 in the law HPST.
Personnel investment	Additional HR is required, specific amount depending on measure.
Outcome measures of the intervention	Because of the complexity of the process, not many 'protocoles de coopération' are opened between healthcare professionals for task

	<p>substitution. Results with regards to the Master in Clinical Nursing Sciences; it is popular, although it is difficult to establish at this point whether graduates start working at ANP level or at RN level.</p>
--	---

2. Rich description of the intervention

Establishment of task substitution and advanced nursing roles

In recent years, further to the Berland report 'Occupational Health Cooperation: the Transfer of Duties and Skills' [in French: *Coopération des professions de santé : le transfert de tâches et de compétences*] which was published in 2003 on the co-operation of health professionals, France has been trialling with task substitution and advanced nursing roles (Delamaire & Lafortune, 2010). Moreover, in 2009 the first MSc degree for nurses was introduced.

Reasons for the establishment of task substitution and advanced nursing roles

The number of full-time doctors in France is decreasing and there are concerns about the uneven distribution of the health workforce. Mechanisms used to regulate the supply of medical professions appear to have been ineffective. A new strategic plan was announced by the government in 2006. This included opportunities to delegate some clinical activities from doctors to other health professionals (Bourgueil, 2008). In recent years, further to the Berland report (2003) on the co-operation of health professionals, France has been trialling advanced nursing roles. This has been done both in response to the projected sharp decline in number of doctors and the desire to improve the career of nurses (Delamaire & Lafortune, 2010).

Objective of the intervention

The transfer of skills from one health professional to another aims to alleviate the problems related to the shortages of health professionals that France is facing. Moreover, it is aimed to contribute to the development of skills and the emergence of new health professions (Ministère des Affaires sociales, 2014b).

Type of intervention

Regulation (introduction of possibility for task substitution) and education (via the introduction of a Clinical Nursing Science master programme).

Professional group(s) targeted

Nurses and to a lesser degree doctors (indirectly other healthcare professionals are involved as well, because of the task substitution taking place).

Level of the intervention

The measures in the area of task substitution and advanced nursing roles are taken at national policy level.

Area covered

France.

Running time of the intervention

After the Berland report was published in 2003, pilot projects for task substitution and advanced nursing practice were conducted. On the 21st of July 2009, article 51 was introduced in the Law "Hôpital, patients, santé et territoires". In October 2009, to

promote new advanced roles for nurses, a Clinical Nursing Science Master's degree was jointly developed by the University of Aix-Marseille and the *Ecole des hautes études en santé publique* (EHESP) (Delamaire & Lafortune, 2010).

Implementation strategy

In 2003, the Berland report on the co-operation of health professionals was published. Further to this report, France has been trialling advanced nursing roles via a number of pilot projects. Based on the positive assessment of these pilot projects by the ONDPS (French National Observatory on the Demography of Health Professions) and HAS (French "High Authority in Health"), in 2009 article 51 was included in the Law "Hôpital, patients, santé et territoires" and the first Master degree for nurses was introduced in October 2009. Hence, the implementation process has been a stepwise process in which various actors were involved, including the Ministry of Health, the Regional Health Authorities (ARS), educational institutions and healthcare institutions (mainly through the pilot projects).

Organisational framework

No information could be retrieved.

Pilot projects conducted in the area of task substitution and advanced nursing roles

In recent years, France has been trialling advanced nursing roles. A number of pilot projects, both in hospitals and in primary care, have been tested in the following areas:

- expert nurses specialised in primary practices (Action de Santé Libérale en Equipe "ASALEE") who in particular offer advanced consultations in the area of health education
- expert nurse in home chemotherapy either in networks or in hospital day care for on-going chemotherapy treatment
- expert nurses specialised in haemodialysis
- expert nurses specialised in the treatment of hepatitis C patients
- contact nurse for neuro-oncology
- nurses specialised in digestive function explorations
- pre-blood donation interview approved by a nurse

The ONDPS (French National Observatory on the Demography of Health Professions) and HAS (French "High Authority in Health"), which assessed the initial pilot projects, concluded that the projects showed that it is possible for the non-medical workforce to perform medical acts without danger to patients through a reorganisation of the work process and close collaboration with doctors (Delamaire & Lafortune, 2010).

Article 51 of the 2009 Law "Hôpital, patients, santé et territoires" (HPST, 21 July 2009)

The next step in the development of co-operation between health professionals was taken in 2009. In 2009, France introduced a section in the law "Hôpital, patients, santé et territoires" which sets out the general principles of co-operation between health professions and allows the transfer of activities, health acts or the reorganisation of health professional procedures with regard to the patient. The

implications of article 51 on human resources for health are significant (Bertrand et al., 2011; Delamaire & Lafortune, 2010).

Article 51 allows the exceptional transfer of tasks in healthcare, based on the initiative of professionals. These local initiatives take the form of 'protocoles de coopération'. Healthcare professionals jointly write a protocol which explains how they will cooperate and how tasks that were previously performed by physicians will be transferred to nurses (other mixes are also possible, such as RN to Nurse aides, MD to physio etc.). These are then transmitted to the Regional Health Authorities (Agences Régionales de Santé or ARS). Since 2009 there have been mainly two types of protocols presented (Petit dit Dariel & Debout, 2014):

- 1) A protocol delegating a technical intervention
- 2) A protocol enabling an allied health professional to care for a group of patients with a certain kind of chronic diseases

The writing of such a 'protocole de coopération' is a complex and time-consuming process. After the writing of the protocol, it is examined at two levels:

- 1) At regional level by the regional health authority: at regional level it is checked whether the protocol is a good response to the problem that the concerned professionals face in practice.
- 2) At national level by the national health authority: at national level it is checked whether there are any issues that need to be solved around the required capacities to implement the protocol, whether the training of the professionals involved is adequate, what patients risks are and how they are to be avoided, whether the indicators that are proposed to evaluate the protocol are adequate, and so on.

The authors of the protocols subsequently get a lot of feedback and need to re-write the protocol. The whole process can take months or years to be completed (Petit dit Dariel & Debout, 2014).

New public health law- 2014

In 2014, France will introduce a new public health law. It is expected that the title Advanced Practice Nurse will be introduced at national level, with a unification in capacities, educational, regulation and in the indicators that will be used for evaluation of their practice. However, this isn't sure at this moment. The Ministry of Health only made an announcement that advanced nursing practice will be introduced at national level. The further development of this will take place over the coming months and years.

It can be concluded that at this moment, France is in a state of transition between working with the above described protocols and advanced nursing practice at national level (Petit dit Dariel & Debout, 2014).

Master of Clinical Nursing Sciences

In France, nurses can enrol on an individual basis in Bachelor's or Master's degree courses at university (or through derogations under agreements between healthcare training institutes and the university). They can also acquire specialised skills for which there is often no official qualification. In 2009, a major step has been taken with the recognition of the State nursing diploma as a professional first degree "license professionnelle" within the Bachelor's-Master's-Doctorate degree system. In October

2009, to promote new advanced roles for nurses, a new Master's degree was jointly developed by the University of Aix-Marseille and the *Ecole des hautes études en santé publique* (EHESP) (Delamaire & Lafortune, 2010). At that time, this was the first master programme specifically for nurses. In the meantime, a second Clinical Nursing Master programme was introduced in 2011 by the Université de Versailles Saint Quentin (www.uvsq.fr/master-2-recherche-sciences-cliniques-en-soins-infirmiers-197780.kjsp).

The aim of the Master programme at the EHESP is to build the capacities that advanced practice nurses need in order to practice in these new roles. The Master programme is called "Clinical Nursing Science" and has three specialities (Petit dit Dariel & Debout, 2014):

1. Advanced practice nurse in oncology
2. Advanced practice nurse in gerontology
3. Case management

As explained above, at this moment the title 'advanced practice nurse' has not been officially recognised or protected by the French government. There is also no approved national definition of advanced practiced nursing. For the Master programme Clinical Nursing Sciences, the EHESP used the definition of the International Council of Nurses. This means that graduates of the Master programme at the EHESP are currently not automatically considered advanced practice nurses by (future) employers. So in a sense these graduates are pioneers; there is no real job waiting for them and they have to integrate their advanced practice nursing skills within the existing system (Petit dit Dariel & Debout, 2014). However, this may change if France introduces a new public health law in which it is expected that the title Advanced Practice Nurse will be introduced at national level, with a unification in capacities, educational and regulation.

Barriers in the introduction of task substitution and advanced nursing roles

France differs from other countries by allowing some nurses to work on a self-employed basis in which they are paid by fee-for-service (14.6% of all nurses in 2009). These nurses and/or their union representatives do not always support the idea of working as doctors' employees in grouped practices and prefer to retain the independence afforded by their self-employed status. Fee-for-service, and more generally the system for financing self-employed practice, does not facilitate the movement towards greater co-operation between doctors and nurses in the primary care sector (Delamaire & Lafortune, 2010).

The implementation of Article 51 of the 2009 Law "Hôpital, patients, santé et territoires" is not straightforward and is facing obstacles (Delamaire & Lafortune, 2010). Because of the complexity of the process many of the protocols are in early stages of writing and very few of them are actually being implemented in practice. Moreover, once the protocol has been approved, the nurse will perform additional tasks but she/he will not be paid more money. This acts as a disincentive. Finally, the protocols are written on an individual basis, usually by two people. This is not only time consuming for them, but it also brings up the question; what if one of them leaves? If they are absent, who can take their place? This makes it risky for people to write such a protocol (Petit dit Dariel & Debout, 2014).

For the EHESP, it is difficult to establish whether graduates of their Clinical Nursing Science Master programme start working at ANP level or at RN level, because only four cohorts have graduated since the introduction of the Master. However, it is clear that few students at the end of their study are writing protocols that were described above. It is also clear that it is unusual for any of the graduates to get a salary increase equivalent to a Master's degree. Moreover, it should be noted that there is resistance among the medical profession against nurses taking up advanced nursing positions (Petit dit Dariel & Debout, 2014).

Finances

No information could be retrieved.

3. Results of the intervention

Results with regards to Article 51 of the 2009 Law "Hôpital, patients, santé et territoires"

(HPST, 21 July 2009)

Around the time of introduction of this article, in 2009, the Government expected that many healthcare professionals would take up the task of writing such a protocol. This is not the case. Even though there are no data available about this, it is clear that because of the complexity of the process many of the protocols are in early stages of writing and very few of them are actually being implemented in practice. Moreover, once the protocol has been approved, the nurse will perform additional tasks but she/he will not be paid more money. This acts as a disincentive. Finally, the protocols are written on an individual basis, usually by two people. This is not only time consuming for them, but it also brings up the question; what if one of them leaves? If they are absent, who can take their place? This makes it risky for people to write such a protocol (Petit dit Dariel & Debout, 2014).

Results with regards to the Master in Clinical Nursing Sciences at the *Ecole des hautes études en santé publique*

The "Clinical Nursing Science" programme at the EHESP is popular for new graduates, although there are no strong data to support this. However, it is clear that the programme receives many applications. Our informants state that it is unclear whether these applications mean that new graduates are attracted to the advanced nursing role or just want to postpone start working in clinical practice (Petit dit Dariel & Debout, 2014).

For the EHESP, it is difficult to establish whether graduates of their programme start working at ANP level or at RN level, because only four cohorts have graduated since the introduction of the Master. However, it is clear that few students at the end of their study are writing protocols that were described above. Hence, it is unlikely that they will be working at ANP level (Petit dit Dariel & Debout, 2014).

References

Bertrand, X., Pecresse, V., Berra, N. (2011). *Rapport relatif aux métiers en santé de niveau intermédiaire*.

Bourgueil, Y. (2008). Towards increased cooperation between health professions (delegation, transfer of tasks, new jobs): findings of a process of experimentation and consultation in the French context. Global Health Workforce Alliance: First Global Forum on Human Resources for Health.

Delamaire, M. L., & Lafortune, G. (2010). Nurses in advanced roles. *OCDE, ed. OECD Health Working Papers*, (54).

Ministère des Affaires sociales, de la Santé et des Droits des femmes (2014a). *La Loi "Hôpital, patients, santé et territoires"*. <http://www.sante.gouv.fr/la-loi-hopital-patients-sante-et-territoires.html> (accessed 30-10-2014)

Ministère des Affaires sociales, de la Santé et des Droits des femmes (2014b). *La coopération entre les professionnels de santé*. <http://www.sante.gouv.fr/la-cooperation-entre-les-professionnels-de-sante.html> (accessed 30-10-2014).

Petit dit Dariel, O. & Debout, C. (2014). Telephone interview for the Recruitment and Retention study.

Appendix 4.5. Case report 4.5

Topic 4. Attracting and retaining nurses through the extension of practice and development of advanced roles

Case 4.5. The function of 'verpleegkundig specialist' [nurse specialist], the Netherlands



Research methods applied:

Desk research: October- November 2014

Telephone interview: November 2014

1. Summary of the intervention – The function of ‘verpleegkundig specialist’ [nurse specialist], the Netherlands

Dimension of interest	Categories/description
Objective of the intervention	Retention (and recruitment)
Type of intervention	Education Regulation
Professional group(s) targeted	Registered nurses
Level of intervention	Policy
Type of organisation	National Ministry of Health, Dutch Nurses’ Association, educational institutions.
Kind of services provided by organisation	Various
Size of organisation	Large
Area covered	The Netherlands
Intervention period / duration of intervention	On 27-01-2009, the title nurse specialist was officially recognised by the Minister of Health, Welfare and Sport and it has been legally protected since then.
Key actions	Nurse specialists work at the interface between medical and nursing care, and treat defined groups of patients with whom they establish an individual treatment relationship.
Financial investment	High. Nurse specialists are educated via the MANP. Because of the social importance of the education, it is jointly financed by grants from the Ministry of Education (in-school fees) and the Ministry of Health (salary costs). The statutory tuition fee for RNs to follow the MANP is € 1.906. Nurse specialist registration and re-registration (>5 years) costs are €150 excluding VAT (€181,50 including VAT).
Implementation strategy or processes used	The legal recognition of ‘nurse specialist’ was the end point of a process that started in the course of the 1990s already, with several reports and advices to the MoH, research into the future of nursing, lobbying by professional organisations, and finally the start of a legal introduction process for the function.
Personnel investment	Where a nurse specialist is introduced, this

	can be as 'replacement' of a RN or medical specialist or as addition to existing staff.
Outcome measures of the intervention	It is impossible to say something about whether the introduction of the function of nurse specialist has affected R&R. Currently, there are 2519 nurse specialists in the Netherlands.

2. Rich description of the intervention

Case under study

The function of 'verpleegkundig specialist' [nurse specialist] that was introduced in the Netherlands in 2009. Nurse specialists work at the interface between medical and nursing care, and treat defined groups of patients with whom they establish an individual treatment relationship. To be allowed to use the title 'nurse specialist', nurses must have successfully completed a two year Master's degree programme in Advanced Nursing Practice and must afterwards have registered their names in the Nurse Specialist Register (Dutch: Verpleegkundig Specialisten Register).

Establishment of the function of 'verpleegkundig specialist' [nurse specialist]

On 27 January 2009, the title 'nurse specialist' was officially recognised by the Dutch Minister of Health, Welfare and Sport and it has been legally protected since then.

Reasons for the establishment of the function of nurse specialist

There are two main reasons for the introduction of the function of nurse specialist:

1. To retain (and recruit) nurses for healthcare by offering them a career perspective. Before the function of nurse specialist was introduced, the only professional growth possibilities/career possibilities for (specialised) RNs were in management, education or research. With the introduction of the function of nurse specialist, they have the possibility to further their career 'on the bedside'. Hence, they are retained for the nursing profession (Van Bronkhorst, 2014).
2. The current climate of task substitution in healthcare. A number of important changes took place in the Dutch legal framework for health care over the past few decades that paved the way for task substitution. Several reports appeared that recommended task substitution in Dutch health care (e.g. Commissie LeGrand, 2003; RVZ; 2002.). Moreover, in view of the expected capacity problems in health care and professional developments taking place on the work floor, the Dutch Ministry of Health developed a positive attitude towards task substitution, stating that task substitution would enable the optimum utilisation of health care professionals in terms of quality and efficiency (Van Bronkhorst, 2014). As a result, new roles were introduced in Dutch healthcare, including the physician assistant and nurse specialist (Kroezen, 2014).

Objective of the intervention

The function of nurse specialist is aimed to contribute to improved quality of care, better career prospects for nurses and increasing the supply of staff (Peters, 2014).

Type of intervention

Regulation (introduction of new function and task shifting) and education (via the introduction of the Master of Advanced Nursing Practice and additional courses to facilitate task shifting).

Professional group(s) targeted

Registered nurses who have at least two years of practice experience.

Level of the intervention

Policy level.

Area covered

The Netherlands.

Kind of services provided by nurse specialists

Nurse specialists work at the interface between medical and nursing care, and treat defined groups of patients with whom they establish an individual treatment relationship.

Running time of the intervention

On 27 January 2009, the title 'nurse specialist' was officially recognised by the Dutch Minister of Health, Welfare and Sport and it has been legally protected since then.

Education to become a nurse specialist

To become a nurse specialist, nurses need to follow the 2-year Master of Advanced Nursing Practice. The admission criteria for this Master are (Saxion, 2015):

- Successfully completed nursing training (according to Article 3 Act of the Dutch Wet BIG)
- Minimum of two year work experience as RN
- Have a training place in a hospital, rehabilitation centre, nursing home, home for the disabled, mental health, general practice or other healthcare facility, with a medical- and nurse specialist mentor.
- Have an employment contract for at least 32 hours per week

Implementation strategy

In January 2009, the title 'nurse specialist' was legally recognised in the Netherlands. This was the end point of an introduction process that had started years earlier (Van Bronkhorst, 2014). In the Netherlands in the course of the 1990s, several developments already took place that preceded the introduction of the function of nurse specialist. In the early 1990s, advises were already being published to offer registered nurses (RNs) a career 'at the bedside'. By the end of 1997, inspired by American example, the first Master of Advanced Nursing Practice in the Netherlands started in Groningen. This education offered RNs the possibility to exercise their profession at a higher level. And this time not in management, education or research, but at a higher level in patient care. In this way, nurses with ambitions are retained for healthcare (V&VN, 2012).

In 2002, the concept of 'task substitution in healthcare' is given a new boost by the advice of the Council for Public Health and Care (Dutch: Raad voor Volksgezondheid en Zorg) that is being taken over by the Dutch Ministry of Health. The report is called 'Task substitution in health care' and advocates for more task substitution. Moreover, in the same period, the number of universities of applied sciences that are offering the Master of Advanced Nursing Practice is increasing (V&VN, 2012).

In 2006, the Ministry of Health commissions the Steering Nursing Profession Structure and Training Continuum (VBOC) with the task to describe the professional structure of nursing with room for renewal. The final report of this steering group mentions that it is desirable to distinguish between two professionals: the registered nurse (article 3 in

the Dutch Individual Healthcare Act) and nurse specialist (article 14 in Dutch Individual Healthcare Act).

In July 2007, the Dutch Ministry of Health approves and finances the VBOC-project 'Implementation Nurse Specialist'. The goal of this project is to realise a number of essential preconditions for positioning the nurse specialist within the nursing professional career structure (V&VN, 2012). After this, the real implementation process can start. Several parties are involved in this, including the Dutch Ministry of Health, the Dutch Nurses' Association V&VN, and the College Nurse Specialisms (Van Bronkhorst, 2014). The College Nurse Specialisms (CSV) was established in 2006 and the Registration Committee Nurse Specialisms (RSV) in 2008.

In 2009, the CSV designates five nurse specialisms, namely: preventive care, chronic care, intensive care, acute care and mental health care. In 2009, the five specialisms are legally recognized by the Minister of Health (V&VN, 2012).

Per January 2012, article 36a of the Dutch Individual Healthcare Act came into force. This article, also called the 'experimental article', allows nurse specialists to perform reserved procedures, including the prescribing of medicines, for an experimental period of five years (1 January 2012 – 31 December 2016). Upon positive evaluation, a permanent arrangement may be included in the law that will grant nurse specialists permanent authority to perform reserved procedures, including prescribing (V&VN, 2012). The Dutch Nurses' Association and the Royal Dutch Medical Association both advised the Ministry of Health about this 'experimental article' (Van Bronkhorst, 2014).

Organisational framework

The function of nurse specialist is legally established in article 14 of the Dutch Individual Healthcare Act (in Dutch: Wet BIG). In addition, article 36a of the Individual Healthcare Act allows nurse specialists to perform reserved procedures, including the prescribing of medicines, for an experimental period of five years.

College Nurse Specialisms

In the context of article 14 of the Wet BIG, which requires that nurse specialists are registered in a 'speciality register', the College Nurse Specialisms was established (Van Bronkhorst, 2014). The main responsibilities of the College are to designate the nurse specialisms, establish the nurse specialist register and determine the requirements for training and (re)registration of nurse specialists (V&VN, 2012). The College Nurse Specialism is built up of nurse specialists, the branch organisations and educational institutions (and since 2013 also a member of the Royal Dutch medical Association).

The college is an independent public body of the Dutch Nurses' Association V&VN that deals with policies and regulations for training and registration of nurse specialists. The 18 members and advisory members are nurse specialists (in training), representatives of educational institutions or from one of the trade associations, the Royal Dutch Medical Association and university education. The Chairman of the Board is independent and has no voting rights. The College is supported by a secretary, who also acts as advisor.

The college is independent of the Board of V&VN, but the board of V&VN does have an important advisory role in the decisions made by the College. The decisions of the

College only take effect after approval by the Minister of Health. Other parties in the field in which the College operates include the nursing profession itself, represented by the Dutch Nurses' Association Department of Nurse Specialisms (V&VN VS), the ten educational institutions and the industry. Furthermore, the College works closely with the Registration Committee Nurse Specialisms.

Challenges for the College in the coming years include the broad regulatory review of the College itself and in particular of the nurse specialisms, and a strong positioning of the College in the constantly evolving field surrounding the nurse specialist.

Registration Committee Nurse Specialisms (RSV)

The Registration Committee Nurse Specialisms (RSV) implements the decisions taken by the College Nurse Specialisms. It is legally responsible for the registration of nurse specialists, as defined in Article 14, paragraph 2, of the Wet BIG. Only nurses who are registered in the register of nurse specialists are entitled to carry one of the legally recognized nurse specialist titles. The Registration Committee has the following tasks (V&VN 2012; Verpleegkundigspecialisten, 2015):

- Designing the training records for nurse specialists in training;
- The registration of nurse specialists in training in the training records;
- The recognition of main- and practice trainers, educational institutions and practice settings;
- Supervising compliance with college decisions by educators and training institutions (eg by visitation);
- Setting up of the registers for nurse specialists;
- Registration and re-registration of nurse specialist in the specialist registers, i.e.:
 - o preventive care in somatic disorders
 - o chronic care in somatic disorders
 - o intensive care in somatic disorders
 - o acute care in somatic disorders
 - o mental health care

The RSV is completely independent in its performance of duties and receives no subsidy. The Dutch Nurses' Association V&VN is responsible for the administration and the support for the management of the RSV (Verpleegkundigspecialisten, 2015). The rates charged by the RSV for registration, re-registration and approval are determined by the Board of V&VN, based on advice by the RSV, and become effective upon approval by the Minister of Health (Verpleegkundigspecialisten, 2015).

Reactions on the introduction of the function of nurse specialist

As with any new introduction, the introduction of the nurse specialist required some 'running-in time', some time for the new function to find its place. This type of new functions need time to 'land'. There were precursors; enthusiastic nurse specialists, physicians, general practitioners, medical specialists and healthcare institutions. But the introduction of the nurse specialist also evoked some resistance. This resistance was/is mainly situated at the individual level in institutions. There are individual healthcare professionals who do not see the need or added value for such a new professional. But at this moment, it looks as if the phase is reached where many

professions and healthcare institutions increasingly come to see the usefulness of the function of nurse specialist (Van Bronkhorst, 2014).

Facilitators in the introduction of the function of nurse specialist

Facilitating factors for the introduction of the function of nurse specialist can be distinguished between two levels. The first is the political level. As explained earlier (see heading "implementation strategy"), the Dutch Ministry of Health over the years developed a positive attitude towards task substitution. This was for example boosted by the advice of the Council for Public Health and Care that was taken over by the Ministry of Health and which advocated for more task substitution in healthcare. Hence, there was a political will to introduce task substitution and related new functions in healthcare (Kroezen, 2014).

At the work floor level, facilitating factors in the introduction of the function of nurse specialist were the individual success stories. The first people who would start with the education were the ones that already had a very good cooperation with medical specialists. These were generally very experienced nurses with a senior position, who already undertook many procedures. When the Master of Advanced Nursing Practice was introduced, the individual doctors and nurses who worked in such a way clearly saw the added value of this Master for their everyday practice. Hence, nurses were allowed to follow the Master in order to make a step in their career and become even better. These were often great success stories which encouraged others within the team or within the institution to pursue the same goal (Van Bronkhorst, 2014).

At this moment, many nurse specialists are being trained in elderly care. There are two reasons for this; the fact that there is a shortage of medical specialists in geriatric care and secondly the awareness that many of the tasks can be performed in teams of nurse and medical specialists in geriatric care (Van Bronkhorst, 2014).

Barriers for the function of nurse specialist

There are a couple of impeding factors for the function of nurse specialist. One of them is the political uncertainty in the Netherlands about the status of main practitioner in mental health care (can a nurse specialist in mental health care be the main practitioner for a patient or should this always be a medical professional?). Another difficulty is the introduction of the new structure within mental healthcare and the role of healthcare insurances in this new structure. Finally, the changing Diagnosis Treatment Combination (in Dutch: Diagnose Behandeling Combinatie - DBC) is problematic and this applies to all nurse specialisms (Van Bronkhorst, 2014). Dutch hospitals calculate the costs of treatment using a DBC. This is an administrative code for the whole course of the treatment that a patient with a given diagnosis undergoes in the hospital. Per 2015, nurse specialists are allowed to 'open' a DBC as well (prior, only medical doctors could do this) but it is unclear how this will affect practice and whether all necessary requirements are in place (Kroezen, 2014).

All these things cause a bit of uncertainty, often with a financial background. This is a barrier, as this may lead to institutions and/or individual physicians taking a cautious approach with respect to introducing (more) nurse specialists (Van Bronkhorst, 2014).

Finances*Educational costs*

Nurse specialists are educated in the Master programme of Advanced Nursing Practice (MANP). It is a dual programme, where students alternate between learning and working. Because of the social importance of the education, it is jointly financed by grants from the Ministry of Education, Culture and Science (OCW) and the Ministry of Health, Welfare and Sport (VWS). The Ministry of Education pays for the in-school fees and the Ministry of Health compensates (part of) the salary costs for the replacement of a student who follows the MANP. Currently, the contribution of the Ministry of Health for one training place is €45,000 for the entire study period of 24 months. The contribution of the Ministry of Education is €7,650 per training place (Peters, 2014). In 2014, these subsidies were evaluated and it was concluded that they are effective, i.e. they contribute to improved quality of care, better career prospects and increasing the supply of staff (Peters, 2014).

The statutory tuition fee for nurses to follow the Master Advanced Nursing Practice is € 1.906 for the college year 2014-2015. Nurses also have to pay the additional costs for study books and study material.

Registration and re-registration costs

After nurse specialists have finished their MANP they are legally required to register themselves in the Register for Nurse Specialist. Only after they registered themselves, they obtain the title 'nurse specialist'. The registration costs are €150 excluding VAT (€181,50 including VAT). Every five years, nurse specialists are legally required to re-register themselves and costs are €150 excluding VAT (€181,50 including VAT) each time.

The employers of nurses who follow the MANP need to register themselves with the Registration Committee Nurse Specialisms (RSV) as "recognized practice educator". If they do not do this, nurses cannot follow the MANP (because of the requirement that they need to have a qualified practice place). There are costs involved for the employers if they register themselves.

3. Results of the intervention

Effects on recruitment and retention

At this moment, it is impossible to say something about whether the introduction of the function of nurse specialist has effected recruitment and retention numbers. It is impossible to say whether more people remain in the nursing profession who may have been lost, had the function of nurse specialist not existed. There is currently (still) no (quantitative) research done. However, the leading thought within the nursing profession is that of the 2519 nurse specialists who are currently practising, a substantial part would have left the nursing profession if this opportunity had not existed. Another part would have remained working as RN and another part would have pursued a career 'away from the bed', for example in management, education or research. But, at present there are no hard figures available to underpin this thought.

Growth in number of nurse specialists

Ever since the function of nurse specialist was introduced, their number continues to grow. At the time of writing (January 2015), there are 583 nurse specialists who are being educated, and 2519 registered nurse specialists. However, it should be noted that the VBOC-report '*Verpleegkundige toekomst in goede banen*' in 2006 advised, based on numbers from the USA, to aim for a number of nurse specialists of 5% of the total nursing profession in the Netherlands. This number has not been reached.

References

Commissie Implementatie Opleidingscontinuüm en Taakherschikking (Commissie LeGrand) (2003). *De zorg van morgen, flexibiliteit en samenhang*. Den Haag: Ministerie van Volksgezondheid, Welzijn en Sport.

Kroezen, M. (2014). *Nurse prescribing. A study on task substitution and professional Jurisdictions*. Utrecht: NIVEL.

Peters, F. (2014). *Evaluatie van de 'Subsidieregeling opleiding tot advanced nurse practitioner en opleiding tot physician assistant'*. Nijmegen: Kenniscentrum Beroepsonderwijs Arbeidsmarkt.

Raad voor de Volksgezondheid en Zorg (2002). *Taakherschikking in de gezondheidszorg [Task substitution in healthcare]*. Zoetermeer: RVZ.

Saxion (2015). *Master Advanced Nursing Practice (Deeltijd/Duaal)*. Available at: [http://www.saxion.nl/wps/portal/saxion_nl!/ut/p/b0/DY0xDsMgEATfkoIaonTp_IvEzWnDnTAKHAIwHfn1odwZjdau9mVXXxREDRiyKNPf79PIZMTZzfyzG1f1D8GDJUSjIVZQ3idyv0oJxHb_ZkSbjSk2TRw2ixmX0IY3AB9QLk-6tT0W1wY_ohXgQ75iH9bvc_un-am0/](http://www.saxion.nl/wps/portal/saxion_nl!/ut/p/b0/DY0xDsMgEATfkoIaonTp_IvEzWnDnTAKHAIwHfn1odwZjdau9mVXXxREDRiyKNPf79PIZMTZzfyzG1f1D8GDJUSjIVZQ3idyv0oJxHb_ZkSbjSk2TRw2ixmX0IY3AB9QLk-6tT0W1wY_ohXgQ75iH9bvc_un-am0!/) (accessed: 14-01-2015).

Van Bronkhorst, S. (2014). Telephone interview for the Recruitment and Retention study.

Verpleegkundigen & Verzorgenden Nederland (2012). *Beroepsprofiel Verpleegkundig Specialist. Verpleegkundigen & Verzorgenden 2020. Deel 4*. Utrecht: Verpleegkundigen & Verzorgenden Nederland.

Verpleegkundigspecialismen (2015). *Registratiecommissie*. Available at: <http://www.verpleegkundigspecialismen.nl/Registratiecommissie.aspx> (accessed: 14-01-2015).

Appendix 5.1. Case report 5.1

Topic 5. Providing good working environments by putting professional autonomy & worker participation first

Case 5.1. The home care organisation *Buurtzorg* (the Netherlands)



Research methods applied:
Desk research: July-August 2014
Telephone interview: November 2014

1. Summary of the intervention – Buurtzorg the Netherlands

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Personal and professional support/autonomy
Professional group(s) targeted	(Community) nurses and community carers
Level of intervention	Organisational level
Type of organisation	Non-profit home care organisation
Kind of services provided by organisation	Home care
Size of organisation	Large
Area covered	Buurtzorg the Netherlands is active across the entire country. Its home care teams operate on a regional basis and cover both urban and rural areas.
Intervention period / duration of intervention	Buurtzorg the Netherlands started in 2006. There is no expected end date.
Financial investment	Additional financing is required to introduce the 'Buurtzorg' model.
Implementation strategy or processes used	The start and implementation of Buurtzorg gradually developed and were not part of a detailed implementation strategy.
Day-to-day running of the intervention	Buurtzorg the Netherlands is a non-profit organisation with a flat network organisation. The overhead is limited and comprised 30 persons in 2013. Financing, contracting, boundary conditions etc. are organised centrally and are removed as much as possible from the primary care process.
Personnel investment	Buurtzorg the Netherlands currently has around 700 teams active across the country. This requires 30 persons overhead, including the back office, 15 coaches and two directors.
Outcome measures of the intervention	Buurtzorg was not originally introduced as R&R intervention, proxy measures include the growth in number of staff (from 100 in 2007 to 7600 in 2013), staff turnover

	<p>resistance (9,3 in 2013) and sickness absence level (< 2%). Moreover, Buurtzorg was awarded 'Best Employer' of the Netherlands in 2011, 2012 and 2014 and was runner-up in 2013. In the category 'Healthcare' Buurtzorg ended on the first place for four years in a row; 2011 – 2014.</p>
--	--

2. Rich description of the intervention

Case under study

Buurtzorg the Netherlands [Community Care the Netherlands], a non-profit home care organisation that promotes professionally autonomous working.

Establishment of Buurtzorg

Buurtzorg was established in February 2006 by Jos de Blok en Gonnie Kronenberg. Gonnie Kronenberg and Ard Leferink developed the lean, technology-enabled administrative system that operates within the organization's intranet and clinical documentation platform, called Buurtzorgweb (Monsen & De Blok, 2013).

Reasons for the establishment of Buurtzorg

According to Jos de Blok, one of the founders of Buurtzorg, Dutch community nurses had considerable autonomy and worked closely with patients and their families until the 1980s. Because of market incentives that were introduced to reduce costs, home care subsequently became highly regulated, with reimbursement tied to individual nursing actions and services. The result was fragmentation of care, more paperwork, a focus on productivity, and less time spent caring for patients. The resulting growing dissatisfaction among home care nurses represented an opportunity to introduce a new way to provide care. Being a home care nurse himself, with management experience and a background in business administration, Jos de Blok had long envisioned a new care model in which nurses would provide community care in self-directed teams, supported by new technology and minimal administrative oversight (Monsen & De Blok, 2013).

Buurtzorg the Netherlands was introduced as reaction to a number of developments taking place in community care:

- The increase in time pressure and scale in home care, the emphasis on productivity.
- The increasing fragmentation of home care; home care is often provided by different care givers with different expertise levels. This makes it difficult to establish a bound between caregiver and caretaker. Moreover, it increases the risks for clients if there is insufficient time and attention for coordination and alignment between the different care providers (De Veer et al., 2008).

Type of intervention

Buurtzorg strongly emphasizes the personal and professional autonomy that its staff members have. While Buurtzorg was not primarily introduced as a recruitment and/or retention intervention, over the years it has proven to be very effective in both areas. Proxy measures are, for example, the growth in the number of staff employed, staff turnover resistance and sickness absence levels. All these measures are very positive for Buurtzorg.

Objective of the intervention

Buurtzorg is designed to improve patient outcomes, reduce costs and increase nurse and patient satisfaction. At its inception, Buurtzorg the Netherlands had three main goals:

- The client should have one well-educated caregiver for the coordination of all of his/her care with "as less hands as possible on the bedside".
- Buurtzorg-employees should have the professional freedom to provide generalist care.
- General practitioners should cooperate with "own" caregivers from Buurtzorg.

Professional group(s) targeted

Buurtzorg the Netherlands is a home care organisation that employs (community) nurses and community caregivers.

Level of the intervention

Organisational level. Buurtzorg the Netherlands operates at national level and is active across the entire country. It supports the Buurtzorg teams who work at regional level. The Buurtzorg teams operate on a regional basis and cover both urban and rural areas. They are active in delimited areas, ranging in size from a number of quarters in a neighbourhood to an entire neighbourhood. Ideally, a 'neighbourhood' consists of approximately 15.000 to 20.000 inhabitants with more than 17 percent over 65 years of age (Van Dalen, 2010).

Kind of services provided by Buurtzorg

Buurtzorg provides all home care that falls under the Dutch General Act on Exceptional Medical Expenses [in Dutch: Algemene Wet Bijzondere Ziektekosten, AWBZ] (De Blok & Pool, 2010). This includes all long-term home care for people with severe restrictions, including restrictions due to disability, chronic illness or old age.

Running time of the intervention

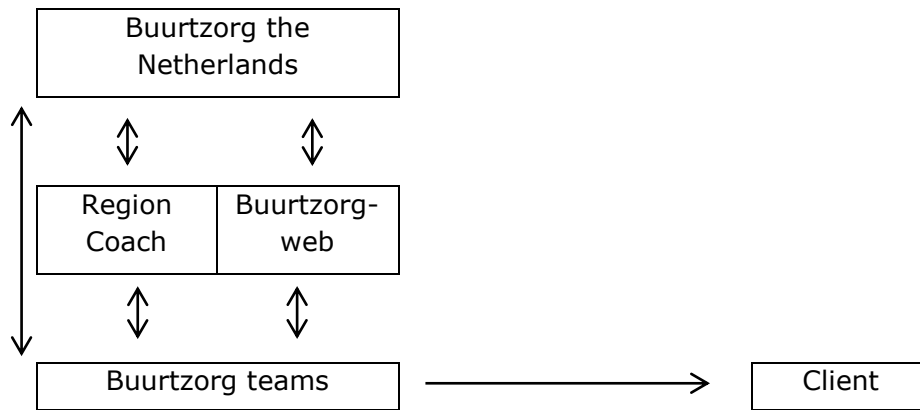
Buurtzorg the Netherlands was established in 2006. There is no expected end date.

Organisational framework

Buurtzorg the Netherlands is a non-profit organisation with a flat network organisation (Ernst & Young, 2009). The Board of Directors is formed by Jos de Blok. He is accountable to the supervisory board. Buurtzorg also has a client counsel and a procedure for participation of the employees (Van Dalen, 2010).

The overhead of this flat way of organising is limited. In 2013, the overhead comprises 30 persons, including the back office (financial administration, client administration, personnel administration and automation via the Buurtzorg-web), 15 coaches and two directors (De Blok, 2013). Financing, contracting, boundary conditions etc. are organised centrally and are removed as much as possible from the primary care process (Ernst & Young, 2009).

Figure 1 Organisational structure Buurtzorg the Netherlands



Central Buurtzorg the Netherlands office

The non-profit organisation Buurtzorg the Netherlands takes a number of administrative tasks, financing tasks and tasks related to being an employer off the hands of the Buurtzorg teams so that they can focus on providing high-quality care (De Blok & Pool, 2010).

Buurtzorg the Netherlands has no management team, no staff or policy department and no departments for PR and communication or staff & organisation/human resources (De Blok & Pool, 2010). When necessary, Buurtzorg consults and hires an external expert in the area of human resources or cooperation agreements.

When it comes to recruiting, selecting and training new team members, Buurtzorg teams have their own responsibility. They do this themselves, in conjunction with the Region Coaches.

Even though every team has the responsibility to track its own revenues and costs and calculate its own team result, Buurtzorg the Netherlands regularly organises workshops to support the teams on this point (De Blok & Pool, 2010). Since September 2010, Buurtzorg provides a number of training programmes based on its own vision. There are for example one year programmes on neighbourhood-centred working and quality with autonomy. There are also short-term courses, for example on working with the OMAHA-system (Pool & Mast, 2011). Buurtzorg the Netherlands also supports the teams by holding conversations about the required professional competencies for teams, and about the competencies that the individual nurses, carers and the team as a whole hold.

Buurtzorg the Netherlands also finances its employees' membership of the Dutch Nurses Association V&VN, the national professional organisation, and the use of the quality register Nurses & Carers.

Three percent of Buurtzorg the Netherlands' total budget is reserved for education and training purposes. Buurtzorg finances training and education that is being organised partly by Buurtzorg itself and partly in cooperation with local educational institutions. Additionally, employees receive a personal budget that they can spend at their own discretion.

Buurtzorgweb

Since January 1, 2008 all Buurtzorg teams are connected with Buurtzorg the Netherlands and with each other via the *Buurtzorgweb*, which contains a lot of information and which gives every team the space to report on- and to keep each other informed about the latest developments of clients. The Buurtzorgweb is developed by the company Ecare, which develops new ICT-concepts for healthcare. Ecare has adapted the Buurtzorgweb to the Buurtzorg way of working.

On the Buurtzorgweb, there is for example a digital version of the Homecare Information System [in Dutch: Wijkverpleegkundig Informatie Systeem] which supports the healthcare professional in the making of care plans (De Blok & Pool, 2010). The Buurtzorg Information System consists of five elements (Pool & Mast, 2011):

- The 'Experience gauger', a questionnaire with which the home care nurse can measure how the client experiences- and deals with his/her health problems: the client perspective;
- The Health Compass, this is an instrument with which the care load en need for support of informal carers can be measured, the client's network;
- OMAHA-classification system for obtaining nursing data: description of problems, interventions and outcomes;
- The Buurtzorg-file (i.e. care file), this file contains all required forms, including interim evaluations and final evaluation;
- Protocols, standards and work instructions.

Buurtzorgweb is an important source of information about training and education and about the expertise of colleagues all across the country (De Blok & Pool, 2010). Moreover, all team results are visible for all teams on Buurtzorgweb. Even though this creates a little bit of competition, it also gives teams the opportunity to learn from each other (De Blok & Pool, 2010).

Even though Buurtzorg web can be used for several purposes, including information sharing between Buurtzorg teams and team members, in 2011 it was found that it is mainly used for administrative tasks (Pool & Mast, 2011).

Region Coaches

Every Buurtzorg team has a Region Coach. All Region Coaches are originally nurses. They have no leadership function and do not have hierarchic- or result responsibilities (Van Dalen, 2010). The coach is explicitly not someone who transfers orders from the central office, but quite the opposite, tries to stimulate the self-efficacy of a team (De Blok & Pool, 2010). A fulltime working Region Coach supports on average 30 Buurtzorg teams.

The first two years that a team is running, the Coach contacts the team once every six to eight weeks (Van Dalen, 2010). During this period and afterwards, Region Coaches, on request, can consult teams about team functioning, expansion and splitting, application procedures and labour disputes (Van Dalen, 2010). Region Coaches also monitor the results of teams. They monitor the registered hours of a team on a monthly basis. The coach will never intervene, but, if necessary, will ask the team some questions and think about how to optimise certain things (Van Dale, 2010).

Buurtzorg teams

The creation and formation of a local Buurtzorg team is by definition an initiative of the community nurses and carers themselves (De Blok & Pool, 2010). Typically, a small group of community nurses who have worked together previously approach Buurtzorg the Netherlands with a request to be officially declared a Buurtzorg team. They are interviewed, during which they discuss their vision and goals to ensure that these align with Buurtzorg the Netherlands' philosophy. A week before a new team starts, they are invited to the Central Office in Almelo where they get a briefing, among others on how the Buurtzorgweb works, and a starter pack. Once a team signs a contract with Buurtzorg the Netherlands, it is given a stipend for office space (Monsen & De Blok, 2013). The team searches for office space itself and, if necessary, members restore the space themselves. The team members are employed by Buurtzorg and their salary is determined on the basis of the Collective Labour Agreement home care (Van Dalen, 2010).

A typical Buurtzorg team consists of a maximum of 12 community nurses, nurses and community carers (De Veer et al., 2008; Monsen & De Blok, 2013). Ideally, a team consists for 50 percent of home care nurses and for 50 percent of community carers (Van Dalen, 2010). Together, the team members fulfil 7,5 FTE (De Blok & Pool 2010). Team members are educated at Intermediate Vocational Education- level (Dutch: MBO) and Higher Vocational Education-level (Dutch: HBO); community carers (level 3-IG) and (community) nurses (level 4 and 5) (Van Dalen, 2010).

Buurtzorg teams are accessible 24 hours a day. They are active in delimited areas, ranging in size from a number of quarters in a neighbourhood to an entire neighbourhood. Ideally, a 'neighbourhood' consists of approximately 15.000 to 20.000 inhabitants with more than 17 percent of inhabitants over 65 years of age (Van Dalen, 2010). Buurtzorg teams provide care for 40 to 60 clients. When this number is exceeded, teams need to split up or a new team is created, so as to maintain the direct contact with clients and keep a good overview (Van Dalen, 2010).

At this moment, there are around 700 Buurtzorg teams active all across the Netherlands (De Blok, 2014).

Teams work autonomously and divide tasks among themselves. They are responsible for housing, planning, work schedules, holiday planning, administration, hiring new colleagues, calculate the team results, and so on (De Veer et al., 2008; De Blok & Pool, 2010). Moreover, they have team consultations, make a year plan and they conduct annual interviews with each other in which they, on the basis of competency lists that were partly prepared by themselves, discuss each other's functioning (Van Dalen, 2010). All teams have one or more coordinating community nurses who, in addition to their work as community nurse, also have responsibility for a number of coordinating tasks, such as the evaluation and monitoring of the team results and participation in application procedures. All other tasks are divided between the team members according to preference and experience (De Blok & Pool, 2010; Ernst & Young, 2009).

Buurtzorg teams are supported by Buurtzorg the Netherlands in several ways. Buurtzorg the Netherlands provides new teams with the opportunity to work with the

Solution oriented Interaction Method (in Dutch: Oplossingsgerichte Interactie Methode) and train their necessary skills. This way of working was developed by the Institute for Cooperation-questions and Buurtzorg teams can follow two sessions to get familiar with it (De Blok & Pool, 2010). Teams are also allowed to spend 3 percent of their wage on training and education; 1 percent on regular training and education provided by Buurtzorg, the other 2 percent can be spend by the team's own discretion. (Van Dalen, 2010). Moreover, Buurtzorg has developed a 'Team Compass' so that teams can monitor their own quality Pool & Mast (2011). The Team Compass has the following sections:

- Feedback of client experiences
- Quality of the care content (including consultations, training and education, etc.)
- 'Household' expenses
- Team roles and mutual connections

Cooperation Buurtzorg with other caregivers

Buurtzorg teams are usually able to establish good ways of cooperation with general practitioners and other professionals in primary care and hospitals very quickly. For a long time, that was not obvious. Transfer nurses and general practitioners had difficulties in setting up the right home care for their patients. With Buurtzorg, they can directly contact the home care nurse who is responsible for a patient's care and they can directly consult them (De Blok & Pool, 2010). The Buurtzorg way of working saves general practitioners time and it makes home care nurses quickly accessible. However, in 2008, general practitioners indicated that they would like to have consultations on a more structural basis with Buurtzorg as well (De Veer et al., 2008).

Subsidiary companies

Buurtzorg the Netherlands also established a number of subsidiary companies:

- Buurtdiensten [Neighbourhood Services]: provides all types of domestic help via small teams. Clients get a permanent employee. There are currently around 90 Buurtzorgdiensten teams active in the Netherlands (De Blok, 2014).
- Buurtzorg Jong [Neighbourhood Care Young]: helps families who have problems with raising children and young people aged 0-23 years. The autonomous, multidisciplinary teams provide professional assistance and support to help the families continue independently again. There are currently around 12 or 13 Buurtzorg Jong teams active in the Netherlands (De Blok, 2014).
- Buurtzorghuis [Neighbourhood Care House]: a place where patients who are severely ill and their families and friends can come for holidays. The Buurtzorg House also houses a hospice where patients can spend the final part of their lives.
- BuurtzorgT: provides care for people with psychiatric or psychological problems. Small teams provide treatment and (practical) support, both the patient and his/her environment. There are currently around 15 BuurtzorgT teams active in the Netherlands (De Blok, 2014).

Buurtzorg Pension: provides temporary stays for clients who, for a short period of time, are unable to live independently or who return from hospital.

Implementation strategy

Buurtzorg developed gradually and no use was made of a detailed implementation strategy.

Financing

Buurtzorg team costs

The start-up costs for a new Buurtzorg team are approximately €25.000 (Van Dalen, 2010). These costs are financed out of the exploitation and fetched by already existing Buurtzorg teams.

In 2009, the Dutch Transition Programme Long-Term Care provided an overview of the costs involved for a typical Buurtzorg the Netherlands team (representative for all Buurtzorg teams and neighbourhoods) (Ernst & Young, 2009):

- Direct costs: expenses for salary, travel, education and other personnel expenses of the executive staff.
- Direct attributable costs: local housing costs and the costs for coaches, allocated on the basis of the team's annual number of client hours.
- Overhead: all 'central' costs, including personnel costs for the board and administrations, automation costs, general costs, depreciations, costs of central housing, and so on.

Table 1: Financial structure typical Buurtzorg team

Description	Costs (per hour)	Description	Income (per hour)
Staff	€26	Exceptional Medical Expenses Act (AWBZ)	€57
Productivity 60%	€44		
IT	€2		
Housing	€2		
Transport	€2		
Overhead	€4		
Total	€54	Result	€3

Table 1 shows the financial structure of a typical Buurtzorg team, which results in a positive result of €3 per hour of care provided.

Financial results Buurtzorg The Netherlands

Buurtzorg the Netherlands has shown fairly consistent positive financial results. In 2008 and 2009 a solvability of 1,3% resp. 1,6% was achieved. Moreover, gross turnover numbers have increased exceptionally since the establishment of Buurtzorg in 2006. This has led to net profits in most years, but in 2013 a net loss of €600.000 was reported. According to Buurtzorg itself, this is due to a modified policy of some Dutch health insurers who do not reimburse Buurtzorg's overproduction. In the Netherlands, production agreements are made between health insurers and care providers. If the care provider produces more care than agreed upon, then this 'overproduction' is the care provider's own risk and comes on the provider's own account. Moreover, Buurtzorg participated in the 'Few Rules Experiment' (ERAI) and much of the care that was provided within the ERAI projects was considered

'overproduction' by the care agencies. Additionally, Buurtzorg invested in Ipads (Zorgvisie, 2013).

Table 2: Solvability Buurtzorg 2007-2009

	2007	2008	2009
Total incomes financial year	1.045.084	€11.708.296	€40.632.908
Results financial year	- €29.613	€184.035	€509.378
Total own capital	- €30.160	€153.875	€663.253
Solvability (own capital/revenues)	-2,89%	1,31%	1,63%

Source: Van Dalen, 2010

Table 3: Gross turnover and net profit

Year	Gross turnover	Net profit
2007	1 million Euro	
2008	12 million Euro	
2009	40 million Euro	
2010	83 million Euro	
2011	129 million Euro	5,5 million Euro
2012	183 million Euro	13,6 million Euro
2013	230 million Euro	- €600.000

Source: De Blok, 2013

Conditions for replicability

Necessities:

- Autonomous working teams with driven professionals who do their job with an eye for the context
- A network organisation which can flexibly adapt itself depending on the support needs of the teams
- Availability of coaches who can help solving the practice dilemma's that every team will face at a certain point in time (De Blok & Pool, 2010).

Buurtzorg Advice

Buurtzorg the Netherlands has received quite some attention and interest from other (home)care organisations both nationally and internationally and also from organisations operating in other sectors, such as education and the police. These organisations are interested in making the 'Buurtzorg model' or parts of the Buurtzorg model, suitable for their own organisation. Buurtzorg and the ICT-company Ecare are regularly consulted by these organisations. Therefore, in 2011, Buurtzorg the Netherlands, Ecare Services and the Dutch Institute for Cooperation Issues established 'Buurtzorg Advice to better serve interested organisations.

In 2011, Jos de Blok told in an interview (Nieuworganiseren, 2011) that: "It is not very effective for organisations if they only do ICT or only take over the model. You have to start with the question what you really want. Because else, it becomes some sort of trick and that won't work. So you have to get it and make some conscious choices. And from there you can say whether you want to do certain things this way or that way. There is flexibility, in that sense that you can adapt the model to the circumstances of the organisation. But the ingredients need to be there, else you

better shouldn't do it. We do not want to make money with 'Buurtzorg Advice', we want to make a structural change."

Replications of Buurtzorg the Netherlands

Over the last years, Buurtzorg has been replicated to a greater or lesser extent in other (home care) organisations in the Netherlands, but also in Belgium (Wit-Gele Kruis Oost-Vlaanderen and Wit-Gele Kruis Vlaams-Brabant, see case reports 5.2 and 5.3, and the province of Limburg), Sweden (see case report 5.4), Minnesota, USA and Japan (Buurtzorg USA, 2014; NOS, 2014).

While some countries decided to replicate the Buurtzorg way of working, many more countries have shown an interest to do so, including: China, Korea, Switzerland, England, Scotland, Canada, Germany, Turkey, the Czech Republic, Norway and Finland. Hence, there is loads of interest in the concept (De Blok, 2014). Buurtzorg never approaches countries itself to promote its way of working, it is always asked for help or advice. Moreover, when countries or people are interested from a commercial perspective, Buurtzorg does not participate. Buurtzorg the Netherlands is a non-profit foundation and it focuses on the intrinsic motivations of people, not commercial reasons (De Blok, 2014).

The most important questions that countries who are thinking about introducing the Buurtzorg way of working have is: how can this way of working be introduced within the context of that particular country? Taking into account the legal rules, financing rules, et cetera? In all countries where Buurtzorg Netherlands has explained the Buurtzorg way of working, it is generally pretty clear for nurses and doctors how things are arranged. Thinking from the profession and the client perspective, nurses and doctors generally think it is a good idea. The question then becomes; the way of financing is different, how to arrange that? Each country has to find its own way in arranging this. Often, Buurtzorg and the interested parties in the respective country investigate these issues jointly. Buurtzorg supports the local people through GPs, nurses, coaches, the IT-support and often Jos de Blok is involved as well. As Buurtzorg explains, you need people in the other country who know the system. However, a big risk is that people start arguing on the basis of the existing system. Buurtzorg tries to say; look inside the system to see how you can apply the Buurtzorg way of working within the existing system, taking into account how things are arranged. One needs some creativity to do this.

Because Buurtzorg is involved in this process in multiple countries, it gains experience and knowledge on how you can use the concept in different contexts. Buurtzorg gets familiar with different financing systems, the histories of how healthcare has developed in countries. "You learn to devise something that fits the history and the culture of that country" (De Blok, 2014).

Different contexts

For other countries that are also thinking about introducing the Buurtzorg way of working, a number of issues are of crucial importance, as director Jos de Blok explains:

- The concept needs to be understood and supported by the top of organisations as well. When a manager does not get it and only parts of the concept are being introduced, and compromises are being made, organisations will never obtain the advantages of this way of working.

- The legal system in place
- The financial system in place

According to Jos de Blok, it should be possible to introduce the Buurtzorg way of working in a fairly similar way across different contexts. It shouldn't differ too much between different contexts. He does note, however, that for example the culture in the USA surrounding legal regulations, the 'claim culture', leads to a careful way of working. Where in Sweden, the home care nurse that started Grannvard Sverige just started working and arranging things, the development of Buurtzorg US was a much slower process, because of the carefulness in which things needed to be arranged first, et cetera. But this is a difference that originates from the culture and behaviour. In principal, the Buurtzorg way of working can be introduced in both contexts.

Moreover, the problems of clients are the same across all countries that showed an interest. What you can do about that could also be the same. Only if you look at the way things are being arranged in countries, how things are being financed, how many rules there are, then you see (considerable) differences between the countries (De Blok, 2014).

IT-system

For countries that are also thinking about introducing the Buurtzorg way of working, it is crucial to also have a similar IT-system. By introducing a self-steering way of working, the communication patrons, the way information is being shared and administration arranged, are all things that take place in a different way than usual within an organisation. The IT-infrastructure is then of crucial importance, because the whole back-office is organised in a different way. In Sweden, Buurtzorg and Grannvard are currently working on which elements of Buurtzorg's Buurtzorgweb (the internal IT-system) can be used in Sweden and which parts need to be country-specific. Communication and knowledge are predominantly generic parts of the programme that are being translated into modules, so that they can also be used in countries other than the Netherlands. When it comes to declarations and administration, which are very country-specific, Buurtzorg tries to cooperate with partners from the respective country. Although at the same time, Buurtzorg tries to influence the discussion within countries on how these things can be arranged.

Buurtzorg the Netherlands invested money to develop its own IT-system Buurtzorgweb. When other countries are going to use (part of) the system as well, arrangements are being made about a certain financial reimbursement. This is kind of a franchise light construction, in which organisations make use of the knowledge and possibilities of Buurtzorg NL and its IT-support, and Buurtzorg receives a certain reimbursement in return. Once organisations start using the Buurtzorgweb, a certain license agreement is signed and paid, in which countries can use the IT-system for an x number of years (De Blok, 2014).

3. Results of the intervention

As said before, Buurtzorg was not originally introduced as a recruitment and/or retention intervention. However, since its introduction, it has proven to be very effective in both areas. Proxy measures include the growth in the number of staff employed, staff turnover resistance and sickness absence levels.

Proxy measures

Number of Buurtzorg Teams and employees:

Buurtzorg has grown ever since its establishment in 2006 (see table 4). Throughout the years, the breakdown by educational level of all employees remains the same; approximately one third of all employees are community nurses, one third are nurses and one third are community carers (Buurtzorg, 2012).

Table 4: Number of Buurtzorg Teams and employees

Year	Teams	Employees
2007		100
2008		1000
2009		2000
2010		3000
2011	430	4500
2012	530	6000
2013	698	7600
2014	700	

Source: De Blok, 2013; 2014

Turnover

In 2013, the turnover-resistance of Buurtzorg was scored 9,3 (out of 10) by its employees, making it both an effective recruitment and retention intervention (Effectory, 2014a).

Sickness absence

The average percentage of sickness absence for Buurtzorg is slightly lower than two per cent. The average percentage in the home care branch is 6,5 percent (Ernst & Young, 2009).

Prices and awards:

Buurtzorg the Netherlands won the Effectory award for 'Best Employer' (with more than 1000 employees) twice in a row in 2011 and 2012, was runner-up in 2013 and won again in 2014. This title is awarded on the basis of independent employee surveys among at least 300 employees in each organisation (Effectory, 2014a). In the category 'Best Employer in Healthcare' Buurtzorg has ended on the first place for four years in a row; in 2011, 2012, 2013 and 2014 (Effectory, 2014b).

For five years in a row (2009- 2013), Buurtzorg Nederland has received the *Golden Gazelle Award* of the Dutch Financiële Dagblad (Financial Journal) for being the fastest growing big company in the East of the Netherlands (FD, 2013).

In 2012, the magazine 'Management Team' elected Jos de Blok, one of the founders of Buurtzorg Nederland, as 'Gamechanger' of 2012. This is an award for the most innovative contribution to healthcare (Management Team, 2012).

Client numbers

The number of clients has increased ever since the establishment of Buurtzorg in 2006. In 2012, Buurtzorg teams cared for 45.000 clients annually. In 2013, this number had climbed to 55.000 clients on annual basis. Client satisfaction is high; in 2012 and 2013 clients rated Buurtzorg with a 9.1 (on a scale of 10) (Buurtzorg 2012; Buurtzorg 2013).

References

Buurtzorg (2012). *Jaarekening 2012*. Stichting Buurtzorg Nederland.

Buurtzorg (2013). *Jaarekening 2013*. Stichting Buurtzorg Nederland.

Buurtzorg USA (2014). The History of Buurtzorg. <http://buurtzorgusa.org/about.html> (accessed: 29-10-2014)

De Blok, J. (2013). *Buurtzorg*. Presentation at KPMG.

De Blok, J. (2014). Telephone interview for Recruitment & Retention study. November 2014.

De Blok, J. & Pool, A. (2010). *Buurtzorg: menselijkheid boven bureaucratie*. Den Haag: Boom Lemma uitgevers.

De Veer, A.J.E., Brandt, H.E., Schellevis, F.G., & Francke, A.L. (2008). Buurtzorg: nieuw en toch vertrouwd. *Een onderzoek naar de ervaringen van cliënten, mantelzorgers, medewerkers en huisartsen*. [Care in the neighbourhood. A study about experiences of clients, care staff and general practitioners involved]. Utrecht: NIVEL.

Effectory (2014a). *Stichting Buurtzorg Nederland*. <http://www.beste-werkgevers.nl/beste-werkgevers/plus1000/stichting-buurtzorg-nederland/> (accessed: 08-07-2014).

Effectory (2014b). *Beste Werkgevers 2014 - ANP*. <http://www.beste-werkgevers.nl/evenement/videos/beste-werkgevers-2014---anp/> (accessed: 08-12-2014).

Ernst & Young (2009). *Maatschappelijke Business Case Buurtzorg Nederland*. Report by Ernest & Young. <http://www.transitiepraktijk.nl/files/maatschappelijke%20business%20case%20buurtzorg.pdf> (accessed: 08-07-2014)

Financieel Dagblad (2013). *FD Gazellen 2013*. <http://fd.nl/events/fdgazellen/442262-1311/fd-gazellen-2013-arends-techniek-grootste-groeier-in-noord-nederland> (accessed: 16-07-2014)

Friese Wouden (2014). Financiering thuiszorg. <http://www.friesewouden.nl/thuiszorg/financiering> (accessed: 25-08-2014)

KCE (2010). Financiering van de thuisverpleging in België. KCE Reports 122A. Brussel: Federaal Kenniscentrum voor de Gezondheidszorg.

- Management Team (2012). *Jos de Blok Gamechanger 2012*.
<http://www.mt.nl/1/67629/home/jos-de-blok-gamechanger-2012.html> (accessed: 08-07-2014)
- Ministry of Health, Welfare and Sport (2011). *Health Insurance in the Netherlands*. Den Haag: Ministry of Health, Welfare and Sport.
- Monsen, K. & De Blok, J. (2013). Buurtzorg Nederland. *AJN The American Journal of Nursing*, 113(8), 55-59.
- Nieuworganiseren (2011). Buurtzorg geeft advies.
<http://www.nieuworganiseren.nu/netwerk/buurtzorg-geeft-advies/> (accessed 17-07-2014)
- NOS (2014). Nederlandse buurtzorg voor vergrijzing in Japan.
- Pool, A. & Mast, J. (2011). *Eerst buurten, dan zorgen. Professioneel verplegen en verzorgen bij Buurtzorg*. Den Haag: Boom Lemma uitgevers.
- Van Dalen, A. (2010). *Uit de schaduw van het zorgsysteem: Hoe Buurtzorg Nederland zorg organiseert*. Den Haag: Boom Lemma uitgevers.
- Zorgvisie (2010). *Buurtzorg Nederland groeit 3683 procent*.
<http://www.zorgvisie.nl/Home/Nieuws/2010/11/Buurtzorg-Nederland-groeit-3683-procent-ZVS009805W/?intcmp=terug-naar-artikel> (accessed 08-07-2014)
- Zorgvisie (2013). *Buurtzorg leidt verlies van 0,6 miljoen euro*. Zorgvisie.

Appendix 5.2. Case report 5.2

Topic 5. Providing good working environments by putting professional autonomy & worker participation first

Case 5.2. The self-managing teams of the home care organisation *Wit-Gele Kruis Oost-Vlaanderen*, Belgium



Research methods applied:

Desk research: August – September 2014

Case site visit: September 2014

1. Summary of the intervention – Self-managing teams of the home care organisation WGK Oost-Vlaanderen

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Personal and professional support/autonomy
Professional group(s) targeted	Nurses and nursing auxiliaries
Level of intervention	Organisational level
Type of organisation	Non-profit home care organisation
Kind of services provided by organisation	Home care
Size of organisation	Large (1.550 employees)
Area covered	The province of Oost-Vlaanderen, Belgium
Intervention period / duration of intervention	Per January 2014, first six 'expedition teams' started working as 'self managing teams'. There is no expected end date.
Key actions	Providing home care via 'self managing teams'. Teams work autonomous, divide tasks among themselves, and the function of head nurse is removed.
Financial investment	Additional financing is required to introduce the new way of working via self-managing teams. WGK Oost-Vlaanderen was able to acquire limited funding for this.
Implementation strategy or processes used	WGK Oost-Vlaanderen prepared itself for the introduction of self-managing teams by looking for inspiration at Buurtzorg. Subsequently, the new way of working was communicated to all employees. An incremental phased implantation strategy was adopted, taking approx. 2 years. During the first phase, six teams started working in the new way. In the second phase, 30-35 teams followed. Afterwards, all teams will follow.
Personnel investment	Additional HR is required. WGK Oost-Vlaanderen hired an external consultant. Moreover, head nurses disappear but the function of 'team coach' is introduced.
Outcome measures of the intervention	WGK will monitor whether the new way of working appeals to young people, i.e. leads to higher retention rates. It is too early to

	say something about this at this point. In September 2014, WGK received the 'Award for Care Organisation 2014' for its innovative way of working via self-managing teams.
--	---

2. Rich description of the intervention

Case under study

The self-managing teams of the Wit-Gele Kruis Oost-Vlaanderen that are being introduced in a phased way in the organisation since the beginning of 2014. The new way of working was strongly inspired by the Dutch Buurtzorg concept.

Reasons for the introduction of self-managing teams within the WGK Oost-Vlaanderen

The WGK Oost-Vlaanderen wants to be prepared for the future of home care nursing.

Objective of the intervention

The most important goal for the WGK Oost-Vlaanderen is to offer 'total care'. Self-management is therefore not an end in itself for the WGK Oost-Vlaanderen, but a means to provide total care (Colman & Van Landuyt, 2014). Nonetheless, with the introduction of self-managing teams, the WGK Oost-Vlaanderen aims to increase the involvement of its nursing and caring staff and thereby increase their job satisfaction. Through the use of self-managing teams, staffs keep ownership over the primary care process (WGK OV, 2013). The WGK Oost-Vlaanderen wants to introduce an innovative and productive work organization method within the organisation (ESF, 2014).

Type of intervention

By introducing self-managing teams, the WGK Oost-Vlaanderen hopes to recruit and retain (especially younger) staff by providing them with more ownership over the primary care process (Colman & Van Landuyt, 2014).

Professional group(s) targeted

The Wit-Gele Kruis Oost-Vlaanderen is a non-profit home care organisation that employs nurses (about two third associate level A2 nurses and one third bachelor's level A1 nurses) and nursing auxiliaries (in Dutch: zorgkundigen, people who are educated specifically to support nurses, under supervision of the nurse) (Colman & Van Landuyt, 2014).

Level of the intervention

Organisational level.

Area covered

The province of Oost-Vlaanderen, Belgium. The WGK Oost-Vlaanderen is active at provincial level across the entire province of Oost-Vlaanderen. It operates via 29 local departments.

Kind of services provided by the WGK Oost-Vlaanderen

WGK Oost-Vlaanderen provides home care for all inhabitants of the province of Oost-Vlaanderen. This includes all short- and long-term home care for young and old people with acute and/or chronic conditions.

Running time of the intervention

In the autumn of 2013, the first of six so-called 'expedition teams' of the WGK Oost-Vlaanderen started working as self-managing teams. On the first of January 2014, the other five expedition teams followed. It is expected that a second group of 'expedition teams' will start working in the new way in February/March 2015 and subsequently all staff will follow (Colman & Van Landuyt, 2014). There is no expected end date to the intervention.

Implementation strategy

The implementation strategy that WGK Oost-Vlaanderen is using for the introduction of self-managing teams within the organisation is characterised by its rigor. It was devised well in advance and has a phased approach.

Inspiration via Buurtzorg the Netherlands

Buurtzorg the Netherlands was an example for the WGK Oost-Vlaanderen in the introduction of self-managing teams, but explicitly no blueprint. The WGK Oost-Vlaanderen has talked to Buurtzorg the Netherlands for several years, has gathered inspiration, conducted work visits to the headquarters of Buurtzorg, it met with a Buurtzorg team coach and it met Ben Wenting of the Institute for Cooperation Issues. The goal of this preparation for WGK Oost-Vlaanderen was to make use of the methodology, philosophy and experience that Buurtzorg the Netherlands had already gained in working with self-managing teams (Colman & van Landuyt, 2014).

Inspiration via other resources

While Buurtzorg the Netherlands was a big help for the WGK Oost-Vlaanderen, preparation also included literature research and visits to other organizations that introduced the self-managing way of working, such as Volvo and other major nursing organizations *Amstelring* and *Zorgaccent*. Furthermore, the directors at the WGK Oost-Vlaanderen followed specific courses, such as unifying leadership, value-oriented negotiating and dealing with change. In addition, Tom van Acker, a senior consultant in innovative work organization of Flanders Synergy and expert in labour innovation, provided the WGK Oost-Vlaanderen with help in developing and introducing the self-managing teams (Colman & Van Landuyt, 2014).

Communication to employees and other external parties

WGK Oost-Vlaanderen communicated a lot about the introduction of its self-managing teams. Both to its employees and external partners. Communication included:

- Think- session organised in Flanders Expo; a round table with different stakeholders, including patients, carers, healthcare professionals, educational institutions etc., to jointly think about the future of home care nursing.
- Communication with 1.600 employees via interactive company theatre.
- Soapbox sessions were organised, based on a recommendation by the consultant of Flanders' Synergy. Director of care Katalien Dendooven and general manager Katlyn Colman visited all departments to tell about what the aims are of the WGK.

- 'Good for each other' sessions; each month 60 employees were invited to the main office to directly talk with the management. During these sessions, the first six 'expedition teams' shared their experiences.
- Four times a year coverage in staff magazine.
- A movie was shot of the 'expedition teams'.
- Information sessions with external contacts such as hospitals.

Introduction within the organisation

In January 2013, the new way of working via self-managing teams was introduced to the 1.550 employees of the WGK Oost-Vlaanderen via interactive company theatre (WGK OV, 2013). WGK Oost-Vlaanderen is using an incremental phased implantation strategy for the introduction of self-managing teams within its organisation. It has established a timeframe for the introduction that roughly runs from the beginning of 2013 until the end of 2015. Moreover, while the broad lines are outlined by the management of the WGK Oost-Vlaanderen, the details are filled in by its employees in practice. That is also why at the beginning of 2013, five working groups were established, each with an own task (WGK OV, 2013):

Working group structure

This working group engages in how the ideal self-managing team should be built-up.

Working group human

This working group deals with the question what knowledge and skills need to be able to work in self-managing teams and how the organisation can support them in this.

Working group culture

This working group focuses on how to engage everyone in the new way of working and deals with internal and external communication.

Working group systems

This working group checks – from a primary care process perspective – which ICT-systems are needed to support the self-managing teams.

Working group outside world

This working group meets with experts from the care sector and tests ideas with them and consults with the right care partners.

First phase of introduction – six expedition teams

Because the introduction of self-managing teams within an existing organization is disruptive, the WGK Oost-Vlaanderen decided not to implement this change all at once. They started a first 'test phase' with six 'expedition teams' that would be the first ones to start working under the principle of self-managing work. These teams could nominate themselves. In the end, six teams from four departments were chosen as 'expedition teams' by the Board of the WGK Oost-Vlaanderen.

Besides the disruptiveness argument, another reason for this phased introduction approach was that at board level the WGK Oost-Vlaanderen knew where it wanted to go, but it wanted to invent the actual practicalities of how to get there along with the nurses and health care experts (Colman & Van Landuyt, 2014).

In autumn 2013, the six expedition teams of nurses and carers started preparing to try out the new way of working. They received instructions and six preparation meetings were being organised with the management board. Many issues were discussed during these meetings, such as which tasks belong to the team and which not, role divisions, care vision, and so on. Teams were also asked what they felt they needed in order to start working as self-managing teams.

From January 2014 onwards, all six started working in self-managing teams and along the way tested and evaluated this new way of working. Again, meetings with the management board took place. Based on the experiences of these expedition teams, the primary process and the new way of working were evaluated at management level as well (WGK OV, 2013; Colman & Van Landuyt, 2014).

Second phase of introduction – 30 to 35 expedition teams

The WGK Oost-Vlaanderen is currently preparing the second phase of the introduction of self-managing teams. During this second phase, the aim is that 30 to 35 teams become 'expedition teams', at least one team from each of the 30 departments. The number of 35 is the maximum, because the WGK Oost-Vlaanderen wants to make sure that it can support each team in an appropriate way. Teams can nominate themselves. Each application will then be reviewed by the management board and will be reviewed on things as motivation, geographical location, occupation regimes versus work in the region, and so on. Once the next wave of expedition teams is chosen, they will be prepared for working as self-managing teams in various preparatory meetings. The next range of expedition teams is planned to start operating in February or March 2015.

As said before, first six expedition teams originated from departments of the WGK Oost-Vlaanderen. The aim is that all teams within these departments will start working as self-managing teams during the second phase of the implementation.

In general, the signals that come from the departments are good. However, among a small number of departments there is some resistance against the idea of working as self-managing team (Colman & Van Landuyt, 2014).

Third phase of introduction – all teams

In 2015, preparation sessions will be organised for all teams to prepare them to start working as self-managing teams (Colman, 2013).

Organisational framework

The Wit-Gele Kruis Vlaanderen is the Federation of the five autonomous Flemish provincial Wit-Gele Kruis associations that organise home nursing. Both the Federation and the provincial associations have the status of non-profit association. It should be noted that the Wit-Gele Kruis Vlaanderen has no hierarchical power over the five provincial associations. It serves as an umbrella employers' organisation and acts as representative, advocate and negotiator at federal and Flemish level for the collective interests of the five provincial Wit-Gele Kruis- associations, of which the WGK Oost-Vlaanderen is one.

The WGK Oost-Vlaanderen is an organisation which has responsibility for 1,600 employees and 40,000 patients annually (Colman & Van Landuyt, 2014). In 2013, the WGK Oost-Vlaanderen had 16.824 patients on average per month and a total of 4.468.632 patient visits were conducted (WGK Oost-Vlaanderen, 2013).

Self-managing teams

In redesigning the organization of care provision, the WGK Oost-Vlaanderen has the premise that tasks which are no longer logically organized or processes that no longer run efficiently should be reviewed. Even if this means that existing functions will disappear, such as the head nurse. Naturally, it is then determined where the tasks, that still deserve a place in the new way of working, can best be placed.

Head nurse disappears and is replaced by team coach

One of the significant changes that the WGK Oost-Vlaanderen is making is that the function of head nurse disappears. Instead of a head nurse, each team will have a 'team coach', who helps the team to achieve shared leadership for all team members. Each team coach (1 FTE) supports approximately 10 teams. The team coaches have been trained by the Dutch Institute for Cooperation Issues, which also provides training for the teams and coaches of Buurtzorg the Netherlands (Colman & Van Landuyt, 2014).

The function of the team coach is to support the teams, solicited and sometimes unsolicited, in working in a self-managing way. The support concerns the way of working and not so much the content of the work. The function of the team coach is explicitly supportive and not controlling. The result areas of the team coach are (Colman, 2013):

- coach and support team members
- raise issues which prevent good team performance
- provide a safe environment (ask questions and discuss errors)
- help without judging
- identify trends in team management
- to network

Role holders within teams

The task that all members of self-managing teams share is to provide care to the patient. But the other tasks, such as administrative tasks, going through intranet information, preparing staff planning, and so on, can be taken up by one of the team members. He or she then becomes the 'role holder' for that task. The essence is that the team members discuss with each other who takes up which tasks, come to agreement and review the division of tasks at least once a year. This ensures that tasks become not again embedded in persons or functions (Colman & van Landuyt, 2014). The 'role holder' within a team is a contact person who fine-tunes with the team members and others issues around his/her task (Colman, 2013).

Barriers in the introduction and running of the self-managing teams

Based on the results of the first six expedition teams, it turned out that one of the things that is difficult for the teams is discussing during meetings and jointly reach decisions. This became evident during the follow-up sessions that the management had with the teams. The Dutch Institute for Cooperation Issues has 'meetings and solution-oriented thinking' as one of its standard trainings in its training package. The first teams have now received training and it is expected that this will improve their ability in discussing and reaching joint agreements.

Facilitators in the introduction and running of the self-managing teams

It helped the WGK Oost-Vlaanderen to have Buurtzorg the Netherlands as inspiration for the introduction of self-managing teams. It was not only helpful to look at the methodology, philosophy and experience of Buurtzorg the Netherlands, but also to convince the government board of the WGK Oost-Vlaanderen of the added value of self-managing teams. On the basis of the results of Buurtzorg the Netherlands, it could be proven that it works. In addition, Buurtzorg the Netherlands acts as a mental support. The WGK Oost-Vlaanderen is an organisation which has responsibility for 1,600 employees and 40,000 patients annually. The introduction of working in self-managing teams is disruptive to an organization and it is good to have the support of Buurtzorg and to know that it works well in the Netherlands (Colman & Van Landuyt, 2014).

Finances

For introducing self-managing teams, the WGK Oost-Vlaanderen received € 100,000 funding from the European Social Fund. But that is not even close to the costs that an organization the size of WGK Oost-Vlaanderen has got to make to introduce a new way of working (Colman & Van Landuyt, 2014).

Factors that influence successfulness of replicating this intervention

- The Belgian context differs from the Dutch context. There is a different way of financing home care, different labour laws, etc.
- The Dutch culture differs from the Belgian culture: the Netherlands has a more open feedback culture, which influences how self-managing teams operate.
- Buurtzorg the Netherlands started from scratch, the WGK Oost-Vlaanderen is making changes in an existing organisation; this is a completely different way of working.
- The support of an adviser from Flanders Synergy, an organisation which aims to make organisation more effective and helps them change to an innovative work organization.
- It was beneficial to have Buurtzorg as an example to convince the government board of the WGK Oost-Vlaanderen of the added value of self-managing teams. On the basis of the results of Buurtzorg the Netherlands, it could be proven that it works.
- Having an example as Buurtzorg the Netherlands has also been important in introducing the new way of working with self-managing teams. It was important for the WGK Oost-Vlaanderen that it could make use of the methodology, philosophy and experience that Buurtzorg the Netherlands had already gained in working with self-managing teams. No need to reinvent the wheel.

3. Results of the intervention

Working with self-managing teams was not introduced with the primary aim to increase recruitment and retention of staff. However, as said before, with the introduction of self-managing teams, the WGK Oost-Vlaanderen aims to increase the involvement of its nursing and caring staff and thereby increase their job satisfaction.

Results related to recruitment and retention

The WGK Oost-Vlaanderen has a relatively experienced workforce with an average age of 41 years in health care workers. It is therefore a challenge to attract and retain young staff. The WGK Oost-Vlaanderen will monitor specifically whether the new way of working appeals to young people. If so, then that should result in a higher retention of young employees. However, it is too early to say something about this at this point.

Proxy measure

In September 2014, the WGK Oost-Vlaanderen received the 'Award for Care Organisation 2014' from the European care think tank PRoF for the trajectory it started in introducing innovative way of working via self-managing teams (HLN, 2014).

References

Colman, K. (2013). Presentatie 'Goed voor mekaar'.

Colman, K. & Van Landuyt, D. (2014). Interview for R&R study during case site visit, 09-09-2014.

Europees Sociaal Fonds (2014). *Organisatie van de toekomst*. <http://www.esf-agentschap.be/nl/projectenkaart/organisatie-van-de-toekomst> (accessed: 31-10-2014).

Het Laatste Nieuws (2014). *Wit-Gele Kruis in de prijzen*. <http://www.hln.be/regio/nieuws-uit-aalst/wit-gele-kruis-in-de-prijzen-a2034195/> (accessed: 10-11-2014).

Wit-Gele Kruis Oost-Vlaanderen (2013). Jaaverslag 2013. Alle puzzelstukjes doen passen.

Wit-Gele Kruis Oost-Vlaanderen (2014). *Dienstverlening*. <http://www.wgkovi.be/fb111gegb459ocn1oan10.aspx> (accessed: 31-10-2014).

Appendix 5.3. Case report 5.3

Topic 5. Providing good working environments by putting professional autonomy & worker participation first

Case 5.3. The self-managing 'We Care Teams' of the home care organisation *Wit-Gele Kruis Vlaams-Brabant*, Belgium



Research methods applied:

Desk research: July-August 2014

Telephone interview: July 2014

1. Summary of the intervention – ‘We Care Teams’ Wit-Gele Kruis Vlaams-Brabant

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Personal and professional support/autonomy
Professional group(s) targeted	(Community) nurses, reference nurses and carers
Level of intervention	Organisational level
Type of organisation	Non-profit home care organisation
Kind of services provided by organisation	Home care
Size of organisation	Large
Area covered	The province of Vlaams-Brabant, Belgium
Intervention period / duration of intervention	The ‘We Care Teams’ have been in operation since February 2013. There is no expected end date.
Financial investment	Additional financing is required to introduce the new way of working via self-managing teams. WGK Vlaams-Brabant was able to acquire funding for this.
Implementation strategy or processes used	The WGK Vlaams-Brabant introduced the new more autonomous way of working via ‘We Care Teams’ to the different professionals in the organization in a phased approach. An external coach supported the implementation of the self-managing teams. All teams started working as We Care Teams at the same moment.
Day-to-day running of the intervention	We Care Teams are jointly responsible for the overall process in which services are provided to clients.
Likelihood of acceptance and/or uptake of the intervention by different groups of stakeholders	With the introduction of We Care Teams, a significantly different way of working has been introduced. This may have led to some nurses leaving while others were attracted. Other stakeholders (e.g. clients, health insurers) will notice little of the change.
Personnel investment	There are currently 70 We Care teams active across the province of Vlaams-Brabant.

<p>Outcome measures of the intervention</p>	<p>The WGK Vlaams-Brabant has prioritized indicators to determine the success of the We Care Teams, including turnover rates and staff satisfaction levels. No firm conclusions can yet be drawn about the effectiveness on retaining (and recruiting) staff. A proxy measure is the sickness absence level, but no significant difference is visible in this since the introduction of the We Care Teams.</p>
---	--

2. Rich description of the intervention

Case under study

The 'We Care Teams', the self-managing home care teams of the home care organisation Wit-Gele Kruis Vlaams-Brabant that have been in operation since February 2013. They were inspired by the Dutch Buurtzorg-model.

Reasons for the establishment of We Care Teams

There were two main reasons why the WGK Vlaams-Brabant decided to introduce the principle of self-managing working via the 'We Care Teams':

1. Previously, the province of Flemish Brabant was divided into twenty local WGK departments. In 2012, the WGK Vlaams-Brabant chose to match its departments with the 14 Local Multidisciplinary Networks of general practitioners (Nursing, 2013). This meant that the number of departments was reduced from 20 to 14 and head nurses were forced to lead much bigger teams from 40 to 50 persons (this was an increase of more than 30% compared to the old situation in which teams would consist of a maximum of 30 people). Because this requires a different way of management, it was clear that a modified model of working was needed (ESF, 2014).
2. Next to that, the WGK Vlaams-Brabant was struggling to retain its staff. As the demand for staff in Flanders is large, it is easy for staff to change jobs. The WGK Vlaams-Brabant was therefore searching for ways to retain its staff.

Both of these developments have led to the introduction of self-managing professionally autonomous working home care teams, the so-called 'We Care Teams'. This decision was also based on the literature, which shows that self-managing teams lead to higher levels of job satisfaction. Moreover, as Director of Care Veroniek Rooryck explained, this way of working fits with how young people look at their work (Rooryck, 2014).

Type of intervention

By introducing the We Care Teams, the WGK Vlaams-Brabant hoped to retain its staff by providing them with more professional autonomy. There are also signs that the We Care Teams are an attractive factor for newly graduated nurses (Rooryck, 2014).

Objective of the intervention

Several goals were pursued with the introduction of the self-managing We Care teams. The goal of introducing self-managing teams works on several levels (WGK VB, 2012):

- WGK Vlaams-Brabant wants to achieve an increased commitment and motivation of its employees;
- WGK Vlaams-Brabant wants to be an attractive employer and consider the home care nurse as a full professional;
- WGK Vlaams-Brabant wants to reduce the workload of head nurses and deputy head nurses.

The We Care Teams were introduced with the goal of increasing staff involvement by giving staff more autonomy, a better work-life balance, more involvement in policy choices, more space to develop their own individual competences and create a labour situation that is as attractive as possible (Nursing, 2013). By increasing staff involvement via the We Care Teams, the WGK Vlaams-Brabant hopes to retain its staff and lower its turnover rate, as was explained by Director of Care Veroniek Rooryck (2014).

Moreover, with the We Care Teams, the WGK Vlaams-Brabant wants to concretize one of the aims of its strategy 2011-2015, which runs: "Responsibilities are delegated to the teams and to the team members according to the rules of participation and self-management." (WGK VB, 2013a).

Professional group(s) targeted

The Wit-Gele Kruis Vlaams-Brabant is a non-profit home care organisation that employs (community) nurses, including a number of 'reference nurses' (in Dutch: 'referentieverpleegkundigen', nurses who have specialized in a particular field of care and make their expertise available to the patient, colleagues and the GP) and carers (in Dutch: 'zorgkundigen', people who are educated specifically to support nurses, under supervision of the nurse).

Level of the intervention

Organisational level.

Area covered

The province of Vlaams-Brabant, Belgium. The WGK Vlaams-Brabant is active at provincial level across the entire province of Vlaams-Brabant. It operates via fourteen local departments, which comprise relatively large areas. In each department, multiple We Care Teams are active at neighbourhood-level (ESF, 2014; WGKVB, 2014).

Kind of services provided by We Care Teams WGK Vlaams-Brabant

The WGK Vlaams-Brabant and the We Care Teams provide home nursing care to all in need in the province Vlaams-Brabant (WGK VB, 2013b).

Running time of the intervention

The We Care Teams have been in operation since February 2013. There is no expected end date.

Implementation strategy We Care Teams

March 2012

In March 2012, the first steps for the implementation trajectory of the We Care Teams were taken in the home care organisation WGK Vlaams-Brabant. The WGK Vlaams-Brabant started the trajectory by contacting Flanders Synergy, a competence pool innovate work organisation founded by the Flemish Government, to support its self-managing teams project. The aim of Flanders Synergy is to make organizations more agile and to create more attractive (workable) jobs. Eventually, WGK Vlaams-Brabant was directed to Ms Veerle Put, manager of Input HR Consulting. Since 2012, she professionally supports the WGK Vlaams-Brabant with the implementation of the self-managing teams (WGK VB, 2012).

September 2012

From September 2012 onwards, the We Care Teams have been followed up by a steering group and a think tank (WGK VB, 2013). The WGK Vlaams-Brabant chose to create these two groups in order to make the group of nurses more representative.

Steering group (in Dutch: stuurgroep)

The steering group was founded in September 2012 and is composed of the following members:

- Project leader: Veroniek Rooryck, Director of Care at WGK Vlaams-Brabant
- External consultant: Veerle Put, she supports Veroniek Rooryck
- Internal consultant: Geertrui de Jonghe, who supports the deputy head nurses. She is also educated by the external consultant so that she can educate and support the self-managing teams on issues of leadership.
- Financial director of WGK Vlaams-Brabant
- Five head nurses
- Two deputy head nurses

The steering group meets every 3 months. During these meetings, the state of affairs is discussed, new initiatives are discussed, experiences are shared and agreements are made. The meetings are also a way of keeping everyone aware of the We Care Teams (WGK VB, 2013). From February 2013 onwards, the steering group feeds into the head nurses' meetings.

Think tank (in Dutch: denktank)

The think tank consists of a mixed group of nurses and carers: young and older, recent and long in the organization. The think tank meets every 3 months. During these meetings, experiences are shared, agreements are made and the meetings are also a way to boost the We Care Teams-concept (WGK VB, 2013). One person from the think tank does the feedback to the steering group along with the project manager, external and internal coach. The think tank also links back to all nurses and carers and takes into account the input from these employees.

October 2012

In October 2012, head nurses and department heads received individual coaching concerning leadership style. They were also supported with the implementation of the concept of self-managing teams (WGK VB, 2013). Moreover, a brainstorm session was organised with all head nurses and deputy head nurses (WGK VB, 2012).

January 2013

In January 2013, all employees were informed about the upcoming processes by their head nurses and managers, with the help of a framework and toolkit, and the implementation trajectory in everyday practice was started. A phased approach was used for both the individual and the team (WGK VB, 2013).

February 2013

In February 2013, all teams of WGK Vlaams-Brabant became 'We Care Teams' and started working according to the principles of self-managing teams.

Below, a more detailed implementation trajectory per professional group is given. Three implementation strategies can be discerned that were tailored to the following groups:

1. Head nurses (in Dutch: hoofdverpleegkundigen)
2. Deputy head nurses (in Dutch: adjunct-hoofdverpleegkundigen)
3. Self-managing/directing teams (in Dutch: zelfsturende teams)

Head nurses

From March till June 2012, all head nurses were individually coached by Veerle Put, the external consultant. The We Care Teams were also a recurring theme during the consultation sessions that the head nurses had with Veroniek. From February 2013 onwards, the steering group around the We Care Teams feeds into the head nurses meetings (which take place once a month). The head nurses meetings on their turn feed into the We Care Team meetings (WGK VB, 2013). By the end of March 2014 at the latest, all head nurses must have had a coaching-training and be familiar with their new role in the self-managing teams.

Deputy head nurses

In March 2012, deputy head nurses were individually trained by internal coach Geertrui de Jonghe to learn to work according to the self-managing teams principle. This is also a recurring theme during their meetings with Veroniek Rooryck. Since the start of 2014 and by the end of March at the latest, deputy head nurses must be able to work according to the principles of self-managing teams (WGK VB, 2013).

Teams

The new way of working was fed into the teams through several ways. The steering group feeds into the think tank, while the think tank feeds into the We Care Teams. Also the head nurses' meetings feed into the We Care Team meetings.

Since April 2013 and until March 2015, all teams get one hour extra per 14 days to discuss all issues related to the self-managing teams. The We Care Teams now have a biweekly consultation about the primary care process and a biweekly consultation about other processes which mainly focuses on the self-managing team concept. They discuss how they can achieve their goals, where they need support, how they can grow, et cetera (WGK VB, 2013).

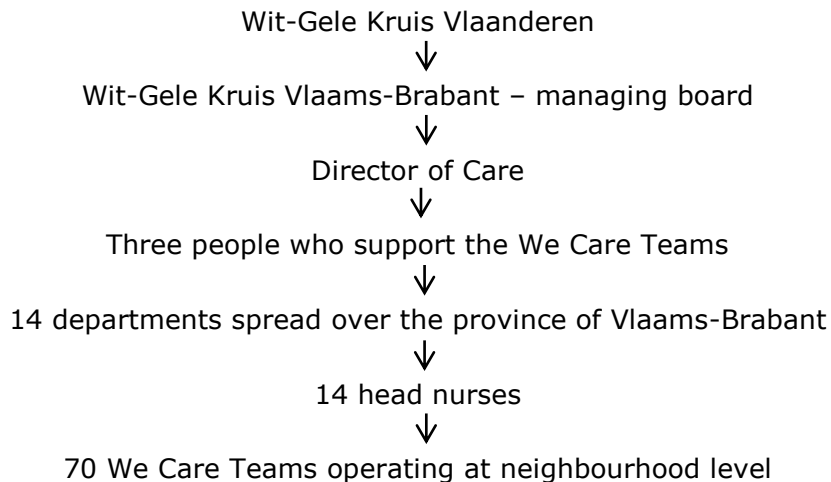
Organisational framework WGK Flemish Brabant and We Care Teams

The Wit-Gele Kruis Vlaanderen is the Federation of the five autonomous Flemish provincial Wit-Gele Kruis associations that organise home nursing. Both the Federation and the provincial associations have the status of non-profit association. It should be noted that the Wit-Gele Kruis Vlaanderen has no hierarchical power over the five provincial associations. It serves as an umbrella employers' organisation and acts as representative, advocate and negotiator at federal and Flemish level for the collective interests of the five provincial Wit-Gele Kruis- associations, which are:

- Wit-Gele Kruis Antwerpen
- Wit-Gele Kruis Limburg
- Wit-Gele Kruis Oost-Vlaanderen
- Wit-Gele Kruis Vlaams-Brabant
- Wit-Gele Kruis West-Vlaanderen

The Wit-Gele Kruis Vlaams-Brabant is a non-profit organisation and, with 850 employees, the smallest of the five provincial Wit-Gele Kruis associations. The economy of scale is therefore smaller compared to the other provinces and this has a negative influence on the business results (ESF, 2014). The organisation is led by a general manager with four directors: a director Care, a director Administration and Finance, a director Quality of Care and Innovation and a director HRM (ESF, 2014). The We Care Teams are the smallest organisational units within the organisational hierarchy of the WGK Vlaams-Brabant. Figure 1 shows the organisational structure of the WGK Vlaams-Brabant.

Figure 1: Organisational structure Wit-Gele Kruis Vlaams-Brabant



With the introduction of the We Care Teams, the WGK Vlaams-Brabant started working with the so-called 'star-model'. This model aims to prevent that supervisors will place themselves above the team. This way of working also means that coordination tasks can be shared between multiple team members and that they can be taken up and performed by multiple team members. This makes team members feel more responsible for the team and increases their involvement with the team (ESF, 2014).

Head nurses

Each of the 14 departments is led by a head nurse, who is responsible for the financial and operational management of the department. The head nurse is supported in her role by one or two deputy head nurses who are responsible for care-related issues, quality of care, reference domains and formations (ESF, 2014).

In contradistinction to the Dutch Buurtzorg model, WGK Vlaams-Brabant has explicitly decided to remain working with head nurses, even though their role has become different since the introduction of the We Care Teams. The reason to remain working with head nurses, as Director of Care Veroniek Rooryck explained, is that the organisation is going through a change process. A new corporate culture is being introduced. If people have been working in the 'old structure' for 20 or 25 years, you

can't expect them to be totally autonomous at once and start working in a different way all by themselves. That is why the head nurses were retained and given a coaching and coordinating role in the formation of the self-managing We Care Teams (Rooryck, 2014).

Head nurses have final responsibility for the global work planning, so making sure that enough nurses are available. They are also responsible for the screening of new employees when it comes to the content of care (Rooryck, 2014). Moreover, head nurse have a coaching role when it comes to decision processes within Teams and they oversee whether the division of work within a Team is in proportion (Van Hoorick, 2013). Head nurses and deputy head nurses help and support the teams in their growth to become self-managing teams.

We Care Teams

The We Care Teams are the smallest organisational units of the WGK Flemish-Brabant (ESF, 2014). The WGK Vlaams-Brabant adopts the following definition of a self-managing team: a group of employees in an organization that is collectively responsible for the overall process in which services are provided to an internal or external client. All team members hold shared responsibility, are self-managing and focus on results. A typical We Care Team consists of about 8 to 12 members. Each team is made up of community nurses and one carer (in Dutch: 'zorgkundige') who supports the nurses (Van Hoorick, 2013). Team members are educated at bachelor's (A1) level and associate (A2) level in nursing.

Teams decide autonomously how they organise their patient care and they divide tasks among themselves. They are responsible for the efficiency of the rounds of the community nurses, the work schedules, holiday planning, continuity of care in case of sickness absence, support of new colleagues and interns, scoring of patients' care dependence, the need for additional support, etc. (Van Hoorick, 2013). Besides, every nurse within the team is given two themes for which he/she is responsible. For example, being the fixed contact point for the GP or supporting and integrating new employees and interns, and so on. Every six months, there is an evaluation and employees can choose for another theme. This gives them the opportunity to develop new competences (Van Hoorick, 2013; Nursing 2013). During weekly team consultations, lasting for about 1 to 2 hours, the team discusses how they can achieve their goals, which support they need, how they can grow and further develop themselves, and so on (ESF, 2014; Nursing, 2013).

We Care teams are accessible for clients between 07.30 and 21.00, every day of the year. In very specific cases, such as a terminal illness, treatment outside these hours can be discussed as well (WGK VB, 2014). The Wit-Gele Kruis is accessible 24 hours a day by telephone. This is a central number and not a direct number to a nurse or the We Care Team that handles a patients' care. All We Care Teams are active at neighbourhood level and provide care to about 150 clients per month. At this moment, there are approximately 70 We Care Teams active across Vlaams-Brabant (Rooryck, 2014).

Financing

The WGK Vlaams-Brabant is a non-profit organisation. Its 'We Care Teams' have been developed with financial help of the European Social Fund (ESF) and the Flemish Co-financing Fund (VCF).

European Social Fund

The ESF provides resources for innovations which contribute to more and better jobs for more people. The 'We Care Teams' are financed through the ESF-call "People-oriented business". This theme seeks to increase the quality of work for employees. Within this call actors are encouraged to work on recruitment, competency management, learning policies, feedback policy, policy justification, knowledge, leadership and structure of the organization of work (ESF, 2014).

In December 2012, the WGK Vlaams-Brabant submitted its application and asked for support from the ESF to help implement the We Care Teams 'in an effective way'. Its application was approved and the WGK Vlaams-Brabant will receive a total sum of €45.000 from the ESF (ESF, 2014).

Flemish Co-financing Fund (VCF)

The Flemish Co-financing Fund (in Dutch: Vlaams Cofinancieringsfonds) is specifically established for the co-financing of ESF-actions. The percentage is determined from call to call and is automatically paid to the promoters of which the application is approved. The WGK Vlaams-Brabant will receive a total sum of €55.000 from the VCF (ESF, 2014).

It should be noted that the funding of the ESF and VCF will only be received at the end of the project, after all required information has been submitted to both funding agencies by the WGK Vlaams-Brabant.

Other financing

In addition to the approved ESF and VCF funding, the WGK Vlaams-Brabant invests a total sum of €103.923,44 in its We Care Teams (ESF, 2014).

3. Results of the intervention

The WGK Vlaams-Brabant has prioritized three indicators to determine the success of the We Care Teams:

1. Turnover rates
2. Staff satisfaction levels
3. Number of questions of head nurse and deputy head nurse to project manager and external/internal coaches

1. Turnover rates

The WGK Vlaams-Brabant constantly measures its turnover rate, i.e. the ratio in percentage of the number of employees with an indefinite contract who left the organisation in the running 12 months in relation to the total number of employees with an indefinite contract in the running 12 months. Moreover, every time an employee leaves the WGK Vlaams-Brabant the HRM Department conducts an 'exit-talk' with the employee to determine the reason(s) for him/her leaving.

In 2011, the WGK Vlaams-Brabant had the highest turnover rate of all five provincial Wit-Gele Kruis associations (see table 1). One of the goals of the introduction of the We Care Teams was to lower the turnover rate.

Table 1: Turnover rates five provincial WGK associations in 2011

WGK 2011	Turnover total	Turnover nurses	Turnover carers
Antwerpen	7,70	8,58	5,77
Limburg	6,9	7,99	3,64
Oost Vlaanderen	7,73	6,9	15,18
Vlaams-Brabant	8,58	9,70	5,12
West Vlaanderen	7,86	/	/

Source: Wit-Gele Kruis Vlaams-Brabant (2012)

If we look at the number of staff entering and leaving the WGK Vlaams-Brabant, there is a shift visible since 2011 (see table 2).

Table 2: Number of staff entering and leaving WGK Vlaams-Brabant

	Number of new staff	Number of staff leaving	Netto
2011	84	103	-19
2012	123	123	0
2013	115	92	+23

Source: Rooryck (2014)

Table 3: Key indicators Wit-Gele Kruis Vlaams-Brabant (2006-2011)

	2006	2007	2008	2009	2010	2011	2012	2013
Average number of patients per month	9905	10120	10268	10346	10335	10429	10062	9875
Number of treatments	3.711.981	3.830.355	3.896.559	3.897.070	3.868.198	4.063.320	4.135.352	4.120.736
Personnel	804	817	809	837	844	844	824	850
Man	29	31	37	42	45	45	42	44
Woman	775	786	772	795	799	799	782	806

Source: WGK VB, 2012

At this moment, no firm conclusions can be drawn about the effectiveness of the introduction of the We Care Teams on retaining (and recruiting) staff. However, as Director of Care Veroniek Rooryck explained to us, there are indications that young people remain longer in the organisation since the introduction of the We Care Teams. Moreover, nurses from adjacent hospitals are attracted to this autonomous way of working which is not known in hospitals. While some older nurses have left because of this new way of working, overall there seems to be less outflow of the organisation since the introduction of the We Care Teams, although it should be emphasised that no firm conclusions can be drawn as yet (Rooryck, 2014).

2. Staff satisfaction levels

The WGK Vlaams-Brabant determines its staff satisfaction level every two years via a survey research, conducted by the HRM department. In December 2011, the main issues that were mentioned for not recommending the WGK Vlaams-Brabant as employer were work pressure, schedule/holiday issues and the fact that overtime is not easily returned. Hence, the prioritized issue by the WGK Vlaams-Brabant was work pressure and attention for stress. In spring 2013, a new survey was conducted. However, because of the low response rate (< 60%), the WGK Vlaams-Brabant decided not to draw any conclusions from this survey (Rooryck, 2014). The next survey is scheduled for spring 2015 (Wit-Gele Kruis Vlaams-Brabant, 2012).

3. Number of questions of head nurse and deputy head nurse to project manager, external and/or internal coach

As the project progresses, the number of questions from head nurses and deputy head nurses to the project manager and external/internal coaches should diminish. Moreover, as time progresses questions should focus more on further stages in the project and not so much on start-up issues. This is monitored by an internal system based on the registration of questions (Wit-Gele Kruis Vlaams-Brabant, 2012).

Proxy measures

The WGK Vlaams-Brabant constantly measures its sickness absence levels. With the introduction of the We Care Teams, the WGK Vlaams-Brabant hopes to decrease the sickness absence level (WGK VB, 2012). However, up to now, there is no significant difference visible in sickness absence levels (see table 4).

Table 4: Sickness absence level Wit-Gele Kruis Vlaams-Brabant (2011-2014)

	2011	2012	2013	2014 (until August)
Sickness absence level	3%	3,13%	3,42%	3,21%

Source: Rooryck, 2014

References

- Europees Sociaal Fonds (2014). *We Care Teams*. <http://www.esf-agentschap.be/nl/projectenkaart/we-care-teams-0> (accessed: 13-08-2014).
- KCE (2010). *Financiering van de thuisverpleging in België*. *KCE Reports 122A*. Brussel: Federaal Kenniscentrum voor de Gezondheidszorg.
- Nursing (2013). *Buurtzorg inspireert Vlaamse thuiszorg*. <http://www.nursing.nl/Verpleegkundigen/Nieuws/2013/5/Buurtzorg-inspireert-Vlaamse-thuiszorg-1258398W/> 17-05-2013.
- Rooryck, V. (2014). Interview for R&R study, 28-07-2014.
- Van Hoorick, K. (2013). *Iedereen baas bij Wit-Gele Kruis*. Challengez, 2013.
- Wit-Gele Kruis (2009). Memorandum Wit-Gele Kruis van Vlaanderen 2009. www.eyes-e-tools.com/customer/wgkfederatie/Nieuws/upload/MemorandumWGK2009.pdf (accessed: 03-07-2014)
- Wit-Gele Kruis Vlaams-Brabant (2012). *Projectvoorstel Wit-Gele Kruis*. We Care Teams. Naar zelfsturende teams in de thuisverpleging. ESF Oproep Mensgericht ondernemen 2012.
- Wit-Gele Kruis Vlaams-Brabant (2013). *Stand van zaken, december 2013*. Presentatie.
- Wit-Gele Kruis Vlaams-Brabant (2013a). We Care project: opstart van de WE CARE teams.
- Wit-Gele Kruis Vlaams-Brabant (2013b). Project We Care: naar zelfsturende teams binnen Wit Gele Kruis VL Brabant.
- Wit-Gele Kruis (2014). *Wit-Gele Kruis Missie*. factoren.witgelekruis.be/fb111eioe778jvbb1kubb197.aspx (accessed: 03-07-2014)
- Wit-Gele Kruis Vlaams-Brabant (2014). *We Care Teams*. <http://www.wit-gelekruisvlaamsbrabant.be/we-care-teams> (accessed: 13-08-2014).

Appendix 5.4. Case report 5.4

Topic 5. Providing good working environments by putting professional autonomy & worker participation first

Case 5.4. The home care organisation *Grannvård Sverige*, Sweden



Research methods applied:

Desk research: October-November 2014

Telephone interview: November 2014

1. Summary of the intervention – Grannvård Sverige, Sweden

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Personal and professional support/autonomy
Professional group(s) targeted	Nurses and nurse assistants
Level of intervention	Organisational level
Type of organisation	Non-profit home care organisation
Kind of services provided by organisation	Home care
Size of organisation	Small
Area covered	Grannvård Sverige operates at regional level, currently in two municipalities: Bålsta and Enköping
Intervention period / duration of intervention	Grannvård Sverige started in December 2011. There is no expected end date.
Financial investment	Considerable financing is required to set up an organization like Grannvård Sverige. Grannvård Sverige is financially supported Buurtzorg the Netherlands.
Implementation strategy or processes used	Grannvård Sverige was developed as a 'copy' of Buurtzorg Netherlands and received support from Buurtzorg and an external adviser during the implementation stage.
Organisational framework	Grannvård Sverige is a sister-company of Buurtzorg the Netherlands.
Day-to-day running of the intervention	Grannvård Sverige is a non-profit organisation which currently employs two self-steering home care teams.
Personnel investment	Grannvård was set up by one home care nurse, with support from an external advisor and Buurtzorg the Netherlands. Further HR is formed by team members.
Outcome measures of the intervention	Grannvård Sverige was not introduced as explicit R&R intervention, proxy measures include the growth in number of staff

2. Rich description of the intervention

Case under study

Grannvård Sverige [in English: Homecare Sweden], a non-profit home care organisation that promotes professionally autonomous working. It was established after the original Dutch example Buurtzorg Nederland.

Establishment of Grannvård Sverige

Grannvård Sverige was established in December 2011 by Mona Lindström, a Swedish registered nurse who previously worked for Buurtzorg Nederland. Financial support was provided by Buurtzorg Nederland (Lindström, 2014; Regeringskansliet Socialdepartementet, 2013).

Reasons for the establishment of Grannvård Sverige

The idea to establish a Swedish copy of the originally Dutch concept Buurtzorg, originated simultaneously in Sweden and the Netherlands. The founder of Buurtzorg Nederland, Jos de Blok, met the Swedish researcher Stig Tegle in 2010. Mr Tegle had conducted a study on care for the elderly across eight European countries. Via this study, he learned about Buurtzorg the Netherlands. When he and Jos de Blok met, they both concluded that Sweden and the Netherlands were facing similar problems in elderly care, and hence the Buurtzorg concept could be a solution for Sweden's problems as well (Grannvård Sverige, 2014; Lindström, 2014). In 2011, Jos de Blok stated it as thus in a Dutch newspaper: "The concept needs no adjustment for international growth. The problems with split and splintered care are not only a problem here [the Netherlands], but also abroad" (Nieuworganiseren, 2011). Therefore, Jos de Blok decided he would like to introduce the Dutch Buurtzorg way of working in Sweden as well.

Type of intervention

Grannvård Sverige strongly emphasizes the personal and professional autonomy that its staff members have. Just as Buurtzorg the Netherlands, Grannvård Sverige was not primarily introduced as a recruitment and/or retention intervention. However, just as Buurtzorg the Netherlands, the first proxy measures show that it is very successful in this area.

Objective of the intervention

The main aim of Grannvård Sverige is to provide an innovative way of home care in Sweden for the elderly, people with disabilities and chronic diseases. According to Grannvård, this requires an effective strategy which places the client at the centre.

Professional group(s) targeted

Grannvård Sverige is a non-for profit home care organisation that employs nurses and assistant- or auxiliary nurses. Its goal is that 50 per cent of staff should be registered nurses (Enköpings Kommun, 2014).

Level of the intervention

Grannvård Sverige operates at regional level. It currently has two teams, one in Bålsta (located in the Håbo municipality) and one in Enköping municipality (covering the parishes of Yttergran, Övergran, Kalmar). Both teams are situated in Uppsala county, Sweden (Enköpings Kommun, 2014; Grannvård Sverige, 2014).

Kind of services provided by Grannvård Sverige

Grannvård Sverige provides high quality home health care services. It also offers services such as housekeeping, shopping, meal assistance, money and banking, companionship, respite care and more (Grannvård Sverige, 2014).

Running time of the intervention

Grannvård Sverige was established in December 2011. There is no expected end date.

Implementation strategy

When Jos de Blok decided he would like to introduce the Dutch Buurtzorg concept in Sweden as well, he already visited Sweden a couple of times and had met with Swedish politicians and policymakers. At that time, the originally Swedish nurse Mona Lindström worked for Buurtzorg the Netherlands. Early 2011, Jos de Blok contacted Ms Lindström to ask whether she would be interested to travel with him to Sweden to meet some people and explain the differences between the 'usual' way of working (which is similar in Sweden and the Netherlands) and the Buurtzorg way of working. Subsequently, Jos de Blok started looking for someone who could set up the Swedish Buurtzorg (Lindstrom, 2014). Partly fed by personal reasons and partly professional reasons, Ms Lindström decided she would like to move back to Sweden and start the Swedish Buurtzorg. In the spring of 2011, she began preparing to start operating in Sweden (Grannvård Sverige, 2014). Mr Stig Tegle provided her with some help during this stage (Lindström, 2014).

Jos de Blok and Mona Lindström subsequently travelled to Sweden again and visited the small town where Ms Lindström would like to set up Buurtzorg. She sent emails to her ex-colleagues over there and Jos and she gave a presentation on what the Buurtzorg way of working entails. In November 2011, Ms Lindström started with the paperwork that was required from the municipality (Lindström, 2014). According to Jos de Blok, Grannvard was introduced very much through a 'trial and error' way of working and by discussing issues about preconditions with the respective municipalities (De Blok, 2014).

In December 2011, Grannvård Sverige officially started with Ms Lindström as head nurse and the first team was established in Håbo municipality (Bålsta) (Grannvård Sverige, 2014; Healthcare Europa, 2012; Lindström, 2014). In the weeks that followed, Grannvård Sverige started visiting all relevant organisations within the region to present itself. Although they didn't get a client for the first three months, once the first one was in, it went fast (Lindström, 2014).

Organisational framework

Grannvård Sverige is a sister organisation from Buurtzorg the Netherlands. It was started with funding from Buurtzorg the Netherlands (Lindstrom, 2014; Nieuworganiseren, 2011). The expectation is that Buurtzorg will start cooperating with partners in Sweden that will help bring the Grannvard Sverige initiative further. What

Buurtzorg the Netherlands ideally likes to do is introduce their way of working to another country, such as in this case to Sweden, show how it works, and then find a partner in the respective country to develop the further growth of the concept (De Blok, 2014).

The organisational framework of Grannvård Sverige is aimed at approaching the framework of Buurtzorg the Netherlands as closely as possible. While this is an agreement between the two organisations, nothing has been officially and formally written down about this (Lindström, 2014).

Grannvård Sverige currently has signed contracts with the municipalities of Bålsta (since 2011) and Enköpings (since 2013) to perform home care and home health care in these municipalities (Healthcare Europa, 2012).

Grannvård Sverige teams

Grannvård operates with the same concept as Buurtzorg the Netherlands. Their teams are small autonomous self-steering teams with highly educated, motivated and committed team members. They consist of nurses and assistant nurses. All clients have a contact nurse from the team who is working as a case manager coordinating efforts from different care providers (Grannvård Sverige, 2014; Healthcare Europa, 2012). Grannvård Sverige teams are available from 07.00 until 22.00 on a daily basis. Good relationships with clients' family doctors and other health care providers such as physiotherapists, dieticians and specialists are considered very important (Enköpings Kommun, 2014; Grannvård Sverige, 2014).

IT-system

Buurtzorg the Netherlands developed its own Buurtzorgweb, which is optimally tailored to the wishes and needs of home care nurses. In Sweden, Buurtzorg and Grannvard are currently working on which elements of the Buurtzorgweb (the internal IT-system) can be used in Sweden and which parts need to be country-specific. Communication and knowledge are predominantly generic parts of the programme that are being translated into modules, so that they can also be used in countries other than the Netherlands. When it comes to declarations and administration, which are very country-specific, Buurtzorg tries to cooperate with partners from the respective country (De Blok, 2014).

Facilitators in the introduction and running of Grannvård Sverige

The fact that Ms. Lindström had worked for Buurtzorg the Netherlands and had experience with working in autonomous self-steering teams, made it easier for her to introduce this way of working in Sweden and explain it to other nurse and nurse assistants who had never worked in this way before (Lindström, 2014).

Barriers in the introduction and running of Grannvård Sverige

Grannvård Sverige was introduced in Sweden as a copy of the Dutch example, as Sweden is facing the same problems as the Netherlands when it comes to healthcare and the need for the ageing population to remain longer at home, instead of relying on hospital care. However, the Dutch and Swedish context differs significantly. This has hampered the introduction of Grannvård Sverige. The two main problems are:

1. In Sweden, municipalities have much power. As a home care organisation, Grannvård Sverige is required to work with the IT-system (for logging client

details and billing times) that the municipality in which it operates requires. Buurtzorg the Netherlands developed its own innovative IT-system, *Buurtzorgweb*, which is extremely well tailored to the needs of home care nurses. But as the nurses of Grannvård Sverige are not allowed to work with this system, carrying out their administrative jobs is much more complex and takes more time (Lindstrom, 2014; Healthcare Europa, 2012).

2. The financial system in Sweden, in which only direct client time is reimbursed and not indirect costs, such as travel time and administration time, creates a difficult situation for Grannvard Sverige. In the Netherlands, insurers reimburse both direct and indirect costs (Lindstrom, 2014; Healthcare Europa, 2012). As travel distances in the sparsely populated areas of Sweden are much greater than in the densely populated Netherlands, this complicates the situation even further for Grannvard. Below, under the heading 'finances', this situation is extensively discussed.

Another barrier is that in Sweden, the laws governing what Grannvård can and cannot do vary wildly from municipality to municipality. Sweden's form of free choice (LoV) leaves it up to each municipality as to whether private provision of care is allowed, as well as what level of care they are authorised to provide. For example, in Bålsta, one of the municipalities in which Grannvård is active, nurses are not allowed to provide higher levels of medical homecare. This is frustrating for Grannvård's nurses, who have the education required and many years of experience performing these services, but are not allowed to do so (Healthcare Europa, 2012). In the Netherlands, Buurtzorg also employs highly educated nurses, and Dutch municipalities are not allowed to restrict their practice as this is part of national law.

Financing

The financial means to cover the start-up costs for Grannvård Sverige were provided by Buurtzorg the Netherlands. As Grannvård Sverige is a non-profit organisation, its aim is to make break-even. However, Grannvård Sverige has not yet been able to achieve this goal and it continuously makes losses. Up to now, these losses have been paid for by Buurtzorg the Netherlands (Lindström, 2014).

The reasons why Grannvård Sverige up to now has been unable to make break-even are related to the Swedish financing system of home health care, which is significantly different from the Dutch one. In the Netherlands, insurers pay enough to make up for all direct *and* indirect time spent on providing care - travel between clients, time spent on administrative work, and so on (Healthcare Europa, 2012). But in Sweden, municipalities decide themselves how much they pay home care organisations per hour for the work they do, and only the minutes that are directly spent with the client are being covered. This means that for example the time that home care nurses are driving towards clients or doing administrative work, is not covered. Hence, the tariffs that are paid by the municipalities are often too low to cover both direct and indirect costs. Ms Lindström estimates that approximately 65% to 70% of the productivity of Grannvård Sverige is covered by the payments of the municipalities. The resulting losses have up to now been paid for by Buurtzorg the Netherlands.

This financial construction of home care in Sweden also means that Grannvård Sverige is not playing on a level field with the public sector. Sweden's form of free choice (LoV) leaves it up to each municipality as to whether private provision of care is allowed, as well as what level of care they are authorised to provide. Under LoV, the municipal homecare service is just one competitor among many; clients can choose whichever provider they would prefer for their care. Everyone is paid the same tariff. The municipal homecare provider, however, will regularly make a loss, but then simply receive money reallocated from the municipality's general budget to make up the shortfall. This is not the case for Grannvård Sverige (Healthcare Europa, 2012; Lindstrom, 2014).

Ms Lindström has discussed this issue with politicians and recently received the promise that the tariffs would be increased. However, elections were held last September, resulting in a political shift (Lindstrom, 2014). Hence, the future must show whether the tariffs will really be increased.

Factors that influence successfulness of replicating this intervention

- Financial context: in the Netherlands, health insurers finance both indirect and direct costs. As the Buurtzorg way of working brings with it a lot of indirect costs, countries or organisations who are also thinking about introducing this way of working should make sure that these indirect costs can be covered as well. If not, organisations may not be able to survive financially.
- Human resources: it is very important to have the right kind of people working in your organisation. People who are motivated to work autonomously and are aware that they carry a lot of responsibility.

3. Results of the intervention

Grannvård Sverige was not primarily introduced as a recruitment and/or retention intervention. However, the first proxy measures show that it is successful in this area.

Proxy measures

Prices and awards:

In November 2014, Grannvård Sverige ranked first in a survey that studied how satisfied home care clients are in the Uppsala region.

Number of Grannvård Sverige teams and employees:

Now we have 2 teams with 7 or 8 nurses each team. We have around 30 clients per team, so 60 in totals (Lindstrom, 2014).

Client numbers

The number of clients of Grannvård Sverige has been steadily increasing since its start (Healthcare Europa, 2012). Additionally, Ms Lindström, who set up Grannvard Sverige, mentions that positive differences are visible at an individual client level. For example, clients who used to go to the hospital by ambulance once a month and now haven't gone to the hospital for a year.

References

De Blok, J. (2014). Telephone interview for Recruitment & Retention study. November 2014.

Enköpings Kommun (2014). *Grannvård Sverige AB*. Available at: http://www.enkoping.se/files/pdf/vardohalsa/Kundval/utforarpresentation%20_grannvard.pdf (accessed: 03-11-2014).

Grannvård Sverige (2014). *Grannvård*. Available at: <http://www.grannvard.se/> (accessed: 03-11-2014)

Healthcare Europa (2012). Buurtzorg falters in Sweden. *Healthcare Europa*, 05-10-2012.

Lindström, M. (2014). Telephone interview for the Recruitment & Retention study. 7 November 2014.

Nieuworganiseren (2011). *Buurtzorg goes international*. Available at: <http://www.nieuworganiseren.nu/featured/buurtzorg-goes-international/> (accessed: 03-11-2014)

Regeringskansliet Socialdepartementet (2013). Hemtjänst efter populär holländsk modell. 16 januari 2013.

Appendix 6.1. Case report 6.1

Topic 6. Making the hospital workplace more attractive by improving employment and work quality

Case 6.1. Kindergarten General University Hospital Prague, Czech Republic



Evropský sociální fond
Praha & EU: Investujeme do vaší budoucnosti

Research methods applied:

Desk research: September – November 2014

Case site visit: November 2014

1. Summary of the intervention – Kindergarten General University Hospital Prague, Czech Republic

Dimension of interest	Categories/description
Objective of the intervention	Retention (to a lesser extent also recruitment)
Type of intervention	Personal and professional support
Professional group(s) targeted	Kindergarten is for children of all hospital staff. Until November 2014, children of nurses were prioritized.
Level of intervention	Organisational
Type of organisation	Hospital
Kind of services provided by organisation	Hospital care
Size of organisation	Large
Area covered	The General University Hospital is situated in Prague and accepts children of hospital staff.
Intervention period / duration of intervention	The Kindergarten launched its operation on September 10, 2012. There is no expected end date.
Key actions	Running of the Kindergarten for children of hospital staff (maximum capacity: 24 children).
Financial investment	Additional financing is required. For the Kindergarten this has been provided by the OPPA fund (until the 30 th of November 2014), the Hospital and fees paid by the parents.
Implementation strategy or processes used	After questions from employees about a Kindergarten, the Hospital conducted an internet-survey among its employees to make sure that it was really wanted. The hospital also looked at how many staff was on maternity leave and how many already had part-time jobs. It was concluded that a Kindergarten could be helpful. Around the same time, the OPPA call came out and the hospital decided to apply.
Personnel investment	Additional HR is required. Kindergarten used to have a headmistress, 4 teachers, a secretary and kitchen staff. Because of the stopping of the OPPA funding per November 2014, only three or two and a half teachers

	will remain.
Outcome measures of the intervention	The possible effects of the Kindergarten on retention of staff are not being monitored nor is the cost-effectiveness of this intervention being calculated. This would be extremely difficult.

2. Rich description of the intervention

Case under study

The Kindergarten for children of hospital staff at the General University Hospital Prague (in Czech: Všeobecná fakultní nemocnice v Praze).

Establishment of the Kindergarten

The current Kindergarten started in December 2012. However, the kindergarten history in General University Hospital Prague goes many decades back. In the 1980s there already was a kindergarten in the Hospital, but in the early 1990s this kindergarten's activities were transferred under the supervision of the City of Prague and so it became a public kindergarten (Janoušková, 2014).

Reasons for the establishment of the Kindergarten

In the Czech Republic, state-run Kindergartens have only limited capacity and there is a shortage of Kindergarten places for children (Svobodová & Janoušková, 2014).

The General University Hospital Prague strives for a long-term retention of its employees. Due to the lack of capacity in public kindergartens, mothers can experience difficulties in returning to work after their maternity leave ends. Hospital staff would go to the management and ask whether there would be a Kindergarten at the hospital again? To retain this staff, the General University Hospital Prague decided to open its own Kindergarten (Janoušková, 2014; Svobodová & Janoušková, 2014).

Objective of the intervention

The aim of establishing the Kindergarten was to support mothers to return to work. In this way, it is a retention support tool (Svobodová & Janoušková, 2014). The prioritized group of healthcare professionals was nurses and when capacity would allow, children of other staff would also be allowed (Janoušková, 2014). The Kindergarten aims to support the reconciliation of work- and private life for parents. It supports friendly working environments for families of hospital employees by facilitating the return to the labour market of parents caring for children (VFN, 2014).

Type of intervention

Professional and personal support.

Professional group(s) targeted

During the funding through the OPPA fund, children of nursing staff who want to return to work during parental leave or within 1 year after their return from parental leave, have prioritized access to the Kindergarten. Children of other hospital staff are accepted in case of available capacity (Skolka, 2014; Svobodová & Janoušková, 2014). After the funding of the OPPA fund ceased (November 2014), nurses are no longer a prioritized target group.

Level of the intervention

Organisational level.

Area covered

The Kindergarten is situated in the heart of Prague (Skolka, 2014). It is available for children of hospital staff of the General University Hospital, regardless of where they live.

Running time of the intervention

The Kindergarten launched its operation on September 10, 2012 (Svobodová & Janoušková, 2014). There is no expected end date.

Implementation strategy*Question of employees*

Employees of the General University Hospital Prague would repeatedly ask whether there would be a Kindergarten at the hospital again. The hospital board in principal was supportive of establishing a Kindergarten, but it was a financial issue. The hospital is not a commercial company and a Kindergarten is expensive build, support and run (Janoušková, 2014).

Research and survey

In 2011, discussion about establishing a Kindergarten came up once again. The hospital board, the management, Ms Janoušková (the current director of the Kindergarten) and the head nurse discussed it more and more and were thinking about the possibilities of how to do it so the hospital could economically bare it. Around that time, the hospital performed an internet-survey among its employees to make sure that the Kindergarten was really wanted. It turned out that a vast majority of parents would welcome it and that there was a potential for it. The hospital looked at data of all staff that were on maternity leave. They looked at how many were on maternity leave and how many already had part-time jobs. It was concluded that a Kindergarten could be helpful (Janoušková, 2014).

Operational Programme Prague – Adaptability (OPPA) call

Just after the hospital had once more started discussing the possibilities of establishing a Kindergarten, an Operational Programme Prague – Adaptability (OPPA) call (the 4th call) came out with a definition that fitted the needs of the hospital, namely establishing a Kindergarten. So eventually the management decided: "okay, let's do it". Ms Janoušková and some others then jointly wrote a plan for the OPPA call (Janoušková, 2014).

Application process for the OPPA funding

The hospital has a project manager (an employee of the hospital) who prepares all the paperwork. The project manager is responsible for the complete processing of the project proposal, all related documents, financial reports, statements and so called monitoring reports.

First there was an online application for the OPPA where all sorts of information about the hospital had to be provided, why they were applying for this, how they wanted to put the project in practice, and so on. The OPPA wanted a very detailed plan. So the hospital had to make calculations, for example regarding the number of forks, plates and towels that they would need for the Kindergarten. Based on these costs, the OPPA

decided how much money would be allocated. The hospital also had to provide information about the number of staff, how they would achieve educational aims, how many clients they expected to help, and so on. In the first half of the project and at the end of the project, the Hospital would have to measure whether it was achieving its aims with regards to client numbers. Ms Janoušková therefore decided it would be wise to leave the aimed number of clients at 48. This aim was reached in the first half year of the operation of the Kindergarten already (Janoušková, 2014).

Implementation of the Kindergarten

The hospital received a positive decision from the OPPA in December 2011, subsequently three months of contract negotiations with the Contracting Authority took place. During March and April 2012 members of the project team - the kindergarten staff - were recruited. The project was officially launched in May 2012, even though the building of the kindergarten was still under construction. Project team had a temporary office in the headquarters building, where their joint meetings took place. Teachers worked out the educational and developmental programme, equipment for the kindergarten was chosen, ordered and purchased. The director of the kindergarten worked out admission plan for processing of the received applications. Applications were accepted starting June 2012. The school year in the Czech Republic begins on the September 1. The kindergarten, however, was inaugurated after completion of construction works on 10 September 2012 (Janoušková, 2014).

The Operational Programme Prague – Adaptability

The Operational Programme Prague – Adaptability (OPPA) is intended to support non-investment projects focused on education, social integration, employment and human resources development in research and development. The programme is designated only for Prague; therefore, all projects have to provide help in the capital city. OPPA is one of two operational programmes for Prague that utilise resources from EU funds under the Regional Competitiveness and Employment objective.

OPPA contains four 'priority axis' dividing the operational programme into logical units:

- Supporting the Development of Knowledge Economics – focused on the target group of employed people. The supported project should increase the quality of the work of these people by furthering their education or by cooperating with another organisation (i.e. research organisation etc).
- Supporting Entrance to the Job Market – focused on people that might be disadvantaged when entering the job market for various reasons (e.g. health disability, mental illness, ethnic minority member, social standing etc), and it also represents an opportunity for the development of organisations that help people who are at a disadvantage.
- Modernisation of Initial Education - focused on the target group of people who are preparing to enter the job market, i.e. students of secondary schools, colleges and universities, but also at their teachers and academic staff working with students.
- Technical Support - to secure the administration of programmes, i.e. securing staff that control programmes, information systems to monitor the use of means from structural funds etc. This means for technical support cannot be used by any other subject but the City of Prague.

The responsibility for the OPPA lies with the City of Prague (i.e. it performs the role of the Steering Body). The OPPA is managed by the Department of the European Social Fund at the Prague City Hall. This Department is responsible, in particular, for the administration of project applications, administration of projects, financial management of projects, and so on (Prague House, 2014).

The Kindergarten

Since the Kindergarten started operating until the end of November 2014, when the OPPA funding stopped, the following admission criteria had to be applied for children to enter the Kindergarten (Skolka, 2014):

- Children of nurses who want to return to work during parental leave or within 1 year after their return from parental leave are prioritized.
- If there is enough capacity after children of nurses are accepted, children of other hospital staff may be accepted as well.
- From the date of acceptance of his/her child in the Kindergarten, the employee must remain in a labour-law relationship with the General University Hospital in Prague for at least six months.
- Accepted children must be aged 3 years (generally).
- If the employee terminates employment in the General University Hospital, the child's attendance in the Kindergarten is also terminated.

Organisational framework

The General University Hospital is located in the centre of Prague and in December 2013 comprised 43 clinics, institutes and independent departments. With 1,500 beds it is a large hospital. The total number of employees is 5.603 (of which 742 physicians and 42 pharmacists) (Svobodová & Janoušková, 2014).

Since its inception, the Kindergarten had 7 employees: headmistress, 4 teachers, a secretary and kitchen staff. The headmistress is fully responsible for the operation of the Kindergarten and regularly cooperates with a project manager and HR specialist regarding reporting for the OPPA funding and staff salary issues (Svobodová & Janoušková, 2014). Because of the stopping of the OPPA funding per 30 November 2014, the Kindergarten has to lower its amount of staff. Instead of four teachers, it will only have three. This might be further reduced to two and a half (Janoušková, 2014).

Finances

The Kindergarten was financed from its inception on the 1st of May 2012 until the 30th of November 2014 through different resources:

- Through the Operational Programme Prague – Adaptability (OPPA) funding: 4.903.798,48 CZK (€178.735,91)
- Through financing by the General University Hospital Prague: 2.361.088,16 CZK (€85.530)
- Financial contribution by parents

This financial construction was in place until the 30th of November, when funding through the OPPA project stopped. The new way of funding is explained below.

Operational Programme Prague – Adaptability (OPPA) funding

The Kindergarten project has received 4.903.798,48 CZK (€178.735,91) from the Operational Programme Prague – Adaptability (Svobodová & Janoušková, 2014; VFN, 2014). The OPPA funding pays for the actual costs of operation, including staff salaries, furnishings and equipment like computers, chairs, and so on. The OPPA money covers approximately 67.5% of the costs. The hospital still has to finance 32.5% or maybe even more of the costs (Janoušková, 2014). The Kindergarten was financed through the OPPA fund until November 30, 2014 and then the funding stopped. To be able to cover all operational costs, the Kindergarten was forced to increase the fees paid by parents by almost the double amount (see below) (Janoušková, 2014; Svobodová & Janoušková, 2014).

Financing by the General University Hospital

The General University Hospital paid 2.361.088,16 CZK (€85.530) from the inception of the programme until the 30th of November 2014 (VFN, 2014). These considerable financial means were, among others, invested into the reconstruction of a suitable building for the Kindergarten (Janoušková, 2014; Svobodová & Janoušková, 2014).

Financial contribution by parents

Parents have to pay a fee and they have to pay for the childrens' food. The amounts of these differ before the 1st of December 2014 and afterwards, due to the stopping of the financing via the OPPA fund (Janoušková, 2014).

Until the 30th of November 2014

For a child's stay in kindergarten parents paid a contribution to the operation of Kindergarten of 160 CZK (€5,80) or 80 CZK (€2,90) in the case of half-day attendance. The costs for meals were paid separately according to real consumption (Skolka, 2014).

After the 1st of December 2014

Costs for tuition and meals are joined in so-called pre-paid packages containing the number of visits that suits parents' needs (see table 1 for an overview of available packages). Package price includes (Skolka, 2014):

- the child's stay in the nursery
- educational and instructional programme compiled in accordance with the Framework Educational Programme Ministry
- all activities
- food and drinks
- basic toiletries

Package price does not include:

- trips
- nurseries in nature
- courses and optional activities offered in the Club Parents

Table 1: Packages

Package	Number of visits	In force	Price per visit incl. meals	Total price incl. meals
1	1	Immediate		690, - CZK
10	10	4 weeks from the start	630, - CZK	6300, - CZK
20	20	4 weeks from the start	400, - CZK	8000, - CZK
30	30	4 weeks from the start	283, - CZK	8500 CZK
40	40	6 weeks from the start	225, - CZK	9000, - CZK

Source: Skolka (2014)

Facilitators in the running of the intervention

Ms Janoušková, the director of the Kindergarten, emphasizes that the project was, among other things successful thanks to a perfectly prepared project proposal, and project documentation. Also there are top professionals with years of experience involved in the project. Moreover, the staff really knows how to communicate, not only with the children, but also with the parents. So the Kindergarten developed a family-friendly atmosphere, which helped with developing good relations with the parents, being open and make them satisfied.

One of the other positive points which works well for the Kindergarten is its location. The Kindergarten is situated right in the middle of Prague, everything is at walking distance, and it has a wonderful garden (Janoušková, 2014)

Barriers in the running of the intervention

The major problems which have occurred related to finances. The major part of the costs, until the 30th of November 2014, was covered by the OPPA funding (as explained above) and the hospital also covered certain parts of the cost. But the service of the kindergarten is and has not been provided free of charge. Initially, this was rather a sensitive issue, but over the project duration employees had accepted it as a natural part of the child's attendance of the kindergarten. The hospital Kindergarten costs more than a public kindergarten, but public kindergartens get supported by the state and the Kindergarten of the General University Hospital Prague does not get this support. This is because the hospital is a state institution and therefore it can't ask the state for more money. That's why the hospital Kindergarten service costs a bit more than a public kindergarten.

The increase in the fee amount after the OPPA funding stopped in November 2014 had a negative impact on the number of clients of the Kindergarten and the number of clients that applied to start in December. The number of applicants decreased, but there are still new clients that will start. This is partly the target group of people who the Kindergarten could not accept before. Example: A physician is an employee of the hospital. His wife is on a maternity leave, and they want their child to attend the hospital kindergarten. Until the completion of the project (11/2014), they would not meet the project criteria (because the mother is not employed by the hospital or the father is not on a maternity leave) and so their child could not be admitted to the kindergarten. Starting December 2014, however, the kindergarten will be able to admit this child. So this is a new group of employees, whom the kindergarten can potentially help (Janoušková, 2014).

One of the barriers at the start of the Kindergarten was that it was a new service without any reputation; parents didn't know what to expect (Janoušková, 2014).

Conditions for replicability

The most important factors for the establishment and continuous running of a Kindergarten are:

- Securing sufficient financial resources
- To secure funding through the OPPA fund (and other funds), the General University Hospital Prague has a project manager who prepares all the paper work (Thomayer Hospital Prague also has a special grant unit which takes the lead in applying for grants, see case report 6.2). To increase success rates for grant applicants, special knowledge in this area is required.

3. Results of the intervention

Effects on retention and recruitment

The possible effects of the Kindergarten on retention of staff are not being monitored nor is the cost-effectiveness of this intervention being calculated. This is because of difficulties in establishing the benefits of a nurse returning to work after maternity leave versus the costs of searching for replacement, hiring replacements and/or paying overtime to other staff (Janoušková, 2014). To date, the Kindergarten has supported nearly 60 hospital employees in returning to their jobs at the hospital, either part-time or fulltime (Svobodová & Janoušková, 2014). Both the director of the Kindergarten and a HR deputy confirm that this has had a positive impact on hospital performance, although profits cannot be quantified. Moreover, it is stated that from an economic point of view, more time is needed (4 or 5 years) to establish the (financial) effects of the Kindergarten (Janoušková, 2014).

At the same time, it should be noted that a clear effect of the Kindergarten on turnover of hospital staff may not be expected. The General University Hospital Prague has nearly 5500 employees, while the Kindergarten can host a maximum of 24 children (Svobodová & Janoušková, 2014).

The fact that the hospital has a Kindergarten probably has a positive effect on the willingness of people to work in the hospital or to remain working there, especially considering the limited capacities in state-run Kindergartens, but the Hospital also admits that it is not the key motivation why people choose to work or not work at the Hospital (Svobodová & Janoušková, 2014).

Number of children in the Kindergarten

The maximum capacity of the Kindergarten is 24 children. As per November 2014, there are seven to eight children in the Kindergarten. This decrease is due to the ending of the OPPA funding and the increase in fees that parents have to pay. Additionally, the Kindergarten finds itself in the middle of the application period for public kindergartens. Most of the children spent two years with the Hospital Kindergarten, until they reach the age of four or five. Then they apply for a public Kindergarten and leave in September. This is because the last year in a public Kindergarten is free of charge and it is written in the law that if parents apply to a public Kindergarten for this last year, the Kindergarten is obliged to accept the child (Janoušková, 2014).

References

Janoušková, Z. (2014). Interview for the Recruitment and Retention study during case site visit. November 2014.

Prague House (2014). *Prague Operational Programmes*. Available at: <http://www.prague-house.eu/en/committee-of-the-regions/eu-funds-and-community-programmes/prague-operational-programmes/> (accessed: 12-11-2014)

Skolka (2014). Školka ve VFN v Praze. Website: <http://skolka.vfn.cz/default.aspx>

Svobodová, D. & Janoušková, Z. (2014). Answers per email on questions Recruitment and Retention study.

VFN (2014). Školka pro děti zaměstnanců ve Všeobecné fakultní nemocnici v Praze [Nursery for children of employees at the General University Hospital in Prague]. Všeobecná fakultní nemocnice v Praze [General University Hospital Prague].

Appendix 6.2. Case report 6.2

Topic 6. Making the hospital workplace more attractive by improving employment and work quality

Case 6.2. Kindergarten Thomayer Hospital Prague, Czech Republic



Research methods applied:

Desk research: September – November 2014

Case site visit: November 2014

1. Summary of the intervention – Kindergarten Thomayer Hospital Prague, Czech Republic

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Personal and professional support
Professional group(s) targeted	The childcare facilities are available for children of all hospital staff. However, children are accepted in accordance with the priorities of the hospital. I.e. the Hospital reacts to the shortage of staff it has and children of these staff get priority.
Level of intervention	Organisational
Type of organisation	Hospital
Kind of services provided by organisation	Secondary and tertiary care
Size of organisation	Large (around 1600 employees)
Area covered	Prague
Intervention period / duration of intervention	The Kindergarten was established on the 1st of September 1950 and has been in continuous operation ever since. There is no expected end date.
Key actions	Childcare facility for children of 0 – 3 years and Kindergarten for children of 0 – 6/7 years for children of hospital staff of Thomayer Hospital.
Financial investment	Additional financing is required. The Kindergarten is financed from various resources, including: Prague municipality and Thomayer Hospital (both operational costs), grants (Operational Programme Prague – Adaptability fund), fees paid by parents.
Implementation strategy or processes used	No information could be retrieved, because the implementation of the Kindergarten took place too long ago (1950).
Personnel investment	Additional HR is required. Currently, the Kindergarten employs four teachers and two administrative staff. The childcare facility for children from 0 to 3 years employs four to six nurses.
Outcome measures of the intervention	Data about the effects of the childcare facilities on staff recruitment and retention are not being collected. □ The most important thing for the

	hospital is the conclusion that the Kindergarten is full. This is the evidence that the service is needed and they don't need to do any other statistics for this.
--	--

2. Rich description of the intervention

Case under study

The Kindergarten for children of hospital staff at the Thomayer Hospital Prague (Thomayerova Nemocnice Praha).

Reasons for the establishment of the Kindergarten

In the Czech Republic, state-run Kindergartens have only limited capacity and there is a shortage of Kindergarten places for children. That is why since the 1950s Thomayer Hospital has run its own Kindergarten for hospital staff (Mrkvičková & Petráčková 2014).

Objective of the intervention

To make sure that staff that wants to come work at the Hospital or continue working there, is not hindered in this wish by the fact that they cannot place their child in a childcare facility (Mrkvičková & Petráčková 2014).

Type of intervention

Professional and personal support.

Professional group(s) targeted

The Kindergarten and the facility for younger children that the Hospital also has are available for children of all hospital staff. However, children are accepted in accordance with the priorities of the hospital. This means that the Hospital reacts to the shortage of staff it has and the needs of the units.

For example if one unit really needs a doctor, and there is a young female doctor who is applying and needs to place her children in the Kindergarten, then those children will get priority (Mrkvičková & Petráčková 2014).

Level of the intervention

Organisational level.

Area covered

The Kindergarten is situated at the Thomayer Hospital in Prague. It is available for children of staff of the Thomayer Hospital, regardless of where they live.

Running time of the intervention

The Kindergarten was established on the 1st of September 1950 and has been in continuous operation ever since (Mrkvičková, 2014). However, an important change occurred in 1992, when the Kindergarten became part of the Special Kindergarten at the Thomayer's hospital, established by the Office of Education in Prague 4 (Mrkvičková, 2014).

Implementation strategy

No information could be retrieved, because the implementation of the Kindergarten took place too long ago (1950).

Kind of services provided

Thomayer Hospital offers two sorts of support for its hospital staff with children: a childcare facility for children from 0 – 3 years and the Kindergarten for children from 3 – 6/7 years.

Childcare facility for children aged 0 – 3 years

The childcare facility for children of hospital staff aged 0 – 3 years was established about two or three years ago (2011, 2012). It was established because the Hospital felt it needed to react to developments taking place in society. There are a lot more young single mothers. There is a need for them to be able to put their young children in childcare as well. Hence, the Thomayer Hospital applied to receive a grant to establish this service and it received the grant. At this time, the funding through the grant has finished but the Hospital continues to support the facility because it is needed.

Children who have attended this childcare facility are prioritized to be allowed into the Kindergarten of the Thomayer Hospital (once they are three years of age). In this way, the Hospital keeps the parents who already started working at the Hospital when their children were just a few months old, in the work process (Mrkvičková & Petráčková 2014).

There are currently around twelve children in this childcare facility and there is capacity for a few more children. The children are taken care for by four to six nurses, who were newly hired when the facility opened, depending on the number of children that is in on a particular day (Mrkvičková & Petráčková 2014).

Kindergarten (children from 0 – 3 years)

The Kindergarten at Thomayer Hospital officially accepts children of three years and older. Children stay in the Kindergarten until they are six years old, or maybe seven, after which they go to school (Mrkvičková & Petráčková 2014). The Kindergarten has a capacity for 48 children, divided over two classes. They are taken care for by four teachers and two housekeeping/administrative staff. Operating hours are from Monday to Friday (06.00 – 17.00- if necessary, more) and are tailored to the needs of hospital employees. There are mostly children of nurses, doctors and administrative staff (Mrkvičková, 2014).

Organisational framework

The Kindergarten was established by Thomayer Hospital in 1950. However, it cooperates closely with the municipality of Prague. An important change in the organisational framework occurred in 1992, when the Kindergarten became a part of the Special Kindergarten at the Thomayer's hospital (established by the Office of Education in Prague 4). The Kindergarten has been established by The city of Prague since 2001 (Mrkvičková, 2014).

Currently, the Kindergarten employs four teachers and two administrative staff. The childcare facility for children from 0 to 3 years employs four to six nurses (Mrkvičková & Petráčková 2014).

Facilitators and barriers in the running of the intervention

Thomayer Hospital does not have any structural problems in the running of the childcare facilities, except for the 'normal' everyday problems like maintenance of the place, or personal or interpersonal issues. The success of the facilities results for a

great part from the great director of the school, and the great team (Mrkvičková & Petráčková 2014).

Finances

The childcare facility for children of 0 – 3 years and the Kindergarten are being financed by (Mrkvičková, 2014):

- The city of Prague (operational costs)
- Thomayer hospital (operating costs)
- Use of grants (Operational Programme Prague – Adaptability fund)
- Fees paid by parents

At the time of writing (November 2014), the Kindergarten isn't financed by grants.

Operational Programme Prague – Adaptability fund

The Hospital has a special grant unit which takes the lead in applying for grants. This unit was waiting for an Operational Programme Prague – Adaptability fund- call for proposals to invest money in the buildings. However, this call didn't come, but other calls did. First, the Kindergarten was financed via the OPPA. Later on, the childcare facility for young children was also financed via the OPPA. The Hospital was by that time already experienced in this so it received money to finance extra things and start extra things such as the childcare facility for children of 0 – 3 years. The grant unit at the hospital fills out the application, because it is a complex process.

Once the financing was received, the complex process continues. For example, every six months a detailed monitoring report had to be produced, and so on.

At the time of writing (November 2014), the financing through the OPPA fund has stopped and the Hospital has taken on the costs for continuing the childcare facilities because they are satisfied with it and there is a need among hospital staff for these services.

Operational costs

The operational costs used to be covered by the OPPA fund, but now the grant has stopped they are covered by the hospital. Direct operational costs such as salaries are covered by the municipality. That the municipality is also paying part of the costs stems from a tradition which was established a long time ago.

Fees

The school fee for the Kindergarten is 500 Czech crowns (18 Euro) a month. Parents also pay for the food of the children.

Conditions for replicability

The most important factors for the establishment and continuous running of childcare facilities are:

- Securing sufficient financial resources
- To secure funding through the OPPA fund (and other funds), the Thomayer Hospital has a special grant unit which takes the lead in applying for grants (the General University Hospital Prague also has such a division, see case report 6.1). To increase success rates for grant applicants, special knowledge in this area is required.

3. Results of the intervention

The fact, that the Thomayer Hospital has a Kindergarten and nursery, has a positive effect on the willingness of people to work in the hospital (Mrkvičková, 2014). However, data about the effects on staff recruitment and retention are not being collected.

The Thomayer hospital does have statistics about the amount of children that would like to attend the Kindergarten, the age of the children, and so on. However, the most important thing for the hospital is the conclusion that the Kindergarten is full and large portion of it are children from hospital employees. When the hospital sees this, they know that the service is needed and they don't need to do any other statistics for this (Mrkvičková & Petráčková 2014).

What is most important for the Head of Nursing is that, if she wants to hire a new nurse and she calls the director of the Kindergarten and she says 'I need place in the Kindergarten or in the facility for very young children', she knows that she can have a place there for the child and she can hire the nurse. That is what is most important, according to Thomayer Hospital. The direct impact is visible in the fact that single mothers come and say: "I could start working next month if you could place my child in the facility". And if the Hospital manages to do so, they can hire the new nurse (Mrkvičková & Petráčková 2014).

References

Mrkvičková, J. (2014). Answers received by email to questions Recruitment and Retention study.

Mrkvičková, J. & Petráčková, I. (2014). Interview for the Recruitment and Retention study during case site visit at Thomayer Hospital Prague, 14-11-2014. Visit conducted by Marieke Kroezen and Veronika di Cara (Czech Nurses Association).

Appendix 6.3. Case report 6.3

Topic 6. Making the hospital workplace more attractive by improving employment and work quality

Case 6.3. *Dr DOC* programme, Rural Doctors Workforce Agency, South Australia



Research methods applied:

Desk research: August – September 2014

Telephone interview: September 2014

1. Summary of the intervention – *Dr DOC programme, Rural Doctors Workforce Agency, South Australia*

Dimension of interest	Categories/description
Objective of the intervention	Retention
Type of intervention	Personal and professional support
Professional group(s) targeted	Rural GPs
Level of intervention	Organisational
Type of organisation	The Rural Doctors Workforce Agency, which provides the Dr DOC programme, is the workforce agency for rural South Australia
Kind of services provided by organisation	RDWA provides support to rural practice through professional development opportunities, etc. Doctors have access to a wide range of support including networks of specialists.
Size of organisation	Medium
Area covered	The state of South Australia
Intervention period / duration of intervention	The South Australian Dr DOC programme was instigated in 2000. There is no expected end date.
Key actions	The Dr DOC programme works across the full spectrum of health care, including: prevention, early intervention, acute or chronic situations, telephone support in crisis situations.
Financial investment	Relatively limited (also depending on choice of funding model of the programme, e.g. free for doctors vs. co-payment, etc.). To implement the Dr DOC programme within an existing organisation, additional HR (not necessarily full FTE) are required.
Implementation strategy or processes used	The Dr DOC programme was developed with significant input from Dr Sexton. Together with Dr Sexton, the RDWA was able to fund the development of his ideas.
Day-to-day running of the intervention	Responsibility of Rural Doctors Workforce Agency.
Personnel investment	To implement the Dr DOC programme within an existing organisation, additional human resources (not necessarily full FTE) are required.

<p>Outcome measures of the intervention</p>	<p>There is no monitoring or tracking of the influence that the Dr DOC programme has on retention of rural GPs in South Australia. However, based on an evaluation in 2006 researchers concluded that the Dr DOC programme provides a useful framework for reducing the number of GPs leaving rural practice.</p>
---	---

2. Rich description of the intervention

Establishment of the Dr DOC programme

The Dr DOC programme, a rural workforce support programme offering both social and emotional support strategies, as well as practical interventions, to improve GPs' health and well-being, was instigated in 2000 by the Rural Doctors Workforce Agency (RDWA) in South Australia (Gardiner et al., 2006).

Reasons for the establishment of the Dr DOC programme

The Dr DOC programme was developed for a number of reasons, including the fact that 10% of rural GPs sometimes experience a crisis, rural GPs feel isolated and unsupported and the rural environment brings particular stressors (Sexton, 2004). Moreover, medical practice has been well documented as a stressful occupation, with doctors often reporting high levels of stress and work dissatisfaction. This is also the case among GPs in rural areas, where there is poorer access to professional and personal support services. These factors can have many negative consequences, including increased difficulty in retaining GPs in rural areas (Gardiner et al., 2006).

Objective of the intervention

The Dr DOC programme of the Rural Doctors Workforce Agency (RDWA) in South Australia aims to improve rural and remote doctors' health and wellbeing through both physical and psychological health strategies (Gardiner et al., 2005; 2006). It supports doctors to take care of themselves, their family and their colleagues (RDWA, 2014).

Type of intervention

The Dr DOC programme is a health and well-being programme aimed at rural GPs (Gardiner et al., 2006). The programme tries to look at the issues of doctor's health and wellbeing and how important that is in retaining doctors (Sumner, 2014).

Professional group(s) targeted

GPs who work in rural areas in South Australia.

Level of the intervention

Organisational level; the Dr DOC programme was instigated and is run by the Rural Doctors Workforce Agency.

Area covered

The Dr DOC programme is a state-wide programme and available to all rural GPs in South Australia.

Running time of the intervention

In South Australia, the Dr DOC programme was instigated in 2000. The RDWA still has another 2 years of contract with the Commonwealth Government. This means that the Dr Doc programme will continue to run for at least two more years. There is no reason at this stage why the Dr DOC programme would not be continued afterwards (Sumner, 2014).

Implementation strategy

The Dr DOC programme was developed with significant input from Dr Roger Sexton. He at the time was a practising GP in a rural town in South Australia who had an interest in doctors' health. He approached the Rural Doctors Workforce Agency South Australia because he wanted to try and develop a programme for rural areas. He was then invited to put forward some ideas. Together with Dr Sexton, the RDWA was able to fund the development of his ideas. The RDWA could supply basic funding, but was also able to apply for extra funding to support the ideas. That is how the core elements of the Dr DOC programme were developed. Dr Sexton in the early stages worked as a consultant for the programme (Sumner, 2014).

Kind of services provided by the Dr DOC programme

The Dr DOC programme supports doctors to take care of themselves, their family and their colleagues. It works across the full spectrum of health care; from prevention through early intervention to acute or chronic situations. Moreover, the RDWA is always available by phone in crisis situations (RDA, 2014). The philosophy is to focus on prevention and make sure that rural doctors don't develop stress. However, should they develop stress, the programme focuses on how to recognize it and what ways to deal with that. Hence, the Dr Doc programme covers a whole range of programmes along the continuum from prevention to stress management (Sumner, 2014). The Dr DOC programme is a totally confidential service (RDWA, 2014).

The key parts of the Dr DOC programme that was established in 2000 include:

- Link GPs, who form a peer-support network of experienced rural GPs
- Visiting health check-ups for rural doctors and their families:
The Dr DOC programme tried to encourage healthy behaviours by encouraging all doctors to have their own GP and have a medical check-up. For rural doctors, it is often difficult to go and see a GP, because of their isolated location. Through some extra funding, the Dr DOC programme set up a programme of visiting health checks in rural areas. This was difficult to achieve, but the visiting health checks were well received and ran for a number of years (Sumner, 2014).
The visiting health check-ups are not being performed anymore at this time.
- Crisis plans, which provide assistance for doctors who are experiencing professional or personal distress
- Pamphlets providing information about support services available to rural GPs
- An emergency support line
- Rural retreats, which involve problem solving and cognitive behavioural coaching:

In its early years, the Dr DOC programme also organised retreats for doctors who were most in need of them. Through the literature, doctors with the highest levels of stress were identified. There were approximately 2-3 retreats per year initially. Doctors who thought they needed to come because of their stress were invited to participate. During these retreats, which took the form of a workshop weekend, two psychologists taught the doctors how to reduce their stress. The RDWA together with the psychologists also performed studies at that time to establish whether providing doctors with the opportunity of a retreat, changed their intention to leave practice. It was found that the

intention to leave diminished in doctors who followed the retreat. Hence, having the intervention of a retreat had a positive result (Sumner, 2014).

The rural retreats are not being organised anymore at this time.

- Development of private care networks of GPs and other professionals (both urban and rural), psychiatrists, psychologists and family therapists whom GPs can access confidentially in times of distress. All doctors in distress can call the RDWA confidentially and the RDWA can act as a triage person by referring the distressed doctor to a relevant person in the network.

Changes in the content of the original Dr Doc programme

Over the years, a number of changes occurred in the Dr DOC programme. The visiting health check-ups in rural areas proved very difficult to sustain, for two reasons: because of the high costs and because of the difficulties in maintaining follow up and providing the on-going care that doctors needed. So at this moment, rather than go out and visit the doctors, the RDWA encourages doctors to come to Adelaide or find another doctor in the country.

Another change is that, at this moment, no retreats are being organised. After a while, the RDWA did not get as big a response to attend and it was felt that saturation was occurring and the number of retreats was decreased. Moreover, it was a very expensive programme for the RDWA. The RDWA is currently reviewing whether it wants to do any retreats in the future (Sumner, 2014).

Doctors' Health SA

The changes in the Dr Doc programme were partly the result of the start of a new programme in South Australia called '*Doctors' Health SA*', based in Adelaide. This is a new association that was developed by a group of interested doctors including Roger Sexton, who was one of the key founders of the Dr DOC programme. Doctors' Health SA is broader than the Dr DOC programme in that it also looks after rural and urban doctors, specialists and medical students.

One of the important things that Doctors' Health SA is doing, and the RDWA is part of this, is encouraging doctors to become doctors for doctors. Doctors' Health SA has developed a training programme for that. Moreover, Doctors' Health SA has set up a clinic that's open a couple of times a week and doctors can come in and see someone who has done the training. All doctors who successfully finished the training are recorded on the list that the RDWA has for doctors who experience a crisis or who want a check-up. The number of doctors from rural areas who take the training is increasing. Having a check-up is included in one of the main providers of medical indemnity's risk management programme as a way of gaining points to trigger a reduction in the annual fee (Sumner, 2014).

As Doctors' Health SA is receiving funding from the RDWA, the RDWA has asked them to look at the current programme areas and consider a rural focus. For example, the RDWA asked Doctors' Health SA that when they train GPs to care for other GPs, to make sure that a certain percentage of GPs who do the training come from rural areas. Moreover, if Doctors' Health SA wants to train a number of doctors from rural areas, some of these doctors can become sort of 'ambassadors' for the programme, to make doctors aware of the issue of doctor's health in rural areas (Sumner, 2014).

Organisational framework

The Rural Doctors Workforce Agency (RDWA) in South Australia is a workforce agency. There is one such workforce agency in every state of Australia. The RDWA was funded originally through the Australian Government to look into recruitment and retention issues of medical practitioners in rural areas. In the early years of the RDWA in South Australia, a number of programmes have been developed in the area of retention and one of them was the Dr DOC programme (Sumner, 2014).

Cooperation with Doctors' Health SA

The RDWA works closely with Doctors' Health SA. The RDWA and the Australian Medical Association are the prime board members of Doctors' Health SA. Doctors' Health SA also receives funding from the RDWA. In 2014, the RDWA and Doctors' Health SA got into a more formal agreement to make sure that they aren't both doing separate programmes in the same area (Sumner, 2014).

Facilitators in the running of the Dr DOC programme

One of the key things that made the Dr Doc programme work in the early stages was that there was an individual champion, Dr Roger Sexton, and an organisation champion, the RDWA. It was a strong partnership. To have someone who is an individual champion during the first phase, and who is passionate about it and wants to work for it, is important. Moreover, Dr Sexton was a well-respected GP, so people would listen to what he had to say and were willing to try his ideas. According to the RDWA, having such a champion during the early stages has been significant.

Another thing that made the Dr Doc programme work was that it was well communicated to the rural areas. People were aware of the programme. Moreover, when people rang in with a crisis, the Dr DOC programme was able to offer a way forward. That was important; that it was a confidential service and that if help was needed it was always acted upon (Sumner, 2014).

Barriers in the running of the Dr DOC programme

The most problems were encountered in the area of the health check-ups, because of logistic problems (i.e. getting to the rural doctors). Other problems centred on the issue of follow-up; how to arrange on-going treatment for rural doctors in case it was needed? Eventually, these difficulties forced the RDWA to stop the visiting health check-ups.

Financing

The Dr DOC programme is funded by the Australian Government and the State Government of South Australia (Sumner, 2014). The RDWA receives funding to provide recruitment and retention support and the Dr DOC programme is still seen as a retention programme. The RDWA is usually funded on a 3 year cycle and at the time of writing (October 2014) the RDWA still has another 2 years of contract. This means that the Dr Doc programme will continue to run for at least two more years. Moreover, the RDWA states that there is no reason at this stage why the government would not continue to fund rural workforce agencies such as the RDWA (Sumner, 2014).

In addition, the RDWA was able to acquire extra funding for specific parts of the Dr DOC programme, such as the visiting health check-ups.

According to the RDWA, the costs of the Dr DOC programme are relatively limited. Naturally, the costs vary according to what the RDWA is doing with the programme. When it still organised retreats, the costs were much higher, because doctors were never charged for attending a retreat. However, the RDWA also received extra funding for that initially. But having a list of GPs doesn't cost an organisation very much. To implement the Dr DOC programme within an existing organisation such as the Rural Doctors Workforce Agency, additional human resources (not necessarily full FTE) are required. You need someone who is very well able to work with doctors (Sumner, 2014).

Different funding models

As the RDWA mentions, organisations can also consider different models of funding, for example for the retreats, where doctors are paying part of the costs (Sumner, 2014).

3. Results of the intervention

There are no results available- and there is no monitoring or tracking of the influence that the Dr DOC programme has on retention of rural GPs in South Australia. The RDWA has to report to the Commonwealth Government about the Dr DOC programme and there are certain performance indicators but these are fairly general (Sumner, 2014).

Evaluation of the Dr DOC programme

The Dr DOC programme in South Australia was extensively evaluated. Already in 2004, five years after the establishment of the programme, Dr. Sexton was able to report that there was 100% awareness of the programme among rural GPs in South Australia. Moreover, fewer GPs had the intention to leave their practice within two to five years. In addition, it was reported that more GPs took care of their physical health and there were modest improvements in psychological well-being (Sexton, 2004).

The Dr DOC programme in South Australia was again evaluated in 2006 (Gardiner et al., 2005; 2006). Via survey-research among GPs working in rural practice in South Australia, as identified by the RDWA, the impact of the Dr DOC programme on social support, rural doctor distress, and intention to leave rural general practice was evaluated.

In August 2001, a first wave of data was collected (N= 187). In September 2003, a second wave of data was collected (N= 221), after which the findings from both years were compared. In both years, the majority of respondents was male and between 30 and 50 years old. Most of them had worked in rural practice for more than five years and a majority had a partner at home (Gardiner et al., 2005; 2006).

In 2006, significant improvements were found in the level of feeling social support (see table 1 below). There were a number of significant improvements in rural distress as well, with decreases in GPs feeling unsupported, in crisis with no help and GPs feeling that their mental health was suffering. These reflect the primary aims of the Dr DOC programme initiatives (Gardiner et al., 2006).

Table 1: Social support (significant changes)

	Somewhat – a lot	
	2001	2003
Do you have other GPs with whom you can discuss personal issues?	46.2	56.4
Do you have other people (other than your spouse/partner) with whom you can discuss professional or personal issues?	56.8	66.7

Source: Gardiner et al., 2006

The researchers also asked doctors to evaluate the helpfulness of certain parts of the Dr DOC programme. The results can be found below in table 2.

Table 2: Helpfulness of Dr DOC initiatives

Initiative	Used initiative		Did initiative help? %		
	% of sample	Estimated use (total)	Not at all	Somewhat	Very much so
Link GPs	4.8	19	14.3	71.5	14.3
Visiting health check-ups	21.9	88	9.1	72.7	18.2
Local crisis plans	1.9	8	0.0	66.7	33.3
Information pamphlets	18.5	75	0.0	82.8	17.1
Pool of urban and rural GPs	5.8	23	16.7	66.6	16.7
RDWA emergency support line	5.3	21	0.0	33.3	66.7
Rural retreats	7.2	29	0.0	25.0	75.0

Source: Gardiner et al., 2006

The conclusion of the researchers in 2006 was that “the improvements seen in the areas of support and well-being for rural GPs, and participation in initiatives aimed at enhancing those areas, supports the role of the Dr DOC programme in improving the well-being of rural GPs. As such, the Dr DOC programme provides a useful framework for future programmes aimed at reducing levels of stress and dissatisfaction among rural GPs and for reducing the number of GPs leaving rural practice” (Gardiner et al., 2006).

References

Gardiner, M., Sexton, R., Durbridge, M., & Garrard, K. (2005). The role of psychological well-being in retaining rural general practitioners. *Australian Journal of Rural Health, 13*(3), 149-155.

Gardiner, M., Sexton, R., Kearns, H., & Marshall, K. (2006). Impact of support initiatives on retaining rural general practitioners. *Australian Journal of Rural Health, 14*(5), 196-201.

Rural Doctors Workforce Agency (2014). *Health and Wellbeing*.
<http://www.ruraldoc.com.au/services/support-for-doctors/health-and-wellbeing/>
(accessed: 12-09-2014)

Sexton, R. (2004). Evaluation of Dr DOC Programme. 2000 – 2004. *Presentation*.
Sumner, K. Interview for the 'Recruitment and Retention study'. 17-09-2014.

Appendix 6.4. Case report 6.4

Topic 6. Making the hospital workplace more attractive by improving family-friendly practices

Case 6.4. NUH Health and Wellbeing programme, Nottingham University Hospitals, United Kingdom



Research methods applied:

Desk research: September – October 2014

Telephone interview: October 2014

1. Summary of the intervention – NUH Health and Wellbeing programme, Nottingham University Hospitals, United Kingdom

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Personal and professional support
Professional group(s) targeted	All hospital staff
Level of intervention	Organisational
Type of organisation	Hospital (Nottingham University Hospitals)
Kind of services provided by organisation	Secondary care and specialist tertiary care.
Size of organisation	Large (staff head count > 14.500)
Area covered	Nottingham & Nottinghamshire: providing services to over 2.5 million residents of Nottingham and its surrounding communities and specialist services to a further 3-4 million people from neighbouring counties each year
Intervention period / duration of intervention	The 'Health & Wellbeing programme' began in 2005 as the 'Q Active' project. Since 2009, the current Health & Wellbeing programme has been running. No fixed timeframes are set for the programme.
Key actions	Various actions to improving physical and emotional well being
Financial investment	Additional financing is required. NUH embedded the programme into the organisation through continued funding of the Coordinator post. Additional non-structural funding is obtained through external funds.
Implementation strategy or processes used	Milestones in the implementation of the 'new' Health & Wellbeing programme were: <ul style="list-style-type: none"> - development of the health and wellbeing strategy - recruitment of health and wellbeing coordinator - launch of the health and wellbeing strategy via inaugural health and wellbeing week
Personnel investment	Main actors are the coordinator (full-time), the assistant to the coordinator (part-time), instructors and therapists.
Outcome measures of the	It is difficult to establish a direct link between

intervention	the programme and R&R rates of NUH. Yet it is clear that sickness absence rates came down significantly since the programme started and the programme contributes to staff satisfaction with the Trust as a place to work for. NUH has been awarded multiple times for its Health & Wellbeing programme.
--------------	--

2. Rich description of the intervention

Case under study

The Nottingham University Hospitals NHS Trust (NUH) Health and Wellbeing programme for staff.

Establishment of the NUH Health and Wellbeing programme

The programme which is now called the 'Health & Wellbeing programme' initially began in 2005 as the 'Q Active' project. In 2009, the current Health & Wellbeing programme was established.

Reasons for the establishment of the NUH Health and Wellbeing programme

The programme which is now called the 'Health & Wellbeing programme' initially began in 2005 as the 'Q Active' project. This programme was introduced for several reasons. Part of the reason was the publication of the Choosing Health White Paper in the UK around that time. Moreover, Nottingham University Hospitals NHS Trust had high sickness levels at the time and the Trust wanted to improve these. Another reason was to improve the experiences of staff who worked for the Trust (Knowles, 2014). A final reason is that the Trust is ambitious. Its overarching Workforce Strategy sets down a commitment to become the best place to work by 2016. The Health and Wellbeing Strategy is supportive for achieving this aim (Knowles, 2014; NUH, 2012).

Objective of the NUH Health and Wellbeing programme

Nottingham University Hospitals NHS Trust wanted to encourage and support their staff to develop and maintain a healthy lifestyle to improve their physical and emotional wellbeing in fun and enjoyable ways (NHS Employers, 2014).

The overall aims of the Health and Wellbeing strategy are to (NUH, 2012; NHS Employers, 2014):

- create a safe and healthy working environment
- improve physical and emotional wellbeing
- encourage and support employees to develop and maintain a healthy lifestyle
- support people with manageable health problems or disabilities to maintain access to or regain work
- improve staff satisfaction, recruitment and retention.

An important sub-aim is reducing the sickness levels across the Trust (Knowles, 2014).

Type of intervention

Personal and professional support.

Professional group(s) targeted

All NUH hospital staff.

Level of the intervention

Organisational level.

Area covered

Hospital staff from all three sites (Queen’s Medical Centre, Nottingham City Hospital and Ropewalk House) of Nottingham University Hospitals NHS Trust can participate in the programme. The activities of the Health & Wellbeing programme are divided over the three hospital sites. Ropewalk House is significantly smaller than the other two and only small events take place there. All ‘big’ events of the Health & Wellbeing programme are run on both main campuses. Programme activities are divided equally between the two campuses, to the extent possible, so that staff can do the activities on the campus where they are based (Knowles, 2014).

Running time of the intervention

The programme which is now called the ‘Health & Wellbeing programme’ began in 2005 as the ‘Q Active’ project. Since 2009, the current Health & Wellbeing programme has been running. No fixed timeframes are set for the programme (Knowles, 2014).

The NUH Health and Wellbeing programme

The Health & Wellbeing programme is made up of the following content, activities and services (NHS Employers, 2014):

Physical activity:

- weekly fitness classes on both campuses
- gym facilities on both campuses – provided at the physiotherapy gyms outside of clinic times
- regular pedometer challenges – 6 weekly team challenges
- great NUH Walk Off – to celebrate National Walking Month
- multi activity challenges – NUH 2012 Challenge, Summer Fun Triple Challenge
- learn2run courses – complete beginners, Couch to 5k
- netball team
- discounts with external gym providers.

Know your numbers:

- Quarterly health checks in January, April, June and September, which include blood pressure testing, Body Mass Index (BMI), cholesterol, blood glucose, waist measurement, body fat and body water.

Staff Occupational Physiotherapy Service:

- Fast track physio service for staff. Three full time physiotherapists, see staff within three weeks of referral.
- Self-referral system – specific referral criteria set.

Support for staff:

- An Employee Assistance Programme with dedicated telephone and website support service.
- Staff support groups through the Equality and Diversity team.
- Counselling provided through Occupational Health.
- Spiritual and Pastoral Care team.

Mental wellbeing:

- Programme of coping with stress and building resilience workshops developed and delivered by the trusts clinical psychologists.
- Coping with stress for managers workshops, these have been delivered in-house by the trusts' HR managers and externally by a local provider.
- One-to-one slots for managers with OH counsellors to discuss particular cases in confidence.
- Annual Mental Wellbeing Week.
- Employee Assistance Programme and support for staff.

Health promotion:

- *Health and Wellbeing Week* – June each year (the fifth one will take place from 14 June 2014). A week-long series of road shows on all three campuses including a range of information and activities on Know your Numbers, Be Active, Eat Well and Relax.
- *Mental Wellbeing Week* – October each year (3rd one completed in October 2013). Activities have included relaxation workshops, coping with stress, free fitness classes, lunch time walks.
- *Smoking cessation* – provision of onsite clinics with our local smoking cessation provider, Kick the Butt weeks to promote a smoke free site, active promotion of No Smoking Day and Stoptober.
- *Wellbeing Zone* – online health and lifestyle website.

Active travel:

- Partnership work with Sustrans Ucycle Nottingham project with dedicated project officer for NUH – the project coordinates monthly Dr Bike sessions on both main campuses, bike maintenance classes, bike security campaigns, support with developing new infrastructure, information on cycling facilities and individual travel planning, promotion events and campaigns.
- Cycle2Work scheme.
- Secure parking and changing facilities.
- Promotion of walk to work week.

Healthy eating (element added in 2013):

- Introduction of new range of healthier sandwiches. Work underway on providing a healthy option hot meal each day with a loyalty scheme attached.
- Healthy eating week – April 2013, included range of information stands and cooking demos.
- Staff weight management group – pilot 12 week programme introduced in Sept 2013 (evaluation underway).
- Obesity Strategy in development.
- Healthy recipe competition.

General wellbeing:

- A range of therapies provided onsite by qualified therapists.
- Readers Group at Queens Medical Centre.

Implementation strategy

The programme which is now called the 'Health & Wellbeing programme' initially began in 2005 as the 'Q Active' project and was funded externally. This three year project ended in 2008. The Q Active project focused solely on physical health because of the evidence that was available on physical activity improving health. Moreover, one of the Trust consultants, who was a professor in Exercise Medicine was highly involved in the project.

In 2008, the external funding for the programme stopped. However, as the project had proven to produce positive effects, Nottingham University Hospitals NHS Trust decided to continue funding the programme itself directly. The subsequent main milestones in the implementation of the 'new' Health & Wellbeing programme were (NHS Employers, 2014):

- development of the health and wellbeing strategy (January 2010)
- recruitment of the health and wellbeing coordinator (May 2010)
- launch of the health and wellbeing strategy via inaugural health and wellbeing week (June 2010)

Because the Trust had continued supporting the Q Active project after the original funding ceased, there was no gap between the Q Active project stopping and the Health and Wellbeing programme starting (Knowles, 2014).

Organisational framework

In 2009, a Health & Wellbeing strategy was written for Nottingham University Hospitals NHS Trust. The main actors in the programme are the Health & Wellbeing coordinator, the assistant to the Health & Wellbeing coordinator (who works 2 days a week), (self-employed) instructors who run fitness classes and gym instructors plus 3 therapists who provide complementary and beauty therapies. Some of the Health and Wellbeing programme activity is delivered in partnership with a number of other departments in the Trust, most notably Occupational Health nurses, Physiotherapy, Clinical Psychology and Dietetics. There are a number of volunteers who come and help out sometimes. Other partnerships include external partners. For example, active travel initiatives are provided through a partnership with Sustrans, the national sustainable transport charity as part of Nottingham City Council's Local Sustainable Transport Fund initiatives (Knowles, 2014).

Responsibilities in terms of the Health & Wellbeing programme

The health and wellbeing strategy is reviewed annually alongside a review of activity and its implementation is overseen by the trust board. The Director of Workforce and Planning has been appointed as board level champion of the programme.

The assistant director of Human Resources is the strategic lead for the Trust on health & wellbeing and is responsible to the Trust board for reporting back about what the programme has been doing, monitoring the budget, and monitoring the strategy, and so on.

One of the HR managers within the Trust has responsibility for the wellbeing & attendance policy, updating the policy, and so on (Knowles, 2014).

Health & Wellbeing steering group

A health and wellbeing steering group was set up to oversee the implementation of the health and wellbeing strategy and action plans. The group reviews sickness

monitoring data, evaluation of programme activities and provides direction for the operational group. Group membership is as follows (NHS Employers, 2014; NUH, 2012):

- Assistant Director of Human Resources (Resourcing and Planning)
- Health and Wellbeing Co-ordinator
- Directorate HR Manager with responsibility for health and well-being
- Directorate HR Manager with responsibility for staff surveys
- Staff Side Chair
- Staff Side Secretary
- Directorate Representatives
- Occupational Health Representative
- Senior Trust Dietician
- University of Nottingham Representative (Faculty of Medicine and Health Sciences)
- Communications Representative
- Health and Wellbeing Champion Representative

Health & Wellbeing operational group

The health and wellbeing operational group meets monthly to oversee the day to day implementation of activities. The group is made up of the occupational health manager and the occupational health senior nurse specialist, assistant director of HR who is the strategic lead for the programme, the HR manager with responsibilities for wellbeing and attendance and smoke free site policies and the health and wellbeing coordinator. This group reports directly back to the health and wellbeing steering group (NHS Employers, 2014).

Health & Wellbeing Coordinator and Health & Wellbeing assistant

The Health & Wellbeing Coordinator (Agenda for Change, Band 5) was appointed in June 2010 to lead on the day to day implementation of the programme. The trust have since taken on a part time health & wellbeing assistant (15 hours per week, Agenda for Change, Band 2). Both are employed as part of the HR team (NHS Employers, 2014; Knowles, 2014). The Health & Wellbeing Coordinator and Health & Wellbeing assistant undertake operational activity against the action plan and with the support of the above groups. They are responsible for the day to day implementation and delivery of the Health & Wellbeing programme. The Health & Wellbeing coordinator oversees the programme, makes sure that classes are being run, develops new initiatives, events, and so on (NHS Employers, 2014; Knowles, 2014).

Partnerships

There are a number of key partners with whom the NUH Health & Wellbeing programme works to deliver the strategy (NUH, 2012). They are:

- Employees and Managers within the Trust
- Human Resources
- Occupational Health
- Therapy Services (Physiotherapy and Dietetics)
- Estates and Facilities
- Staff Side
- Trade Union Representatives

- Spiritual and Pastoral Care
- Learning and Organisational Development
- Communications
- Health and Safety Committee
- Transport Strategy Group
- NUH active
- PCT's
- Outside agencies e.g. New Leaf, Sustrans

There is also an external partnership with Sustrans, a sustainable transport charity who provide us with a project officer who runs all our cycling activities for the programme (Knowles, 2014).

Involvement of various hospital departments in the Health & Wellbeing programme

The Trust's Occupational Health Service is integral to the health and wellbeing strategy. Each month there is a joint meeting to ensure that Occupational Health services are supporting the health and wellbeing needs of staff. The Occupational Health department has a big role in terms of reporting on the wellbeing & attendance policy. They do the assessments, make recommendations, etc. They also have involvement in terms of when certain events take place, such as the health checks. NUH's Occupational Health nurses come along and actually deliver the checks themselves, blood pressure checks etc. (Knowles, 2014). Occupational Health department nurses also deliver the 'Know your Numbers' project, quarterly health checks road shows. This is funded through OH with consumables for the checks provided by funding from the staff lottery (NHS Employers, 2014).

Clinical psychologists have developed and delivered a coping with stress and building resilience course for staff. The dietetics department have been working on developing a healthy eating programme and have recently delivered a staff weight management group (NHS Employers, 2014).

Communication about the programme

The project has established a good profile within the trust through a robust communications plan. Weekly items are included in the all staff trust briefing, they produce a bi-monthly newsletter and they have a mailing list of just under 2000 staff to which regular updates are sent. The trust has a comprehensive website which outlines the programme and information is given to new starters as part of their corporate induction. They have regular slots on self-care courses, preceptorship days, junior doctors inductions, estates and facilities away days and BELS training courses to provide information about the programme as well as attending other away days or team meetings by specific invitation (NHS Employers, 2014).

There are a number of dedicated notice boards across the sites plus Health Champions to help promote the programme. In 2013 the trust developed a short film giving an overview of the programme which is included on NUHs website and its recruitment website for all prospective employees to view (NHS Employers, 2014).

Facilitators in the running of the intervention

Partnership working has been a key element of the programme and has been the main reason for its success. The key partnership has been between human resources and

occupational health. This was developed at the outset of the programme – the development of the health and wellbeing strategy and subsequent recruitment of the health and wellbeing coordinator were completed in partnership between the two departments (NHS Employers, 2014).

Barriers in the running of the intervention

The main challenge is making the programme accessible to all staff particularly those who work shifts and find it more difficult to access the onsite services. The trust plans to develop their engagement strategy as well as more detailed communications about what is available for staff externally.

Communication is another challenge across a large organisation based on three sites. Key to addressing this has been an effective communications plan and regular marketing of the programme. The trust have a specific logo for the programme and weekly items in the all staff trust briefing which has significantly raised the profile of the programme. They have also used targeted communications, for example through cascade briefings via HR managers or to ward managers email networks (NHS Employers, 2014).

Finally, funding the activities is an area of constant attention (see also below).

Finances

NUH embedded the Health & Wellbeing programme into the organisation through continued funding of the Health & Wellbeing Coordinator post. The coordinator is employed on a permanent basis (Knowles, 2014). However, there is no structural operating budget. There is a small budget for the project which is provided through the cash back from the Cycle2Work scheme provider. This means that if a staff member buys a bike, the Health & Wellbeing programme gets a certain percentage of that (NHS Employers, 2014; Knowles, 2014).

Additional funding for specific activities is sought through the Hospital Charity staff lottery (NHS Employers, 2014). This lottery sometimes provides limited funds for activities or certain things that will benefit staff and they have been very supportive and generous to activities of the Health & Wellbeing programme, such as the health & wellbeing week and the health-checks, etc. (Knowles, 2014). From 2010 until 2012 the Staff lottery has donated circa £20,000 to support the Trust's health and wellbeing programme (NUH, 2012).

Fitness classes, the gym and the wellbeing therapies are self-funded through the fees that staff pay to take part. These are maintained at affordable rates (NHS Employers, 2014). The funds that are raised by this pay for the instructors (Knowles, 2014).

Conditions for replicability

There appear to be a number of crucial factors that need to be taken into account for organisations which are also thinking about establishing a health & wellbeing programme:

- Financial resources: the programme produces considerable costs. Should the organisation not be able to cover these itself, external funding needs to be sought.
- Economy of scale: setting up a health & wellbeing programme is feasible for an organisation such as Nottingham University Hospitals Trust with a staff head count of more than 14,500. Smaller organisations may want to consider

providing their staff with free or reduced memberships for fitness schools, quit smoking therapies, etc. instead of developing their own programme.

3. Results of the intervention

The Health & Wellbeing coordinator informed us that it is difficult to establish a direct link between the programme and recruitment and retention rates of NUH. Individual parts of the programme are being monitored, but it is very difficult to monitor the direct effects of the programme on sickness absence rates, because there are lots of other things going on as well. It is a combination of things that influence the sickness rates of Nottingham University Hospitals staff. However, it is clear that the sickness absence rates came down significantly since the programme started (see table 1). NUH now has one of the lowest sickness absence rates in the UK (Knowles, 2014).

Table 1: Sickness absence rates, October each year

	2009	2010	2011	2012	2013
Sickness absence rate	4.11%	4.08%	3.87%	3.82%	3.40%

Source: Knowles, 2014

Another thing that the Trust looks at is how staff rates the Trust as a place to work for. Again, NUH comes out highly on many criteria in comparison to other trusts in the country. There are lots of things that are directly related to that, but having a health & wellbeing programme is one of them (Knowles, 2014)

Since the first version of this strategy was published in 2010 NUH has made significant progress on a number of key health and wellbeing indicators, such as number of staff sick for more than 28 days and the percentage of staff suffering from work related stress in the last 12 months, see tables 2 and 3 below (NUH, 2012).

Table 2: Workforce Data from the Electronic Staff Record

	2009/10	2011/12
Staff in post	12800	13500
Sickness Absence rate	4.09%	3.78%
Number of staff off sick for more than 28 days with a musculoskeletal problem	382	349
Number of staff off sick for more than 28 days with mental health problems	380	299
Staff Turnover	7.98%	7.9%

Source: NUH, 2012

Table 3: Staff Survey Data

	2009 Staff Survey	2011 Staff Survey
Percentage of staff suffering a work-related injury in the last 12 months	21%	16%
Percentage of staff suffering from work related stress in the last 12 months	33%	25%
Work pressure felt by staff	3.19	3.07
Support from immediate managers	3.51	3.64
Impact of health and wellbeing impacting on ability to perform work or daily activities	1.66	1.56
Staff Job satisfaction	3.39	3.56
Trust commitment to work-life balance	3.28	3.44

Source: NUH, 2012

Proxy measures

NUH featured as a case study of best practice in the Final Report of the independent NHS Health & Well-being Review. Moreover, the Health & Wellbeing programme has been awarded a gold certificate in the NHS's Sport and Physical Activity accreditation scheme. The Trust has also been recognised by NHS Employers as a Healthy Staff Champion (NUH, 2012).

Operational results

Since January 2013, the Health & Wellbeing programme obtained the following results (NHS Employers, 2014):

- 1144 health checks have been completed
- 1100 staff members have been seen by the Staff Physiotherapy Occupational Service
- 30 people completed Couch to 5k
- The netball team won 2 competitions
- 60 teams took part in pedometer challenges and walked over a million steps
- 100 members of staff took part in the 'Great NUH walk off' and walked a quarter of a million steps
- 210 bikes have been purchased through the Cycle2Work scheme
- 300 bikes have been fixed through their 'Dr Bike' sessions
- 25 people completed 2 bike maintenance classes
- Over 2000 attendances at fitness classes
- 20 people completed the pilot staff weight management programme and lost an average of 5 per cent of their weight
- 600 people attended health and wellbeing week, over 400 completed the staff health needs assessment
- 182 members of staff have attended one of the 'Coping with Stress' or mental wellbeing workshops
- 3300 members of staff are registered on the Wellbeing Zone website
- Nearly 2000 members of staff are on the health and wellbeing mailing list.

In 2006 (at the launch of the programme) and 2011 (five year follow up), a large-scale employee questionnaire survey was distributed including measures of physical activity, BMI, diet, self-efficacy, social support, perceived general health and mood, smoking behaviours, self-reported sickness absence, perceived work performance and job satisfaction. Findings showed that following five years of intervention, the proportion of employees reporting that they met government recommendations for physical activity had significantly increased. The proportion of employees reporting that they actively travelled (walked or cycled), both to the workplace and in their leisure time, had significantly increased. The proportion of respondents engaging in incidental physical activities had significantly increased over the five years, and sedentary behaviour ('time spent sitting') had reduced (Blake, 2013).

References

Blake, H., Zhou, D., & Batt, M. E. (2013). *Five-year workplace wellness intervention in the NHS*. *Perspectives in public health*, 133(5), 262-271.

NHS Employers (2014). *Feature trust - Nottingham University Hospitals NHS Trust*. Available at: <http://www.nhsemployers.org/HealthyWorkplaces/Leading-the-way/Pages/FeatureTrustNottinghamUniversityHospitalsNHSTrust.aspx>

Nottingham University Hospitals (2012). *Employee Health and Wellbeing Strategy*. Nottingham University Hospitals NHS Trust.

Nottingham University Hospitals (2011). *Employee Health and Wellbeing Annual Report 2010/2011*. Nottingham University Hospitals NHS Trust.

Appendix 7.1. Case report 7.1

Topic 7. Return to practice for healthcare professionals

Case 7.1. Return to Practice course Northumbria University, United Kingdom



Research methods applied:

Desk research: September – October 2014

Case site visit: December 2014

1. Summary of the intervention – Return to Practice course Northumbria University, United Kingdom

Dimension of interest	Categories/description
Objective of the intervention	Recruitment (re-entry)
Type of intervention	Education Financial incentives
Professional group(s) targeted	Nurses, midwives and health visitors whose registration has lapsed after a break in practice of three years or more.
Level of intervention	Organisational
Type of organisation	University
Kind of services provided by organisation	Various
Size of organisation	Large
Area covered	North East England
Intervention period / duration of intervention	The RTP programme was first delivered in 1987/8 in the College of Nursing and transferred to the University in 1993. It runs once a year.
Key actions	RTP course: 10 theory days, directed learning opportunities, profession specific support and a practice clinical placement.
Financial investment	Additional financing is required. For Northumbria RTP course, students pay no fees. Funding is paid by Health Education North East. Uniforms are provided by the University.
Implementation strategy or processes used	After deciding to establish a RTP course, Northumbria Uni found out that one of the hospitals in the region had already established such a programme. This was used as a basis and further developed.
Day-to-day running of the intervention	Northumbria University acts as a 'bridge' between higher education providers and partner placement providers, i.e. local Trusts. Northumbria Uni also needs to make sure that enough mentors are available for students once they do their internship.
Personnel investment	Additional HR is required in coordinating the programme (and teaching possibly). Mentors are needed, but do not receive any additional

	remuneration.
Outcome measures of the intervention	Northumbria Uni is tracking graduates with a survey to establish if they have secured employment. However, data quality is sketchy. Anecdotal evidence indicates good employment rates.

2. Rich description of the intervention

Case under study

The Return to Practice course at Northumbria University, United Kingdom.

Reasons for the establishment of the Return to Practice course at Northumbria University

In the late 1980s, there probably was a Department of Health ruling that all nurses returning to practice after they had been away for three years should undertake a return to practice programme (MacFayden, 2014). While no evidence of this ruling could be retrieved in 2014, it is likely that the Return to Practice course at Northumbria developed as a result of this. Currently, the NHS faces a shortage of nurses and in particular those nurses with experience. It is estimated that nationally there are 23,000 lapsed nurses who are potentially available to return to the nursing workforce. Nurses who have been out of practice and whose registration with Nursing and Midwifery Council (NMC) has lapsed will need to undertake a period of updating their skills and knowledge. The term used to describe this period of updating is called Return to Practice (HENE, 2014). The increasing NHS demands lead NHS Trusts to encourage practitioners who have left Nursing, Midwifery and Health Visiting, to return to practice (Northumbria University, 2014b).

Objective of the intervention

The aim of the Return to Practice course is to encourage practitioners who have left Nursing, Midwifery and Health Visiting, to return to practice (Northumbria University, 2014b). The Return to Practice programme endeavours to marry the needs of the individual practitioner returning to practice with professional and higher education requirements, preparing the nurse/midwife wishing to return to practice with up to date proficiency, knowledge and skills in order to maintain safe and effective standards of care (Northumbria University, 2014a).

Type of intervention

Educational intervention with the aim of re-recruiting nurses, midwives and health visitors back into the profession. Financial conditions are attractive for participants.

Professional group(s) targeted

Nurses, midwives and health visitors whose registration has lapsed after a break in practice of three years or more (NMC, 2011).

Level of the intervention

Organisational level.

Area covered

Northumbria University has its main campus in Newcastle upon Tyne in North East England. It also has a campus in Central London that was opened in 2014.

Kind of services provided by Northumbria University

Northumbria University offers around 500 study programmes through four Faculties: Faculty of Arts, Design and Social Sciences, Faculty of Business and Law, Faculty of Engineering and Environment and the Faculty of Health and Life Sciences.

Running time of the intervention

The Return to Practice programme was first delivered in 1987/8 in the College of Nursing and transferred to the University in 1993 when the College became part of the University (MacFayden, 2014). The programme runs once a year.

Implementation strategy

After the Department of Health ruling and the decision by Northumbria University to establish a Return to Practice course, it was found out that one of the hospitals in the region (Alnwick Infirmary) had already established such a programme. This was because they had a high level of staff turnover – partly due to nurses married to military personnel from RAF Boulmer, who might have been posted overseas, and partly due to staff crossing the border if there were differences in pay in Scotland/England. The matron in that hospital had already developed the programme for the moment these nurses would return (MacFayden, 2014). This programme was used (with permission) as a basis and then further developed by the former College of Nursing (now Northumbria University) when it was forced by the NHS to develop a curriculum for its Return to Practice course for nurses. Most likely, no money was involved in this exchange. Northumbria University worked with the Alnwick Infirmary on an informal basis of mutual exchange for mutual benefit (MacFayden, Wilkinson & Campbell, 2014).

Organisational framework

Health Education North East commission 49 Return to Practice places per year across two Higher Education Institutions, one of which is Northumbria University. The other is Teesside University (see case report 7.5, appendix 7.5) (Health Education England, 2014; HENE, 2014).

Northumbria University provides the RTP Programme in partnership with local Health Trusts who provide the placements for students, including (NMC, 2007):

- City Hospitals Sunderland NHS Foundation Trust
- Gateshead Health NHS Foundation Trust
- Gateshead Primary Care Trust
- Newcastle Upon Tyne Hospitals NHS Foundation Trust
- Newcastle PCT
- Northumberland, Tyne and Wear NHS Trust
- Northumberland Care Trust
- Northumbria Healthcare NHS Foundation Trust
- North Tyneside Primary Care Trust
- South Tyneside NHS Foundation Trust
- South Tyneside Primary Care Trust
- Sunderland Teaching Primary Care Trust

Northumbria University has the responsibility to act as a 'bridge' between higher education providers and the partner placement providers, i.e. the local Trusts. Northumbria University also needs to make sure that enough mentors are available for students once they do their internship (MacFayden, Wilkinson & Campbell, 2014).

Role of practice placement providers and mentors

It is a challenge to find a sufficient number of practice placements for students as well as finding the right mentors. It is an expectation of all practice accommodations that staff will act as co-mentors and steer students.

Northumbria is actively working with the mentors to make sure that they can provide students with the right practice experience. Moreover, Northumbria tries to work each year with the same group of mentors and practice placements. This ensures that there is an affiliation with the RTP programme, the curriculum and documentation.

The mentor role is quite extensive and sometimes difficult to accomplish in practice: people need to do at least one hour of mentoring per week with RTP students. However, neither designated time nor space is allocated for this. Hence, mentors need to search for ten minutes here, five minutes there, often openly on the ward. Moreover, people who take on the mentor role are not financially rewarded for this. As a result of the time pressures encountered and the lack of recognition, the pool of mentors is decreasing (MacFayden, Wilkinson & Campbell, 2014).

Return to Practice course

The Return to Practice Programme is quite generic; it covers allied health as well as nursing and midwifery (MacFayden, Wilkinson & Campbell, 2014).

The Return to Practice Programme is offered at Level 5 AC0500 (Diploma) and Level 6 AC6618 (Degree). Entry requirements are:

- First or second level registered nursing qualification.
- NMC registration must be lapsed. You cannot apply before this has occurred.
- Entry at level 5: Students will be previously registered practitioners.
- Entry at level 6: Students will need to have evidence of diploma level study and be previously registered practitioners.

There is an application process in place for people wanting to enter the Return to Practice course.

Application

Interested persons must complete an application form and include details of two referees (Northumbria University, 2014b).

Sifting of application forms

The criteria for sifting of the application forms are specified on the application form and applicants are advised to consider this in their application. The cut off score for invitation to interview varies from year to year depending on the number of applicants. Sifting is undertaken by academic staff on the programme team and Practice Placement Facilitators for the trusts/areas in which the applicant has indicated they would like to have as a placement (MacFayden, 2014).

Interview

Applicants are interviewed jointly by an academic member of the programme team, and a Practice Placement Facilitator or clinical manager from the trust /area in which the student has indicated that they would like to be placed. A supervisor of midwives participates in the midwifery applicants' interviews (MacFayden, 2014). At interview candidates are asked a series of questions designed to explore their motivation and ability to study at level five or six as well as to undertake the required hours in practice and to assess their knowledge base regarding current issues (Northumbria University, 2014b). The criteria used at interview are (MacFayden, 2014):

Demonstration of professional qualities:

- Previous experience and transferable skills
- Examples of what they feel they have to offer the profession
- Empathic and caring personality

Awareness of current issues in health care:

- Ability to discuss a contemporary health care issue eg privacy and dignity, contemporary health policy etc.

Commitment to programme:

- Ability to demonstrate flexibility and exploration of any necessary lifestyle changes they feel they may need to make in order to undertake the Programme.
- Time management skills

Effective verbal and non-verbal communication:

- Articulate
- Enthusiastic

NMC Registration status:

- Lapsed – how long for and reason why?
- Suspended – how long for?

Successful candidates will be asked to attend a pre-course briefing day in January. All offers of a place on the programme are provisional on Health and Disclosure and Barring Service Clearance processes, and the receipt of 2 appropriate references. Unsuccessful candidates can request feedback on the reasons why they did not progress to the next stage of the selection process (Northumbria University, 2014b).

Content of the Return to Practice programme

The programme includes 10 theory days, directed learning opportunities, profession specific support and a practice placement. This clinical placement will provide students with the opportunity to work with an identified 'sign off' mentor to enable them to achieve the requisite Nursing and Midwifery Council (NMC) competencies (Northumbria University 2014a).

- Clinical updates including: Medicine management, CPR, moving and handling and infection control
- Holistic care
- Academic writing skills and portfolio development
- Electronic learning
- Clinical Governance
- Review of contemporary documentation of relevance to professional practice (e.g. policies, guidelines)

The curriculum is currently being rewritten on the basis of the national toolkit that has been developed by Health Education England (MacFayden, Wilkinson & Campbell, 2014). "Growing Nursing Numbers" is a national initiative by Health Education England aimed at nurses that are returning to practice. As part of this initiative, Health Education England has reviewed and recommended what needs to be included in the RTP courses that are provided all across the country (Health Education England, 2014). HEE concluded that there was a huge variation across the country in what was being educated. Moreover, some people had to pay for the course, others not, some people had to pay for uniforms, others not, some people had to do a placement before they could apply for the programme, etc. There was a huge national variation. So Health Education England produced a national toolkit for the content of RTP courses. Northumbria University then had to map what percentage of that content it was meeting and inform Health Education England how it would address any gaps. The toolkit covers the whole journey. It explains what should be in the university, what should be in placements and what should be a joint thing (MacFayden, Wilkinson & Campbell, 2014).

The placement

Nurses must complete 100 hours in clinical practice, in an area relevant to their registration. The hours that midwives must spend on placement will be determined by the Lead Midwifery Educationalist (or designated person) and the Supervisor of Midwives. Whilst on placement, students will be allocated a 'sign off' mentor who will help to organise their workplace experiences, and who will also be responsible for the assessment of their clinical competencies (Northumbria University, 2014).

Facilitators in the running of the Return to Practice programme

According to the people who are involved in the programme, one of its strengths is that there is an extensive application procedure. People are supported from their first phone call onwards (MacFayden, Wilkinson & Campbell, 2014). Those students who are not successful through the application process for the programme are given written feedback and have the opportunity to contact the Programme Leader for advice. Many unsuccessful candidates take up this opportunity. There have been students who have been advised to gain some additional education or voluntary experience; some who have done so have been successful in subsequent applications. Many of the students who apply for the programme in this area have been out of practice for a number of years, and the programme team focuses initially on building confidence. The recent involvement of educators from practice in the theoretical sessions has evaluated well. Enabling the students to meet previous students and seeing samples of (anonymised) previous written assignments has been appreciated in the early part of the programme (MacFayden, 2014).

Barriers in the running of the Return to Practice programme

One of the greatest barriers in the running of the programme is in time resources and the limited flexibility that the programme currently has. If the programme could be made more flexible, it could be better adapted to the needs of individual participants and mentors. For example, the mentor role is quite extensive and sometimes difficult to accomplish in practice: people need to do at least one hour of mentoring per week

with RTP students. However, neither designated time nor space is allocated for this. Hence, mentors need to search for ten minutes here, five minutes there, often openly on the ward. As a result of the time pressures encountered and the lack of recognition, the pool of mentors is decreasing (MacFayden, Wilkinson & Campbell, 2014).

In discussions with some of those who have enquired about the programme but not applied, Northumbria University has anecdotal evidence that some potential applicants have been put off from returning to practice by the perceived lack of flexibility in the workload patterns available within areas of the NHS (following completion of the programme). The lack of funding while on the programme has deterred others, and the complexity of the state benefits system has deterred some from claiming expenses which have been available (MacFayden, 2014).

There have been applicants who have been given conditions of practice (that they complete a return to practice programme) by the NMC. These would not influence the offer of a place, but in practice these applicants have performed less well at interview. Some candidates are not able to achieve the competencies within the placement (in line with the minimum of 100 hours required). If the placement can facilitate this, additional hours are made available. Students who undertake their time in placement over a number of weeks appear to find the opportunity to reflect on their learning over a period of time helpful. In the past some students have tried to achieve competencies in the minimum required hours over a few weeks (eg by taking holiday from paid employment). This has proved problematic in some cases, so current practice is to advise students that they spend at least 15 hours in placement each week (MacFayden, 2014).

Finances

Health Education North East commission 20 – 24 places for nurses and 4 places for midwives per year (Health Education England 2014; MacFayden, 2014). Hence, funding for the programme is entirely paid by Health Education North East. Uniforms are provided by the University. As the programme is commissioned by Health Education North East, there are no fees for students from this region. Travel costs are not available for travel to and from the placement or the University (Northumbria University, 2014b).

To enable healthcare professionals to return to practice, Health Education North East (HENE) also provides participants with a contribution of £500 which will be paid in two payments: £200 at the start of the programme and £300 at mid point in the programme (HENE, 2014).

Following a recruitment drive for midwives to return to practice, HENE made available £1500 which could be paid as expenses to midwifery students – half payable midway and half on completion of the programme. Midwifery student are required to undertake additional placement hours (up to 450 as negotiated with the supervisor of midwives, dependent on the length of time they have been out of practice). Despite assurances that this would not affect any state benefits these students might be receiving, few have claimed this (MacFayden, 2014).

3. Results of the intervention

Northumbria University is tracking programme graduates with an RTP questionnaire to establish if they have secured employment. However, it has been reported to us that the quality of this data is sketchy, despite follow up contacts, as it is dependent on students informing the programme team when they have been appointed. Recent discussions with Health Education North East (HENE) have identified a possible solution to this. HENE can track the students' employment in local Trust's employment databases through their Nursing and Midwifery Council Pin number. It is hoped that this will improve the tracking of employment for those who have completed the RTP programme (MacFayden, 2014). Table 1 shows employment rates of RTP graduates for 2010, 2011 and 2012. However, considering the above mentioned issues, it should be noted that these data are neither representative nor reliable.

Table 1: Number of graduates who are employed by the NHS

Academic year	Yes	No, not working as nurse/midwife/health visitor	Response	Contacted	Response rate
2010	2	3	5	21	24%
2011	1	4	5	21	24%
2012	9	10	19	21	90,5%

Source: MacFayden, 2014

Concerning finding employment, Ms MacFayden, the course coordinator, told us: the RTP students don't get priority when applying for jobs, and recently some have had a couple of interviews before they have been successful. Some of the students who do the course have been out practice for several years, so confidence can be a big issue. If they are up against recent graduates, they may feel that they would like more experience – the NMC require them to do 100 hours minimum but many of them negotiate additional hours if the placements can accommodate this (MacFayden, 2014).

In the course evaluation of 2013/2014, the mean score for the overall satisfaction with the quality of the programme (ranking from 5 – definitely agree – through to 1 – definitely disagree) was 4.2. This is a good score (MacFayden, 2014).

Table 2 shows the number of course participants per year.

Table 2: Course participants' details per year

Year	Received applications	Successfull interview	Places offered	Places accepted	Withdrawn	Course completed		
						Nurses	Midwives	HV
2010	39	22	22	22	7	19	-	1
2011	71	29	29	26	6	16	1	4
2012	32	26	25	25	4	17	2	2
2013	37	24	26	24	2	21	3	2

EUROPEAN COMMISSION

2014	31	20	20	?	?	18*	2*	2*
------	----	----	----	---	---	-----	----	----

* Expected to complete course

Source: MacFayden, 2014

References

Health Education England (2014). *Nursing Return to Practice. Review of the current landscape*. Health Education England.

Health Education North East (2014). *Return to practice nursing*. Available at: <http://ne.hee.nhs.uk/return-to-practice-nursing/> (accessed: 02-12-2014).

MacFayden, A. (2014). Answers sent by email to questions Recruitment and Retention study.

MacFayden, A. Wilkinson, J. & Campbell, J. (2014). Interview during case site visit for Recruitment and Retention study.

Northumbria University (2013). *Module Descriptor Report. AC6618 – Return to practice*.

Northumbria University (2014a). *Return to professional practice in health. Student Handbook 2013/2014*.

Northumbria University (2014b). *Return to Professional Practice in Health*. Available at: <https://www.northumbria.ac.uk/sd/academic/sches/programmes/cpd/RTP2011/?view=Standard> (accessed 01-12-2014).

Nursing & Midwifery Council (2007). *NMC UK Wide Quality Assurance Framework Programme Monitoring Report*. Available at: http://www.nmc-uk.org/Documents/QualityAssurance/QAMonitoringReports/2006_2007/2959%20-%20Northumbria_050207_MonitoringReport_Summary.pdf (accessed: 05-12-2014).

Nursing & Midwifery Council (2011). *The Prep handbook*. Nursing & Midwifery Council.

Appendix 7.2. Case report 7.2

Topic 7. Return to practice for healthcare professionals

Case 7.2. Midwifery Refresher Programme, Mater Misericordiae Mothers' Hospital, Australia



Research methods applied:

Desk research: August – September 2014

1. Summary of the intervention – Midwifery Refresher Programme, Mater Misericordiae Mothers’ Hospital, Australia

Dimension of interest	Categories/description
Objective of the intervention	Recruitment (re-entry)
Type of intervention	Education
Professional group(s) targeted	Midwives who have been out of practice for an extended period
Level of intervention	Organisational
Type of organisation	Hospital (Mater Misericordiae Mothers’ Hospital, in cooperation with the Australian Catholic University)
Kind of services provided by organisation	Tertiary maternity services
Area covered	State of Queensland, Australia
Intervention period / duration of intervention	The Midwifery Refresher Programme was offered in 2002, 2003, 2004 and 2005. The Programme ceased running when the market was saturated and no further midwives were looking to refresh their practice.
Key actions	The Midwifery Refresher Programme comprised 80 hours of theoretical content and a minimum of 150 hours of clinical practice.
Financial investment	For the hospital and university involved, it was cost neutral to run this programme, as it was implemented within existing workloads. The costs for participants were \$650, which is significantly lower than the usual \$1800 they would have to pay.
Implementation strategy or processes used	To design an effective programme, the Mater Mothers’ undertook a review of midwifery refresher programmes to identify key elements and issues.
Personnel investment	The programme was cost neutral for both organisations in relation to human resource expenditure. Existing academic, educational and clinical staff implemented the Programme within their existing workloads.
Outcome measures of the intervention	In the first year of the Midwifery Refresher Programme (2002), the programme was very successful in meeting the hospital’s immediate recruitment crisis. All participants achieved

	<p>clinical competence and were subsequently offered employment. The Programme has an employment rate of approximately 90% following completion. However, no follow up data are available to determine how long midwives remained in practice afterwards.</p>
--	---

2. Rich description of the intervention

Reasons for the establishment of the Midwifery Refresher Programme

Despite the implementation of a range of recruitment and retention strategies, in 2002 the Mater Mothers' Hospital continued to experience an acute shortage of midwives (Flowers & Carter, 2004).

Objective of the Midwifery Refresher Programme

Based on a situational analysis performed by the Mater Mothers' Hospital, it became apparent that offering a midwifery refresher programme could be an effective recruitment strategy for the Hospital.

Type of intervention

The Midwifery Refresher Programme provided midwives with the opportunity to update their practice knowledge, skills and confidence in a supported setting (Flowers & Carter, 2004).

Professional group(s) targeted

Midwives who have been out of practice for an extended period.

Level of the intervention

Organisational level. The Midwifery Refresher Programme was provided by the Mater Mothers' Hospital in Brisbane, Queensland, Australia.

Area covered

The Mater Mothers' Hospital provides maternity services for women across Queensland, and beyond.

Implementation strategy

To design an effective programme, the Mater Mothers' Hospital undertook a review of midwifery refresher programmes to identify key elements and issues. In collaboration with the Australian Catholic University, a programme with an evidence-based framework within contemporary midwifery contexts was developed.

Content of the Midwifery Refresher Programme

The Midwifery Refresher Programme comprised 80 hours of theoretical content and a minimum of 150 hours of clinical practice. The theoretical component encompassed the continuum of childbearing, including antenatal, intrapartum, postpartum and neonatal special care. Professional midwifery issues were also included. The content was presented by a variety of academic and clinical staff with recognised expertise in particular topic areas. Unpaid supernumerary clinical practice was provided under the guidance of an experienced midwife preceptor. Participants' involvement in direct clinical care was gradually increased to facilitate confidence in their skills and knowledge (Flowers & Carter, 2004).

To ensure competence on completion of the programme, clinically based assessments were undertaken, and included a workbook revising anatomy and physiology, a case

study analysis and a clinical portfolio with 13 competency based clinical skills. Participants who successfully completed the programme were eligible for academic credit of two subjects towards the Master of Midwifery (for endorsed midwives). This articulation aimed to encourage them to further upgrade their hospital based midwifery qualifications to a postgraduate level (Flowers & Carter, 2004).

Running time of the intervention

The first Midwifery Refresher Programme took place in 2002. Based on the success of the 2002 venture, the programme was offered again in 2003, 2004 and 2005 (Carter, 2014; Flowers & Carter, 2004). The programme then ceased running as it appeared the market was saturated and there were no further midwives looking to refresh their practice (Carter, 2014).

Organisational framework

The Mater Misericordiae Mothers' Hospital is part of the Mater Hospital, a leading private hospital. The hospital's main complex is situated in Brisbane, with Adult, Mothers' and Children's Hospitals.

Finances

Costs for the organisations involved

Resources to develop and implement the Midwifery Refresher Programme were readily available internally at the Mater Mothers' Hospital and through its existing collaborative partnership with the Australian Catholic University (Flowers & Carter, 2004). The programme was cost neutral for both organisations in relation to human resource expenditure. Existing academic, educational and clinical staff implemented the Programme within their existing workloads. Student fees were shared between the hospital and the university, according to the lecture time provided by each organisation (Flowers & Carter, 2004).

Costs for participants

The costs for Programme participants were comparatively low. At a cost of \$650 for the equivalent of two units of postgraduate education compared to the usual fee of \$900 per unit there was a major cost saving for participants (Flowers & Carter, 2004).

Conditions for replicability

This Programme seems well fitted to be introduced in existing structures between Universities and Hospitals. One of the success factors in establishing the programme seems to have been the cooperation between the Mater Mothers' Hospital and the Australian Catholic University. It enabled both organisations to run the programme on a cost neutral basis. Moreover, the involvement of both clinical and academic staff strengthened the alliances of the two organisations by enhancing collegial relationships and increasing awareness of issues in education and service delivery, with the potential for further joint educational ventures (Flowers & Carter, 2004).

One of the things that made the programme very attractive for participants, next to the advantageous financial conditions, was the fact that the programme had a very limited impact on family life. The majority of midwives who expressed interest in the programme had school age children. To decrease the need for after school childcare,

the theoretical sessions were planned within school hours. In addition, a flexible approach to scheduling of clinical hours was adopted, with participants choosing both the days and hours for their clinical practice (Flowers & Carter, 2004). It is likely that the flexibility in terms of family life increased the uptake of the programme.

3. Results of the intervention

No records have been kept of the precise numbers of attending nurses, but there were about 10 midwives in each year that the programme was run (Carter, 2014). In the first year of the Midwifery Refresher Programme (i.e. 2002), the programme was very successful in meeting the hospital's immediate recruitment crisis in a cost effective way. All participants achieved clinical competence and were subsequently offered employment (Flowers & Carter, 2004).

In 2002, outcomes of the programme were evaluated using a written survey and informal focus groups with key stakeholders. Results indicated that the refresher programme had a number of positive outcomes (Flowers & Carter, 2004):

- Firstly, and most importantly it addressed the hospital's staffing crisis.
- Secondly, alliances with the Australian Catholic University were strengthened through this cost effective programme.
- Thirdly, there was a high level of satisfaction demonstrated by both participants and staff involved in the programme. Clinical staff were very satisfied with the programme and its ability to meet their staffing needs. Clinicians felt that the refresher midwives required less supervision and additional work than anticipated and their contributions to a busy workplace were much appreciated. Due to their supernumerary clinical experience, the time needed to orientate the new midwives on employment was reduced and their adjustment to their new working environment was enhanced (Flowers & Carter, 2004).

The Midwifery Refresher Programme ceased running when the market was saturated and no further midwives were looking to refresh their practice. The Programme is considered quite a successful recruitment strategy with an employment rate of approximately 90% following completion of the Programme. However, no follow up data are available to determine how long midwives remained in practice afterwards (Carter, 2014).

Proxy measures

An additional advantage of the Midwifery Refresher Programme was that it enhanced the job satisfaction of midwifery staff who worked with the participants in the Programme. Staff commented positively on the students' enthusiasm and on the opportunity to be involved in the programme. This programme contributed to the pool of midwifery knowledge by promoting lifelong learning in the participants and staff involved. Moreover, a number of participants indicated an intention to apply for academic credit in obtaining a formal postgraduate midwifery qualification (Flowers & Carter, 2004).

References

Australian Health Workforce Advisory Committee 2002, *The midwifery workforce in Australia 2002-2012*, AHWAC Report 2002.2, Sydney.

Carter, A. (2014). Answers to questions Recruitment & Retention study per email.
Flowers, K., & Carter, A. (2004). Rethinking midwifery refresher programmes as a recruitment strategy. *Australian Health Review*, 27(1), 118-123.

Mater Mother's Hospital (2014). *Mater Mother's Hospital*.
<http://www.matermothers.org.au/hospitals/mater-mothers-hospital> (accessed 26-08-2014).

Appendix 7.3. Case report 7.3

Topic 7. Return to practice for healthcare professionals

Case 7.3. 'Return to Nursing Practice' course, Tallaght Hospital Dublin, a teaching hospital of Trinity College Dublin, Ireland



The Adelaide and Meath Hospital, Dublin
Incorporating the National Children's Hospital

Research methods applied:

Desk research: September – October 2014

Telephone interview: October 2014

1. Summary of the intervention – ‘Return to Nursing Practice’ course, Tallaght Hospital Dublin, Ireland

Dimension of interest	Categories/description
Objective of the intervention	Recruitment (re-entry)
Type of intervention	Education Financial incentives Personal and professional support
Professional group(s) targeted	Nurses who have been out of practice for an extended period
Level of intervention	Policy and organisational
Type of organisation	Public voluntary teaching hospital (Adelaide and Meath Hospital Incorporating the National Children’s Hospital)
Kind of services provided by organisation	Secondary and tertiary services
Size of organisation	Large (615 inpatient and day care beds)
Area covered	The hospital serves a catchment area of 450,000 people, covering Tallaght, Clondalkin, Firhouse, Rathfarnham, Terenure, Templeogue, West Wicklow and parts of Kildare.
Intervention period / duration of intervention	Pilot course ran in 2011. RTNP course ran for the first time in 2006 at Tallaght Hospital. The RTNP course is not run structurally, but when deemed needed.
Financial investment	Additional financing is required for this intervention. Institutions that provide the course have to cover the course costs themselves. Participants receive financial compensation through a funding agreement between the Department of Health and Children and healthcare institutions.
Implementation strategy or processes used	In 2001, Tallaght Hospital ran a pilot Return to Practice course. Based on evaluation of this course, the latter Return to Practice courses were adjusted.
Day-to-day running of the intervention	Course is only run when deemed necessary and provided by original staff.
Personnel investment	No extra HR is needed. Course is only run when deemed necessary and provided by original staff.

<p>Outcome measures of the intervention</p>	<p>Participants who completed the course are not being followed up to establish whether they have secured employment. However, Tallaght Hospital mentions that the course has been successful in re-recruiting nurses into their profession.</p>

2. Rich description of the intervention

Case under study

The Return to Nursing Practice course of the Adelaide and Meath Hospital (often referred to simply as Tallaght Hospital), a teaching hospital of Trinity College Dublin in Ireland.

Reasons for the establishment of the Return to Nursing Practice course

The concept of Return to Nursing Practice courses was established by the Nursing and Midwifery Board of Ireland in response to a nursing shortage in the country. One of the recruitment strategies that were implemented, and the main aim of the Return to Nursing Practice courses, is to encourage nurses who used to be in the workforce to return to working. Hence, the Return to Nursing Practice course is a generic programme that is used within the whole country of Ireland. In response to the national programme, the Tallaght Hospital in Dublin introduced the Return to Nursing Practice course within its own organisation (McCarthy, 2014).

Objective of the Return to Practice course

The main aim of the Return to Nursing Practice courses is to encourage nurses who used to be in the workforce to return to working (McCarthy, 2014). The Irish Return to Practice courses are provided to enable nurses returning to practice to update both their theoretical knowledge and clinical skills and to facilitate the attainment of competence and confidence in the provision of nursing/midwifery care (NMBI, 2014).

Type of intervention

Re-recruitment via education.

Professional group(s) targeted

Nurses who used to be in the workforce.

Level of the intervention

Policy and organisational level. The concept of Return to Nursing Practice courses was established by the national Nursing and Midwifery Board of Ireland. Once a course of an individual hospital or teaching facility has been approved by the Board, organisations such as the Tallaght hospital are free to choose when to run the programme.

Area covered

Tallaght hospital serves a catchment area of 450,000 people, covering Tallaght, Clondalkin, Firhouse, Rathfarnham, Terenure, Templeogue, West Wicklow and parts of Kildare. Tallaght Hospital forms part of Trinity Health Ireland, an academic healthcare centre alliance with the School of Medicine, Trinity College Dublin and St James's Hospital.

Running time of the intervention

In 2001, Tallaght Hospital ran a pilot course. The Return to Nursing Practice course was run properly for the first time in January 2006 and has been run 7 times in total

since then. The next course is scheduled for late 2014 or the beginning of 2015. The RTNP course is not run structurally, but when deemed needed.

Nationally, there recently has been a shortage of Return to Nursing Practice courses for people to undertake. Tallaght Hospital is not aware of any organisation within Ireland that has run the course over the past two years. The reason for this is that Ireland had a staffing embargo [i.e. ban on hiring staff]. So organisations were not allowed to recruit nationally and hence there was no point in providing the Return to Nursing Practice course (McCarthy, 2014).

Implementation strategy

In 2001, Tallaght Hospital ran a pilot Return to Practice course. The overall evaluation was that the course was too short and that the theory content was too rushed. It was also said that the length of the course should vary according to the length of time out of practice (McCarthy, 2014). On the basis of this pilot case, the latter Return to Practice courses were adjusted and critic was taken into account.

Organisational framework

All Irish Return to Practice courses must be approved by the Nursing and Midwifery Board of Ireland (NMBI, 2014). Once an educational institution has received approval by the Nursing and Midwifery Board to run the course, it is solely responsible for the course. No other organisations are involved from that point onwards (McCarthy, 2014)

Whilst there is currently no legal requirement to do so, An Bord Altranais strongly recommends that a registered nurse who is returning to practice after an absence of five years or more should complete a Return to Nursing Practice Course prior to engaging in nursing practice or being employed as a nurse (An Bord Altranais, 2005). This means that in concreto it is up to an employer whether they insist on their staff member to complete the programme (McCarthy, 2014).

The Nursing and Midwifery Board An Bord Altranais has drafted a number of requirements for Return to Nursing Practice courses that all courses need to fulfil in order to be approved. First of all, all courses need to have a theoretical component and a clinical component. Other requirements include that all clinical placements must be supported and supervised by Registered Nurses and that clinical placements must take place in a healthcare institution approved by An Bord Altranais for the education of nursing students/nurses.

The course may be delivered in a full-time or part-time mode. The minimum duration of the programme shall be six weeks full time, and twelve weeks part-time. An annual report must be submitted to An Bord Altranais by the providing institution (An Bord Altranais, 2005).

Curriculum

The content of the Return to Practice course is fairly similar across Ireland, because of the national and generic nature of the programme, even though there are local differences. But in general the content of the programme it is two weeks theory and four weeks clinical practice. Educational institutions who want to provide the course must apply to the Nursing and Midwifery Board for accreditation. The accreditation is renewed every 5 years.

Tallaght Hospital indicates that the requirements and standards of the national curriculum, and the indicative content- outline as provided by the Irish Nursing Board, are broad enough to tailor and adapt to local needs. The Tallaght Hospital in Dublin delivers its own local medication policy, nursing processes, nursing documentation, etc. in the programme. These will be different for every organisation (McCarthy, 2014).

Finances

Participants of the Return to Practice course receive a bursary to attend the course of €1500 from the Irish HSE (Health Service Executive). Also, the participants that remain working in the public sector after 6 months of post-completion of the course get a further €1500 bursary.

This financial support for individuals undertaking Return to Nursing Practice Courses is provided through a funding agreement between the Department of Health and Children and healthcare institutions. The terms of this agreement varies from time to time. Participants should be given written information about the funding arrangements that apply at the time of commencement of the course (An Bord Altranais, 2005).

The educational institutions who provide the course don't receive any funding. So from an organisational point of view, it is expensive. No organisation is required to provide the course, but providing the course would be seen as part of the overall recruitment strategy of an organisation. By running the course, organisations hope that they would get some employees from the programme. Considering the severe shortages of nurses that Ireland was facing, especially in the early 2000s, a lot of organisations implemented the Return to Nursing Practice course as a recruitment strategy to encourage nurses who had left the nursing workforce to return (McCarthy, 2014).

Barriers in the running of the Return to Nursing Practice course at Tallaght Hospital

At Tallaght Hospital, barriers in the running of the course had to do with staff availability to teach on it. It would be an extra programme that would be provided and there was no funding for this programme. Because there was no extra funding, this meant that original staff needed to take on an extra workload.

There were also clinical issues. All participants of the Return to Practice course would have to do a 4 weeks clinical placement. This was difficult to achieve, because Tallaght Hospital would have a lot of other staff as well who would need to do a clinical placement, such as undergraduate nursing students. So there was a fear of overloading the clinical areas with a lot of supernumerary staff, whether it would be undergraduate nursing students or nurses on the return to nursing practice course.

There is also a lot of administrative work involved in the course; ensuring that participants are up-to-date with their vaccinations and that they have police clearance to come and work in the clinical areas, and so on. Other issues concern ensuring that there is enough mentoring available in the clinical areas, to make sure that there are enough people to work alongside RTP participants. That would be the main areas of concern.

Conditions for replicability

An important attractor is the lack of costs for participants. Especially for nurses who have left the profession to establish families, financial barriers to follow a course can be considerable. This barriers has been taken away.

3. Results of the intervention

Participants who completed the Return to Nursing Practice course are not being followed up after they finished the course to establish whether they have secured employment. However, Tallaght Hospital mentions that the course has been successful in re-recruiting nurses into their profession. The course properly prepares them for returning to employment. Moreover, the hospital thinks it is very beneficial because it is staff that otherwise wouldn't be available to the workforce for various reasons. Especially within nursing because nursing is so female dominated, nurses tend to leave and go and have their families and once their families are at a certain age, they want to re-enter the nursing workforce. The Return to Nursing Practice course is a very good course to prepare them for that (McCarthy, 2014).

Moreover, every course that has been run has been evaluated. Evaluation of the course by participants, nurse managers, clinical staff and educators is also one of the requirements of the Irish Nursing Board (An Bord Altranais, 2005). Table 1 shows the number of participants per course and table 2 shows the number of participants that agrees to a certain question. It becomes clear that the RTP course increases nurses' confidence about returning to practice, that the topics are deemed relevant and the duration of the clinical component of the course is deemed appropriate by participants. However, participants in the 2011 cohort have a significantly lower score on this item.

Table 1: Number of RTP course participants per year

Year	2001 (pilot)	01- 2006	09- 2006	05- 2007	05- 2008	01- 2009	11- 2009	03- 2011
N participants	9	16	11	8	6	13	17	23

Source: McCarthy, 2014

Table 2: Number of RTP course participants that (definitely) agreed to question

Year	01-2006	05-2008	01-2009	11-2009	03-2011
I have become more confident about returning to nursing practice because of this course	69	100	100	94	100
The topics covered were relevant to my learning needs for returning to nursing practice	57	100	85	81	96
The duration of the clinical component of the course was appropriate to my learning needs	86	100	92	93	65

Source: McCarthy, 2014

Recruitment and Turnover Rates

Table 3 shows the turnover rates and absenteeism rates for Adelaide and Meath Hospital. While the turnover rate in 2006 can be considered high with 10.6%, it was still the lowest turnover rate within the Dublin Academic Teaching Hospitals.

Table 3: turnover rates and absenteeism rates for Adelaide and Meath Hospital

	2006	2007	2008	2009
Turnover rate	10.3%	10.32%	5.87%	5.23%
Absenteeism Adult Nursing	4.93%	5.44%	5.24%	NA
Absenteeism Paediatric Nursing	5.78%	5.52%	3.75%	NA
Health Care Assistants	9.11%	8.77%	6.10%	NA

Sources: Adelaide & Meath Hospital, Incorporating The National Children's Hospital Nursing Service Report, 2006; 2007; 2008; 2009.

References

Adelaide & Meath Hospital, Incorporating the National Children's Hospital Nursing Service Report, 2006.

Adelaide & Meath Hospital, Incorporating the National Children's Hospital Nursing Service Report, 2007.

Adelaide & Meath Hospital, Incorporating the National Children's Hospital Nursing Service Report 2008.

Adelaide & Meath Hospital, Incorporating the National Children's Hospital Nursing Service Report, 2009.

An Bord Altranais (2005). *Return to Nursing Practice Courses. Requirements of An Bord Altranais*. An Bord Altranais.

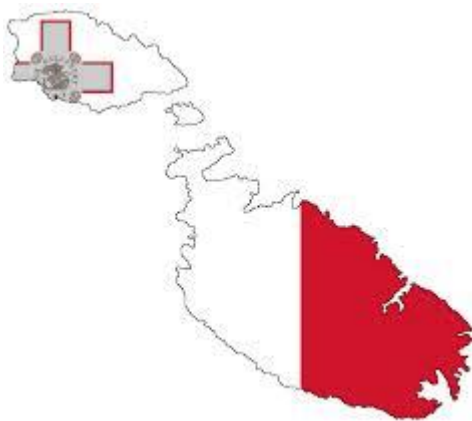
McCarthy, S. (2014). Telephone interview for the Recruitment & Retention study, 14-10-2014.

Nursing and Midwifery Board of Ireland (2014). *Nursing/Midwifery Career Development Post Registration Courses*. Blackrock: Nursing and Midwifery Board of Ireland.

Appendix 7.4. Case report 7.4

Topic 7. Return to practice for healthcare professionals

Case 7.4. Return to nursing practice measures, Malta



Research methods applied:

Desk research: August – September 2014

1. Summary of the intervention – Return to nursing practice measures, Malta

Dimension of interest	Categories/description
Objective of the intervention	Recruitment (re-entry)
Type of intervention	Education Financial incentives Personal and professional support
Professional group(s) targeted	Nurses who have been out of practice for an extended period
Level of intervention	Policy
Type of organisation	Ministry of Health
Kind of services provided by organisation	Various
Size of organisation	Large
Area covered	Country of Malta
Intervention period / duration of intervention	The Government of Malta introduced these measures for the first time in the late 1980s, early 1990s.
Key actions	<ul style="list-style-type: none"> - 'Bridging process': re-entry at same salary level as when leaving the nursing profession - Retraining courses - Various family-friendly measures, including flexible working hours and child care centres. - Nurses' union was given a grant by the Government to market the profession on a national scale.
Financial investment	Additional financing is required, most likely provided by the Government of Malta/Ministry of Health.
Implementation strategy or processes used	No information could be retrieved.
Day-to-day running of the intervention	Various, depending on specific measures.
Personnel investment	Various, depending on specific measures.
Outcome measures of the intervention	Official numbers of the effects of the measures on re-recruiting nurses back into the profession are not available. According to our informants, the measures that contributed mostly to re-

	recruitment and retention were the family-friendly measures.
--	--

2. Rich description of the intervention

Case under study

Various measures used in Malta to re-recruit nurses back into the profession.

Reasons for the re-recruitment of nurses

In the 1980s, Malta was facing a severe nursing shortage. One of the measures taken was enticing female nurses back to the profession (Rechel, Dubois & McKee, 2006).

Objective of the intervention

To attract female nurses back into nursing.

Type of intervention

Re-recruitment via education, financial incentives and family-friendly measures.

Professional group(s) targeted

Nurses who used to be in the workforce.

Level of the intervention

Policy level.

Area covered

The country of Malta.

Measures taken to re-recruit nurses back into the profession

A number of measures were taken in Malta to re-attract nurses into the profession ((Rechel, Dubois & McKee, 2006; Xuereb, 2014a; Xuereb, 2014b):

- The Government of Malta provided all those nurses who had to resign in the past to be able to enter the profession at exit point (salary wise) without losing the years of experience they had attained (Xuereb, 2014a). This system is called the 'Bridging Process'. Through agreement with the Malta Union of Midwives and Nurses, nurses resigning will be placed in the same salary scale and step when rejoining as when they left. For example, nurses and midwives who before resigning, occupied a nursing/midwifery managerial post will, on their return, be employed and placed in the maximum of Scale 8 (equivalent to Senior Staff Nurse/Midwife or Deputy Charge Nurse/Midwife).
- Nurses wanting to re-enter the profession were provided with retraining courses
- All sorts of family-friendly measures were introduced, including flexible working hours and child care centres.
- An agreement between the Government of Malta and the nurses' union in which the latter was given a grant to market the profession on a national scale.

Running time of the intervention

The Government of Malta introduced these measures for the first time in the late 1980s, early 1990s.

Implementation strategy

No information could be retrieved.

Organisational framework

The measures to re-attract nurses back to the profession are part of the workforce plan of the Health Division of the Ministry of Health.

Facilitators and barriers in the running of the intervention

No information could be retrieved.

Finances

No information could be retrieved concerning financing of the measures, although it appears as if the Malta Ministry of Health.

3. Results of the intervention

Official numbers of the effects of the measures on re-recruiting nurses back into the profession are not available. However, our informants mentioned that the 'bridging process' was intended to facilitate the return of nurses (particularly those who were not in employment) to the public sector. Although initially it helped to capture a number of nurses back to the service, a collateral of this measure was that it increased labour mobility between the public and the private sector, in both directions. The reason for this was that nurses who wanted to resign from the public sector to join the private sector, knew 'a priori' that should they lose their job in the private sector or want to resign there, they could easily re-join the public sector.

According to our informants, the measures that contributed mostly to retention, were the family-friendly measures such as maternity leave, part-time work, flexi-hours and responsibility leave that were introduced, because nursing and midwifery are mostly female professions (Sharples, 2014; Xuereb, 2014b)

References

Rechel, B., Dubois, C. A., & McKee, M. (Eds.). (2006). *The health care workforce in Europe: learning from experience*. European Observatory on Health Systems and Policies.

Sharples, J. (2014). Answers received per email to questions Recruitment & Retention study.

Xuereb, A. (2014a). Country report Malta for the Recruitment & Retention study.

Xuereb, A. (2014b). Answers received per email to questions Recruitment & Retention study.

Appendix 7.5. Case report 7.5

Topic 7. Return to practice for healthcare professionals

Case 7.5. Return to Practice course – Teesside University, United Kingdom



Research methods applied:

Desk research: September – October 2014

Email interview: October 2014

1. Summary of the intervention – Return to Practice course – Teesside University, United Kingdom

Dimension of interest	Categories/description
Objective of the intervention	Recruitment (re-entry)
Type of intervention	Education Financial incentives
Professional group(s) targeted	Nurses whose registration has lapsed after a break in practice of three years or more.
Level of intervention	Organisational
Type of organisation	University
Kind of services provided by organisation	Various
Size of organisation	Large
Area covered	North East England
Intervention period / duration of intervention	Return to Practice course has run since 1999. There is no expected end date.
Key actions	RTP course: 20 weeks, structured tutor-led seminars, seminar work/group discussions, practice hours, supported and assessed by qualified mentors
Financial investment	Additional financing is required. For the Teesside University RTP course, course places are funded by Health Education North and students receive a small financial contribution.
Implementation strategy or processes used	The idea for the RTP course originated from the University in conjunction with Health Education North East.
Personnel investment	Relatively limited.
Outcome measures of the intervention	Graduates are tracked with an RTP questionnaire to establish if they have secured employment. This information is collected by Health Education North East. Teesside University offers 50 courses places on an annual basis. The RTP course is well evaluated.

2. Rich description of the intervention

Case under study

The Return to Practice course at Teesside University, United Kingdom.

Reasons for the establishment of the RTP course at Teesside University

The NHS currently faces a shortage of nurses and in particular those nurses with experience. It is estimated that nationally there are 23,000 lapsed nurses who are potentially available to return to the nursing workforce. Nurses who have been out of practice and whose registration with Nursing and Midwifery Council (NMC) has lapsed will need to undertake a period of updating their skills and knowledge. The term used to describe this period of updating is called Return to Practice. The aim of RTP courses is to renew nurses' registration with the NMC and to let them return to practice with competence and confidence to provide high quality care (HENE, 2014). The Return to Practice course at Teesside University was established in 1999 in response to a Department of Health campaign (Bramble, 2014).

Objective of the intervention

The Return to Practice course was established to enable lapsed registrants to renew their registration with their professional body and re-enter practice with competence and confidence in skills, in order to be able to provide high quality care and a safe standard of practice (Bramble, 2014). Healthcare professionals whose registration has lapsed after a break in practice of three years or more, and therefore are unable to comply with practice standards, must successfully complete a return to practice programme approved by the Nursing & Midwifery Council before being allowed to return to practice (NMC, 2011).

Type of intervention

Educational intervention with the aim of re-recruiting nurses back into the profession. Financial conditions are made attractive for participants.

Professional group(s) targeted

Nurses whose registration has lapsed after a break in practice of three years or more (NMC, 2011).

Level of the intervention

Organisational level.

Area covered

Teesside University has its main campus in Middlesbrough in North East England. It also has a campus in Darlington named Teesside University Darlington.

Kind of services provided by Teesside University

Teesside University consists of five schools; the School of Arts & Media, the School of Computing, the School of Health & Social Care, the School of Science & Engineering, the school of Social Sciences, Business & Law.

Running time of the intervention

The Return to Practice course has run at Teesside University since 1999 (Bramble, 2014). There is no expected end date. The course is offered twice each year (September and January).

Implementation strategy

The idea for the RTP course originated from the University in conjunction with Health Education North East (Bramble, 2014).

Organisational framework

Health Education North East commission 49 Return to Practice places per year across two Higher Education Institutions, Northumbria University (see case report 7.1, appendix 7.1) and Teesside University (Health Education England, 2014; HENE, 2014).

Return to Practice course at Teesside University

The Return to Practice Programme is offered at Degree level.

Application process to enter the RTP course

Students apply "online" and are invited to a pre-course briefing in advance of interview dates. Applications are shortlisted in accordance with a number of set criteria, including for example the completeness of the application form and applicants' expression of their commitment to "return". All applicants are assessed on their previous study within 5 years, a satisfactory Disclosure and Barring Service check, satisfactory work place risk assessment, and two satisfactory and relevant references. Successful applicants are required to attend an interview and undertake a drug calculation test as well as a short literacy test. Interview questions focus on their knowledge of changes and concerns within the NHS generally and values inherent within NHS constitution specifically. Questions have been designed with service users and complemented by case study materials to further enable an assessment of values and attitudes to care (Bramble, 2014).

Entry requirements

All applicants must (Teesside University, 2014):

- have a recordable professional qualification - lapsed (verified by the appropriate body)
- complete an enhanced Disclosure and Barring Service check and work place risk assessment
- present evidence of recent study (within 5 years).

Content of the Return to Practice course

The content of the programme reflects the NMC standards. On successful completion of this award, students will be able to:

- understand the influence of health and social policy relevant to the practice of nursing and midwifery.
- understand the requirements of legislation, guidelines, codes of practice and policies relevant to the practice of nursing and midwifery.
- understand the current structure and organisation of care, nationally and locally.

- understand current issues in nursing and midwifery education and practice.
- use relevant literature and research to inform the practice of nursing and midwifery
- identify and assess need, design and implement interventions and evaluate outcomes in all relevant areas of practice, including the effective delivery of appropriate emergency care.
- use appropriate communications, teaching and learning skills.
- function effectively in a team and participate in a multi-professional approach to the care of patients and clients.
- identify strengths and weaknesses, acknowledge limitations of competence and recognise the importance of maintaining and developing professional competence.

Structured tutor-led seminars offer students general knowledge and principles of relevant issues. Seminar work/group discussions allow for greater debate of these issues as applied to practice. Students are allocated a minimum number of practice hours, which increases their knowledge and understanding, and lets them develop skills relevant to practice; this is supported and assessed by qualified mentors (Teesside University, 2014).

Facilitators and barriers in the running of the intervention

Our informant informed us that there have been no problems in the running of the RTP course (Bramble, 2014).

Finances

We weren't able to retrieve any information about the costs of the Return to Practice course as such information would be offered at the discretion of the Dean of the School. However, course places are funded by Health Education North and currently students receive a small financial contribution (Bramble, 2014). To enable students to return to practice Health Education North East (HENE) funds courses fees, placement fee and provides students with a contribution of £500 which will be paid in two payments: £200 at the start of the programme and £300 at mid point in the programme (HENE, 2014).

3. Results of the intervention

Students are tracked with an RTP questionnaire to establish if they have secured employment after they have finished the course. This information is collected by Health Education North East.

Number of course participants

Teesside University offers 50 courses places on an annual basis. Each year, slightly more applicants are received than the number of funded places. The large majority are from the Nursing register - see table 1.

Table 1: Number of RTP course participants per year and specialism

	Nursing	Midwifery	Health visitors	Other
2003/4	24	5	1	
2004/5	32	4		5
2005/6	40			
2006/7	40			
2007/8	10			
2008/9	40			
2009/10	40			
2010/11	40	2		
2011/12	37	2	2	3
2012/13	17		4	7
2013/14	22		2	1
Sept. 2014	15			

Source: Bramble, 2014

Course evaluation

The RTP course at Teesside University is well evaluated. However, the precise details / format of collating the evaluation data cannot be shared. Our informant informed us that generally, students agree or strongly agree with the factors associated with the quality of the information offered from the outset. The learning and teaching methods help them develop their learning and for example the assessment criteria were made clear. The majority of students agree or strongly agree that the course had developed them personally and professionally (Bramble, 2014).

References

Health Education England (2014). *Nursing Return to Practice. Review of the current landscape*. Health Education England.

Health Education North East (2014). *Return to practice nursing*. Available at: <http://ne.hee.nhs.uk/return-to-practice-nursing/> (accessed: 02-12-2014).

Nursing & Midwifery Council (2011). *The Prep handbook*. Nursing & Midwifery Council
Teesside University (2014). *Health & Social Care. Return to Practice (Degree Level)*. Available at: http://www.tees.ac.uk/parttime_courses/Health_&_Social_Care/University_Certificate_in_Professional_Development_Return_to_Practice_%28Degree_Level%29.cfm (accessed on: 26-11-2014).

Appendix 8.1. Case report 8.1

Topic 8. Providing supportive working environments for the ageing workforce

Case 8.1. Programnea de Atención Integral al Médico Enfermo (PAIME) [Comprehensive Care Programme for Sick Doctors], Spain

Programa de Atención Integral al Médico Enfermo (PAIME)

Research methods applied:
Desk research: January 2015

1. Summary of the intervention – Programma de Atención Integral al Médico Enfermo (PAIME), Spain

Dimension of interest	Categories/description
Objective of the intervention	Retention
Type of intervention	Personal and professional support
Professional group(s) targeted	Medical doctors (who suffer from mental illness and/or drug/alcohol abuse)
Level of intervention	Organisational
Type of organisation	Colegio de Médicos [medical organizations]
Kind of services provided by organisation	Colegio de Médicos represent all registered doctors, ensure proper standards and promoting ethical medical practice.
Size of organisation	Large
Area covered	Spain
Intervention period / duration of intervention	The PAIME programme was introduced in 1998. There is no expected end date.
Key actions	Promote and protect the health of physicians by ensuring they receive the right specialist care in terms of mental disorders and alcohol/drug abuse.
Financial investment	Considerable financial investments are needed. For PAIME, these are provided by the medical associations, health authorities and increasingly the Foundation Board and Social Protection of the Spanish Medical Colleges Organization.
Implementation strategy or processes used	No information could be retrieved.
Day-to-day running of the intervention	PAIME is ruled by the 'Colegio de Médicos' of each Spanish region. Every 'Colegio de Médicos' in Spain offers a PAIME outpatient service to their registered physicians. There is only one PAIME inpatient unit, currently located in Barcelona.
Personnel investment	Considerable
Outcome measures of the intervention	Since 1998, PAIME has helped more than 3.500 physicians. More than half of the participants are 51 years and older. Of all doctors that have been treated by PAIME, close to 90% per cent have recovered and

	been rehabilitated into the practice of medicine.
--	---

2. Rich description of the intervention

Case under study

The Programme de Atención Integral del Médico Enfermo (PAIME) [Comprehensive Care Programme for Sick Doctors], established in 1998 in Spain to promote and protect the health of physicians.

Reasons for the establishment of the Programme de Atención Integral del Médico Enfermo (PAIME)

The Programme de Atención Integral del Médico Enfermo (PAIME) was created in 1998 by the College of Physicians of Barcelona (Arteman Jané et al., 2014). It is based on the ethical duty set out in the Code of Medical Ethics. Article 22 says that "if a doctor observed that by reason of age, illness or other causes, his judgment or his technical ability is impaired, advice should be sought immediately to a colleague you trust to help you decide whether to suspend or temporarily or permanently modify their work." (Medicos y pacientes, 2013).

Doctors, like the rest of the population, suffer diseases to be diagnosed and treated. It is estimated that between 10 and 12% of practicing physicians may suffer throughout their career a mental disorder or addiction to alcohol and other drugs. However, doctors are known to postpone action when it comes to their own health, tend to self-diagnose or treat informally and contact trusted physicians companions (Arteman Jané et al., 2014).

When a doctor is at risk of becoming ill from these causes or already suffering, errors and negligence may easily occur in his/her practice. Furthermore, the impact of these diseases also impact negatively on the family atmosphere and relationships with colleagues and the workplace. Many sick doctors are not aware of their problems and are reluctant to get support or help. Other nurses and doctors, aware of their problems, make great efforts to limit the doctor's shortcomings. In both situations, if the doctor continues to exercise without recourse to the assistance of a skilled professional, it is usually only a matter of time before serious problems begin to arise (Arteman Jané et al., 2014).

"Health professionals constitute a risk group," says Dr. Dolores Crespo, head of the PAIME programme at the College of Physicians of Madrid. With a special feature: disease doctor has a direct impact on the health of the population (Arteman Jané et al., 2014).

The PAIME programme follows the similar experiences of other countries, especially the United States, Canada and Australia, which show how specific programmes for medical doctors outperform general population services for this specific patient group. This results in fewer dropouts from practice and a higher level of rehabilitation (FPHOMC, 2015).

Objective of the intervention

The PAIME programme was introduced to promote and protect the health of physicians, thereby assuring the quality of the medical act and improving the health of the population (Arteman Jané et al., 2014).

PAIME has a number of goals, namely (FPHOMC, 2015):

- Help the greatest possible number of ill doctors.
- Ensure that doctors receive the necessary medical specialist care.
- Encourage their rehabilitation as professionals.
- Ensure that practice of medicine takes place under the best possible conditions to secure the health of the population.

Type of intervention

Professional and personal support.

Professional group(s) targeted

Entitled to PAIME assistance are all registered practicing doctors, i.e. doctors who are not in a position of disability or retirement. This is because the PAIME programme has a rehabilitative mission; it was created so that doctors with mental health and/or addictive problems could return to their professional work. Access is through the College of Physicians (FPHOMC, 2015). Future PAIME patients must meet the following requirements to be allowed into the programme (FPHOMC, 2014):

- Hold a degree in medicine.
- Be registered with their respective professional association.
- Being in the profession, or at least, have been so in the past three years and be able to return to the active workforce.
- Having a mental and/or addictive disorder that may adversely affect the quality of practice and cause potential harm to patients.
- Accessed through the PAIME of medical colleges programme.
- Having covered the financing of PAIME services. In the case of Catalonia and other regions that have reached an agreement with their respective governments (Ministries of Health) and the Official College of Physicians (COM), PAIME services may be fully or partially covered. In any case, before entering the programme this aspect must be covered and clear to both parties (see also under the heading 'finances').

Level of the intervention

Organisational level.

Area covered

Spain.

Running time of the intervention

The PAIME programme was established in 1998 (Braquehais et al., 2014). There is no expected end date.

The Programme de Atención Integral del Médico Enfermo (PAIME)

Access to the PAIME programme

The PAIME programme promotes voluntary treatment as well as enrolment for preventive interventions. Treatment becomes obligatory only when risk or evidence of practice difficulties have been identified. Mandatory actions can, for example, oblige ill doctors to undergo psychiatric treatment or if they suffer from an addictive disorder, this may include proving abstinence once treatment has been completed (Braquehais

et al., 2014). Hence, there are various access roads into the PAIME programme (FPFOMC, 2014):

- Voluntary demand for PAIME services: occurs by the will of the ill doctor
- Via confidential communication: when a third person informs the Reception and Monitoring Unit Process of PAIME of a possibly ill doctor. In this case, all the information of the case and the UASP be sought together with the informant to establish a strategy to ensure that the ill doctor willingly enters the programme.
- Formal complaint: formal writing which informs of a possibly ill doctor

The clinical severity of demands for assistance is initially determined by the Reception and Monitoring Unit Process of PAIME, separating the urgent demands from those that are not. Because the Clinical Unit (CCU) of PAIME is currently unprepared to meet urgent demands, these patients are referred to an Emergency Department of a psychiatric hospital (FPHOMC, 2014).

The course of treatment for the sick doctor, after assessment of your case by the appropriate clinician, may require a period of hospitalization or performed on an outpatient clinical programmes which includes the PAIME are (FPHOMC, 2015):

- Programmes for mental disorders:
 - o Programme for affective disorders
 - o Programme for anxiety disorders
 - o Programme for psychotic disorders
 - o Programme for somatization disorders
- Programmes for dual pathologies
- Programmes for addictive disorders:
 - o Programme Drug Free
 - o Programme Detox
 - o Programme Detoxification
 - o Maintenance programmes:
 - With agonists
 - With antagonists
 - o Programme prevention of relapses.
 - o Programme exposure to stimuli.
 - o Programme social skills.
- Tailored programmes:
 - o Programme at holiday time.
 - o Programme hospital overnight
- Programme custom

Exit of the PAIME programme

There are several ways to exit the PAIME, some related to the successful completion of therapeutic process and certain other circumstances (FPHOMC, 2014):

- Administrative reasons:
 - o Declaration of permanent incapacity by the National Institute Social Security (INSS), in any degree.
 - o Irreversible professional disqualification by the College of Physicians

- Patients who take more than a year without practicing medicine for whatever reason.
- A move which makes it impossible to continue participating in the PAIME programme.
- Medical reasons:
 - For complete cure, when the responsible therapist considers the patient is completely cured of the condition which led to his/her entry into the programme and the patient is stable.
 - For depletion of the therapeutic possibilities of PAIME.
 - By continuing relapse.

Implementation strategy

No information could be retrieved.

Organisational framework

In Spain, the PAIME programme was introduced in 1998. It is ruled by the 'Colegio de Médicos' of each Spanish region. 'Colegios de Médicos' are institutions where all practising doctors in Spain need to be registered. They act as Medical Associations and Regulatory Bodies (or Medical Councils). Every 'Colegio de Médicos' in Spain offers a PAIME outpatient service to their registered physicians. There is only one PAIME inpatient unit, currently located in Barcelona (Braquehais et al., 2014).

The doctor-as-patient's last names are changed once he/she enters the programme in order to preserve confidentiality. Their real identity can only be disclosed without their consent if there is a threat to self or others (Braquehais et al., 2014).

Since its inception nearly fourteen years now, the PAIME programme has raised the constant challenge of bringing together the knowledge generated from experience, systematize and share it with all professionals and organizations that are part of the programme (FPHOMC, 2014).

Facilitators and barriers in the running of the intervention

One of the most important facilitating factors in the running of the programme is its commitment to working totally confidentially. This confidentiality can only be broken when:

- The patient has indicated in writing what information may be disclosed
- A medical emergency of the patient, requiring moving to a specialized centre
- In the case of imminent and clear danger to the health and/or physical integrity of others
- By court requirement

Finances

The PAIME programme is funded by (FPHOMC, 2015):

- The Colegios de Médicos [Medical Associations]
- The Fundación Patronato de Huérfanos y Protección Social de la Organización Médica Colegial (OMC) [Foundation Board and Social Protection of the Spanish Medical Colleges Organization]
- The Administraciones sanitarias [health authorities] of most regions, not all

The Fundación Patronato de Huérfanos y Protección Social de la Organización Médica Colegial belongs to the Medical College and its main mission is to ensure solidarity among all registered doctors, by protecting and helping those (and their families) that need it. At the present time of deep economic crisis, with cuts affecting most public subsidy programmes, the PAIME agreements with the regional health authorities are faced with significant budget cuts and even disappearance of the entire grant. Given this fact, Regional Councils of Medical Colleges have chosen to go to the Foundation for help with the receiving of grants and benefits for the promotion and protection of doctors' health. The Foundation, through its Governing Board first, then the Board of Trustees, assesses the requests for assistance from the Regional Councils of Medical Colleges. In case of a positive decision, the Foundations grants money for the place of a doctor in the PAIME programme (FPHOMC, 2014). At present, most Colegios de Médicos [Medical Associations] of Spain have implemented this programme with the help of the 'Fundación para la Protección Social de la OMC' (FPSOMC) and the collaboration of most health authorities (Medicos y pacientes, 2013).

The financial aid that is provided to an ill doctor when participating in PAIME is used for (FPHOMC, 2015):

- Economic aid to cope with the incurred costs on income
- Specializing in the treatment of mental illness and / or addictive behaviors center.
- Financially assist the medical practitioner to the costs incurred by joining specialized centers in the treatment of psychological problems and / or addictive behaviors.

Financial results for 2011-2012

In the years 2011-2012 the costs of PAIME amounted to €1.877.860. 649 first visits and 7.622 attended successive visits and 260 hospitalizations were recorded, with an average income in internment units of 32 days. The total costs are built up as follows (Romero, 2013):

- Average cost first visits: $649 \times €60 = € 38.940$
- Costs medium successive visits: $(7622 - 649) \times €40 = €278.920$
- Costs half placements: $260 \times €6000 = €1.560.000$

Conditions for replicability

One of the key successful factors in the running of the PAIME programme is the importance of the speed of response in patient care, for preventing professional- and social isolation and worsening the risks of inadequate exercise (Arteman Jané et al., 2014).

3. Results of the intervention

Retention

Since its inception in 1998, the PAIME programme has helped more than 3.500 physicians. Mental disorders account for 67% of the caseload, and problematic use of drugs and alcohol for 23% (Arteman Jané et al., 2014; Medicos y Pacientes, 2013). Of the doctors that have been treated by the PAIME programme, close to 90% per cent have recovered and been rehabilitated into the practice of medicine (Medicos y Pacientes, 2013). Hence, these doctors have been retained for medical practice, while it is certain that without the PAIME programme, a substantial percentage of this group would have (been forced) to leave the profession.

PAIME is mainly used by older doctors

The PAIME programme is available to medical doctors from all ages, but it is mostly used by older doctors (> 51 years). In 2011, more than one third of participants were from the age category 51-60 years. And in 2012, their share had grown even further to 40%. More than half of the participants of the PAIME programme in 2012 were 51 years or older (see table 1).

Table 1 Age of PAIME participants 2011-2012

	2011	2012
Up to 30 years	11,8%	7,0%
31 – 40 years	20%	17,7%
41 – 50 years	25%	26,3%
51 – 60 years	36,1%	40,2%
61 years and older	7,1%	8,9%

Table 2 shows the most common clinical diagnoses for PAIME participants.

Table 2 Clinical diagnoses (according to DSM-IV R)

Associated with alcohol use disorders and substance	22,9%
Adjustment Disorders	15,3%
Mood disorder	27,8%
Anxiety disorders	9,4%
Personality disorders	10,2%
Schizophrenia and other psychotic disorders	5,4%
Other disorders	6,3%
Unspecified	2,7%

Source: Romero, 2013

From 1998-2010, PAIME helped 2.435 physicians. In 2011, 351 new patients were admitted and in 2012 313 new patients were admitted (Romero, 2013).

Most PAIME participants enter the programme on the basis of self-referral, voluntarily and on their own initiative (77%). Next in percentage of access paths is the voluntary programme (18%), followed by confidential communication (4%) and the formal complaint (1%) (Medicos y pacientes, 2013). Most doctors (83.2%) were self-referred

to the programme. A study by Braquehais et al. (2014) showed that doctors with non-self-referral types of referrals are significantly older than the doctors with who enter the programme via self-referral. Self-referrals were more frequent among patients with non-substance use disorders (84.6%) than in those with addictive disorders (15.4%), with this difference being statistically significant (Braquehais et al., 2014).

Most participants are from the specialty of Family and Community Medicine (40%), followed by General Surgery (5%), Internal Medicine (5%), Pediatrics (5%), Psychiatry (5%), Anesthesiology (5%), Orthopedics (3%) and Gynecology (2%). Regarding the habitat where they exercise, the highest percentages of physicians cared come from urban areas (78%). The remaining 22% come from rural areas (Medicos y pacientes, 2013).

References

Arteman Jané, A. et al. (2014). *Quién cuida de la salud del médico?* Available at: <http://medicinagaditana.es/quien-cuida-de-la-salud-del-medico/> (accessed: 20-01-2015).

Braquehais, María Dolores, et al. (2014) "Doctors admitted to a Physicians' Health Programme: a comparison of self-referrals versus directed referrals." *BMJ open* 4.7 (2014): e005248).

Fundación Patronato de Huérfanos y Protección Social de Médicos Príncipe de Asturias Fundación para la Protección Social de la OMC (FPHOMC) (2014). *Manual PAIME. Programmea de Atención Integral al Medico Enfermo*. Madrid: Fundación para la Protección Social de la OMC.

Fundación para la Protección Social de la OMC (FPHOMC) (2015). *Programmea de Atención Integral al Médico Enfermo (PAIME) VI CONGRESO PAIME 2015*. Available at: http://www.fphomc.es/paime_fott (accessed: 23-01-2015).

Romero, S. (2013). *Informe 2013. Datos del PAIME*.

Appendix 8.2. Case report 8.2

Topic 8. Providing supportive working environments for the ageing workforce

Case 8.2. 'Wir sind älter als 50, na und?' ['We are older than 50, so what?'], Germany



Research methods applied:

Desk research: November – December 2014

Telephone interview: December 2014

1. Summary of the intervention – ‘Wir sind älter als 50, na und?’ [‘We are older than 50, so what?’], Germany

Dimension of interest	Categories/description
Objective of the intervention	Recruitment and retention
Type of intervention	Education Personal and professional support
Professional group(s) targeted	Nursing and care staff working in elderly care in homes for the elderly.
Level of intervention	Organisational
Type of organisation	Sozial-Holding der Stadt Mönchengladbach GmbH
Kind of services provided by organisation	Homes for the elderly, outpatient and day-care help and support, information system, education platform, employment and qualification support.
Size of organisation	Large (875 employees)
Area covered	City of Mönchengladbach, Germany
Intervention period / duration of intervention	There is no exact starting point for the measures being taken. Since the beginning of the 2000s, the Sozial-Holding increasingly focused on its ageing workforce. There are no expected end dates for the measures.
Key actions	According to the Sozial-Holding, investments need to be made in further education, prevention and health promotion for older employees. It introduced various measures, including Project ‘Hotelfachkräfte’, Project ‘Zahnmedizinische Fachangestellte’, project ‘Betreuungskräfte’, Seminarprogramm 50+, three year education for adults to become elderly care nurses, and free mental health support for employees.
Financial investment	Considerable financial resources are needed. The Sozial-Holding pays part of the costs itself, other costs are taken on by the Agentur für Arbeit, the ARGE Jobcenter and the State of Germany. Even though the measures taken cost a lot, in the end the Sozial-Holding works economically more cost-efficient.
Implementation strategy or processes used	Most of the measures focusing on the ageing workforce were developed by the Sozial-Holding itself. In executing the measures, it cooperates with various partners, including the Agentur für Arbeit, Katholische Bildungsstätte für Gesundheits- und Pflegeberufe, and the Katholischen

	Forum für Erwachsenen- und Familienbindung
Personnel investment	Additional HR is required.
Outcome measures of the intervention	Data on recruitment and retention are currently not available. However, process measures show a high success rate for the individual measures that the Sozial-Holding has taken for the ageing workforce.

2. Rich description of the intervention

Case under study

The measures that the Sozial-Holding der Stadt Mönchengladbach GmbH is taking to support the ageing workforce that it employs in its homes for the elderly.

Reasons for introducing measures for the ageing workforce

In Germany, there is a high shortage of elderly care nurses. According to the Agentur für Arbeit, in 2009 20.000 elderly care nurses were lacking all throughout Germany. At the same moment, the number of elderly people in society is increasing (Westdeutschen Zeitung, 2009). Ever since the Sozial-Holding der Stadt Mönchengladbach GmbH started working with statistics, it has a high awareness of 'ageing', of 'becoming older'. Around 2000, a development came up in German society which focused attention to the fact that society is getting older. Hence, political decisions were taken that people should work longer, until they are 67 years of age. Moreover, prejudices exist in society around the ageing workforce. It is often said that older employees cost more money (higher salary costs etc.). Another often heard prejudice is that they are more often sick. These things resulted in people becoming more aware of the theme of the ageing workforce, including the Sozial-Holding der Stadt Mönchengladbach (Wallrafen-Dreisow, 2014).

The Sozial-Holding started focusing more on this topic. It concluded that in 2000, 30% of its employees was older than 45, but still needed to work another twenty more years. In 2014, 35% of its employees are older than 50 and a mere 3% or 4% of them will retire within the foreseeable future. So the theme of the Sozial-Holding became: how to work when you are 50+? Which new knowledge is needed? How do employees stay healthy? The Sozial-Holding looked at this systematically and in 2008 it produced the brochure "*Wir sind alter als 50- na und!*". This was aimed at raising awareness that also when people are older than 50, one can work well (Wallrafen-Dreisow, 2014). To continue this positive approach to personnel policy, the Sozial-Holding constantly works together with scientific institutes. Based on scientific grounds, the Sozial-Holding developed concepts to be able to respond to the needs of its elder employees (Wallrafen-Dreisow, 2011; Wallrafen-Dreisow, 2014).

The Sozial-Holding states that many organisations and people are talking about this issue, but very little are concretely doing something about the situation. The Sozial-Holding as a company is acting, because for the Sozial-Holding this is an issue of ethics, of attitude. The Sozial-Holding has the deep conviction that only healthy staff and staff that are feeling good can provide good care. Hence, the Sozial-Holding needs to "pflegen", to nurse its own staff. Only if they feel good, they can do their job with motivation and pleasure (Wallrafen-Dreisow, 2014).

Objective of the intervention

Retain the ageing workforce in homes for the elderly by supporting their individual strengths in their work through support and education, and attracting new adult staff to positions in homes for the elderly through further and re-education.

Type of intervention

The Sozial-Holding der Stadt Mönchengladbach is offering its older employees professional and personal support as well as the opportunity for further education. The Sozial-Holding is also looking at the broader society, including the ageing workforce in the broader society, by providing them with educational opportunities.

Professional group(s) targeted

Nursing and care staff working in homes for the elderly of the Sozial-Holding der Stadt Mönchengladbach.

Level of the intervention

Organisational level.

Area covered

City of Mönchengladbach in South-West Germany.

Running time of the intervention

There is no exact starting point for the measures being taken. Since the beginning of the 2000s, the Sozial-Holding increasingly focused on its ageing workforce. There are no expected end dates for the measures.

Measures that the Sozial-Holding has taken for its ageing workforce*Starting point or philosophy for the Sozial-Holding der Stadt Mönchengladbach*

Nowadays people work from 20 till 65. In these 45 years, people do not always have the same skills, mentally nor physically. As an employer, the Sozial-Holding focuses on its employees' strengths and skills, and employs staff according to that. When someone is old and cannot lift as much anymore, but has lots of technical-medical knowledge, he/she needs to fulfil more technical-medical tasks. So the Sozial-Holding constantly tries to look at whether employees work on the right place, where he/she is best (Wallrafen-Dreisow, 2014). It has introduced the innovative concept 'horizontaler Laufbahnstaltung'. This means that systematically new functions and positions are being created and implemented in the organisation. Often, the new activities that staff of 50+ undertake are financially rewarded and new activities and qualifications are learned within the organisation (Sozial-Holding, 2008). Moreover, the Sozial-Holding believes that if employees work in an area in which they can excel, they will also be more motivated to do some further education in the small part where knowledge may be lacking. Hence, the Sozial-Holding always looks at the individual (Wallrafen-Dreisow, 2014).

According to the Sozial-Holding, when the ability to work of older employees needs to be maintained, investments need to be made at an early point in time in the area of further education, prevention and health promotion. The Sozial-Holding has made several efforts to cope with the changing demographic structure (Wallrafen-Dreisow, 2011):

- The Sozial-Holding motivates all employees to follow further education/CPD
- The Sozial-Holding offers employees flexible work arrangements
- The Sozial-Holding supports the spread of positive images of age in the company, among others through the communication of the motto 'Wir sind

alter als 50, na und?'. Also when new employees are recruited, attention is paid to the fact that all age groups should be taken into account.

- The Sozial-Holding offers employees possibilities to participate in health promoting activities
- The Sozial-Holding offers nursing staff in the case of health problems personal employee conversations in which alternative job arrangements/jobs can be discussed.

Concrete measures that the Sozial-Holding has taken over the years include:

Project 'Hotelfachkräfte' and Project 'Zahnmedizinische Fachangestellte'

These projects offer one month education for people who used to work as dental assistants and people who used to work in the hotel branch (not necessarily unemployed people!). For years, there has been a shortage of nurses in homes for the elderly. This will only change if one doesn't only look in the own professional field but also in other professional fields, to find new employees (Extra-Tipp, 2009). Moreover, in the homes for the elderly, the motto of the Sozial-Holding is: living in homes for the elderly is similar to living at home. Hence, it is not only about nursing, it is about cooking, reading, dancing, etc. Yet in homes for the elderly, only nursing staff are employed. But they are only strong in nursing. People want to 'live' and therefore staff is needed which has other qualities, such as former hotel staff, who are service-oriented, and former dental assistants who can care for the mouth. So the Sozial-Holding focused very consciously on other professional areas and invited these people and let them 'feel' the homes for the elderly, made 'hospitationen'. And in this way it recruited staff out of the several professions that were unemployed by the Agentur für Arbeit (Wallrafen-Dreisow, 2014). The Sozial-Holding Mönchengladbach and the Agentur für Arbeit Mönchengladbach are cooperating in these projects. A complete service is offered that mediates suitable applicants to the right profile and further education, so that missing qualifications can be obtained. The further education lasts one month and people are educated in behaviour and diseases (Extra-Tipp, 2009).

Project 'Betreuungskräfte' [support staff]

This project provides unemployed people with 160 hours of education to become additional support staff for people with dementia. This invention was developed by the state of Germany, not the Sozial-Holding. The state said: we need more staff for dementia patients and we will pay for it. The Sozial-Holding is not entirely positive about the 'Betreuungskräfte' programme. The German state reasoned that the 160 hour course could be followed by someone who is unskilled (i.e. did not finish any education). The Sozial-Holding says: this cannot be done by someone unskilled. Since many years no unskilled people are working in their homes for the elderly. In the companies of the Sozial-Holding, everyone that starts needs to have done a job (Wallrafen-Dreisow, 2014).

So the Sozial-Holding introduced an additional criterion for unemployed people who want to follow the 160 hour course and come work in one of the homes for the elderly of the Sozial-Holding: only people who graduated from high school and learned a job (regardless what) can be re-educated and/or further educated. So all the *Betreuungsassistenten* of the Sozial-Holding followed a multiple month educational course in the area of Demenz (160 hours) and had a job before. It should be noted that for

Germany as a whole, people who want to follow this course do not need to have graduated or had a job before (Wallrafen-Dreisow, 2014).

The duration of the course, 160 hours, was also established by the Staat Germany. HThe Sozial-Holding thinks that 160 hours is not enough, but this is what is being financed (Wallrafen-Dreisow, 2014).

Seminarprogramm 50+

This idea was developed by the Sozial-Holding and in 2008 the programme was run for the first time. The Seminarprogramm is offered by the the Katholischen Forum für Erwachsenen- und Familienbindung and is free to use, on a voluntary basis, for 50+ staff of the Sozial-Holding. The Sozial-Holding only certifies that people are an employee and over 50 and then pay the costs for the programmes that are followed, without knowing which programmems this are. There are 8 courses specifically developed for employees of the Sozial-Holding and 8 courses of the general offer of the Katholischen Forum. The courses offer time, space and impetus for dealing with ageing and include questions about (Sozial-Holding, 2008):

- Health and illness
- Job
- Society
- How to stay fit mentally and physically
- Preparation for pension
- Livelihood security
- Provision
- Live design

After the programme ran for the first time, the Sozial-Holding concluded that the 300 employees that were older than 50 didn't use this programmem a lot and it wanted to know why. In Dortmund, the Forschungsgesellschaft für Gerontologie did a survey among the 50+ staff of the Sozial-Holding and asked why they didn't use the Seminarprogramm, what would they wish? This produced a shocking answer. The staff said: the conduct of the management is not value-estimating.

So it turned out there is a close dependence between the management person and the motivation of an employee on whether or not he/she wants to do further education. If you always hear that you are stupid, why do further education? The Sozial-Holding then asked itself: did we educate our managers enough? So it checked its management staff again and qualified them retroactively. Then it educated them in the special needs of elder employees. And the Sozial-Holding changed how the management approached elderly staff. It systematically educated its management staff for three years. And the results are satisfying and now more people are participating in the Seminarprogramm as well (Wallrafen-Dreisow, 2014).

Three year education for adults to become elderly care nurses

There are too little nurses in homes for the elderly. Therefore, since November 2009, the Sozial-Holding Mönchengladbach started educating people itself to become elderly nurses. According to Mr Wallrafen-Dreisow, managing director of the Sozial-Holding Mönchengladbach, adults bring competencies and experience that are important for working in elderly care. In cooperation with the Agentur für Arbeit, the Sozial-Holding therefore started cooperating to provide the qualification of people via a 3 year

education to become elderly nurses. Each year, there are about 25 participants in the age of 19-50 years (Westdeutschen Zeitung, 2009).

The Agentur für Arbeit mediates the applicants for the education. The Sozial-Holding Mönchengladbach is the carrier of the measures. The Katholische Bildungsstätte für Gesundheits- und Pflegeberufe provides the theoretical education and the practice is done via the Sozial-Holding, where participants are also employed (Westdeutschen Zeitung, 2009; Sozial-Holding, 2010).

Free mental health support for employees

In May 2012 the Sozial-Holding signed a contract with a psychological counselling enterprise. It pays 45 euro per year per employee for all its employees, so that employees and their families can become free mental support. About 10% of the employees use this service. In Germany, normal waiting times for mental support are at least half a year. The Sozial-Holding doesn't want that, that's why it signed the contract and employees get a guaranteed appointment within 14 days (Wallrafen-Dreisow, 2014).

Implementation strategy

Most of the measures that the Sozial-Holding has introduced that focus on the ageing workforce were developed by the Sozial-Holding itself. In the executing the measures, it cooperates with various partners. Of crucial importance is the Agentur für Arbeit [in English: Agency for Employment]. They provide the Sozial-Holding with suitable candidates. Two other important partners are the Katholische Bildungsstätte für Gesundheits- und Pflegeberufe, which provides the theoretical education for the three year education for adults to become an elderly care nurse, and the Katholischen Forum für Erwachsenen- und Familienbindung which provides the Seminarprogramm 50+ that the Sozial-Holding is offering to its 50+ staff.

Organisational framework

The Sozial-Holding der Stadt Mönchengladbach GmbH is a company that organises the main social areas quickly, flexibly and efficiently under one roof. The social-Holding is a 100% daughter company of the city Mönchengladbach, which on its turn also houses several daughter companies. Together they provide the citizens with a clearly structured offering (Sozial-Holding, 2014).

Sozial-Holding GmbH

Management and administrative tasks are performed centrally in the Sozial-Holding GmbH. This leads to synergies in the use of human and material resources. The professionals in the daughter companies obtain the necessary space to perform their duties in accordance with customer wishes.

Altenheime GmbH

This is the largest daughter company of the Sozial-Holding and supports the six municipal homes for the elderly in five locations. Distributed throughout the city, it offers a total of 605 places for inpatient care and support.

Ambulante Dienste GmbH

Here customers can find individual advice and a comprehensive range of outpatient and day-care help and support: short-term care, meals on wheels, household help / daily living aids, care for people with dementia, etc.

Beratungszentrum

The information centre informs customers about all the services of the homes for the elderly of the Sozial-Holding and its ambulante Dienste.

Bildungs-GmbH

The educational GmbH performs actions on behalf of ARGE in fields of

- General qualifications for the labour market,
- Qualifications for activities in the field of geriatric care.

Beschäftigungs- und Qualifizierungs-GmbH

The BQG promotes and supports the professional integration of long-term unemployed people in Mönchengladbach.

Service GmbH

Together with the other shareholders procuratio the Service GmbH provides services in home economics. In the central kitchen up to 1,200 meals are prepared daily, including for the municipal nursing homes and meals on wheels.

Facilitators and barriers in the running of the intervention

No information retrieved.

Finances

It should be noted that for none of the measures that the Sozial-Holding has taken, cost-efficiency was the starting point. For the Sozial-Holding it is the content of the measures which counts. But it is clear that the measures it has taken require considerable financial resources, although not all measures are paid (exclusively) by the Sozial-Holding).

For the mental health support, the Sozial-Holding pays 45 Euro per year for each employee of 50+. It also pays the costs for the courses that employees are following in the Seminar 50+ program. The three year education for adults to become elderly care nurses costs a lot of money. All parties involved admit this. The Agentur für Arbeit Mönchengladbach and the ARGE Jobcenter Mönchengladbach contributed around 750.000 Euro for this measure; the Sozial-Holding employed a nursing care teacher to support the students in their education that was provided by the Katholischen Bildungsstätte für Gesundheits- und Pflegeberufe (kbs) (Sozial-Holding, 2012). The one month education for the Betreuungskräfte is paid for by the State of Germany.

However, even though all the measures that are being taken cost a lot of money, in the end the Sozial-Holding works economically more cost-efficient (Wallrafen-Dreisow, 2014).

Conditions for replicability

The Sozial-Holding is systematically doing things different and it is obtaining better results, both in terms of staff outcomes and financial outcomes. Hence, many organisations have showed an interest in the measures that the Sozial-Holding has taken. However, Mr Wallrafen-Dreisow mentions that even though many people and organisations are interested in what the Sozial-Holding does, no one is replicating it (Wallrafen-Dreisow, 2014). Important criteria for replication appear to be:

- Availability of considerable financial resources.
- Commitment from the top of the organisation through the (middle) management to the workforce itself. For example, in case of the Seminarprogramm 50+, it turned out that employees initially barely used this programme, as a result of middle management attitudes towards employees. Once the middle management was specifically trained on managing an ageing workforce, employees started using the Seminarprogramm more.

3. Results of the intervention

Data on recruitment and retention are currently not available. However, process measure show a high success rate for the individual measures that the Sozial-Holding has taken for the ageing workforce.

Project Hotelfachkräfte

Since the Project Hotelfachkräfte started, 45 people showed interest in the programme. In 2009, seven employees who used to work in the hotel sector were further educated via the one month course and were employed in the elderly homes of the Sozial-Holding Mönchengladbach. In 2014, this number has risen to fourteen already (Extra-Tipp, 2009; Wallrafen-Dreisow, 2014).

Three year education to become elderly care nurse

In 2009, the Sozial-Holding started the course for adults to become elderly care nurses. Of the 21 people who started in November 2009, 18 got their diploma in November 2012. All found a job in elderly care (Sozial-Holding, 2012).

Free mental health support for employees

By introducing free mental health support for its employees, the Sozial-Holding Mönchengladbach was able to halve the number of mental health illness days since May 2012. The Sozial-Holding strongly emphasizes though, that this was never its primary aim for introducing this measure. The most important thing is that employees feel valued and get help (Wallrafen-Dreisow, 2014).

Betreuungskräfte

Since 2010, every year 22 persons are being qualified by the Sozial-Holding to become a Betreuungskraft. At this moment, the Sozial-Holding employs 23 Betreuungsassistentinnen. This is additional to all other staff. Almost all the other persons who are qualified by the Sozial-Holding find a job in one of the other homes for the elderly of the city Mönchengladbach (Wallrafen-Dreisow, 2014).

According to the General Director, the Sozial-Holding clearly has lower sickness absence levels than comparable countries (Wallrafen-Dreisow, 2014).

Awards

The Sozial-Holding has won several awards for the measures it has taken (Sozial-Holding, 2014):

- 2014: prize for this from the AOK, the biggest German Krankenkasse, for the mental health support it is offering to its employees
- 2014, 2010 and 2009: AARP International Innovative Employer Award
- ARBEIT PLUS - cachet of the Evangelical Church in Germany (EKD) for forward-looking employment policy, awarded a total of 6 times, the last time in 2013
- 2013: German Company Award Health "Move Europe-Partner EXCELLENCE" for special commitment to workplace health management
- 2007: 6th place at Germany's Best Workplaces in Healthcare

References

Bender, J. (2010). *Personalprobleme? Fehlanzeige! Die Sozial-Holding setzt auf Personalentwicklung in der Pflege – auch 50-jährige noch ausbilden.*

Extra-Tipp (2009). *Weiterbildung als Chance sehen.* Extra-Tipp 14.06.2009

Sozial-Holding (2008). *Wir sind alter als 50, na und?.* Unternehmenszeitung der Sozial-Holding Monchengladbach, 13 April 2008.

Sozial-Holding (2010). *Chancen im Bereich Health Care.* Sozial-Holding Mönchengladbach, 12.01.2010.

Sozial-Holding (2012). *Erster Arbeitstag für 18 frisch examinierte Pflegefachkräfte* Pressemitteilung.

Sozial-Holding (2014). Website. Available at: <http://www.sozial-holding.de/ueber-sozial-holding-gmbh.html> (accessed: 11-12-2014).

Wallrafen-Dreisow, H. (2011). *Schritt für Schritt zum Age-Management.* Die Schwester Der Pfleger 50. Jarg. 02/11.

Wallrafen-Dreisow, H. (2014). Telephone interview for the Recruitment and Retention study. 10-12-2014.

Westdeutschen Zeitung (2009). *Arbeitslose zu Altenpflegern – eine Weiterbildung mit Jobgarantie.* Westdeutschen Zeitung 18.12.2009.

Appendix 8.3. Case report 8.3

Topic 8. Providing supportive working environments for the ageing workforce

Case 8.3. Measures taken in the Italian healthcare sector to improve the working conditions of the aging workforce, Italy



Research methods applied:

Desk research: December 2014 – January 2015

Email interview: January 2015

1. Measures taken in the Italian healthcare sector to improve the working conditions of the aging workforce, Italy

Dimension of interest	Categories/description
Objective of the intervention	Retention
Type of intervention	Regulation
Professional group(s) targeted	Ageing health workforce
Level of intervention	Policy and organizational
Type of organisation	Various (Ministry of Health, individual healthcare institutions, etc.)
Kind of services provided by organisation	Various
Size of organisation	Large
Area covered	Italy
Intervention period / duration of intervention	Measures aimed at the ageing workforce have been taken since the late e1990s, early 2000s, but have become much more important since the Law Fornero (92/2012) came into force in July 2012.
Key actions	Several measures have been taken at both policy and organisational level: the 2007 financial law introduced job-sharing, to allow older workers to leave the labour market gradually, and simultaneously transfer their skills to younger workers. At organisational level, measures taken include the exclusion of older workers from night shifts and e.g. excluding older workers from activities on heavy machines (CT, MRI) to daytime activities on outpatients for conventional radiography.
Financial investment	No information could be retrieved.
Implementation strategy or processes used	Measures taken at policy level have taken a long time to be introduced due to opposition from social partners. Also at organizational level there is a strong view of encouraging early exit routes rather than retaining older workers in employment.

Day-to-day running of the intervention	No information could be retrieved.
Outcome measures of the intervention	No information could be retrieved.

2. Rich description of the intervention

Case under study

The measures that have been taken in the Italian healthcare sector to improve the working conditions of the aging working population.

Reasons for the introduction of measures to improve the working conditions of the aging working population

In Italy, the proportion of over-50 workers in the labour market has generally been low. Pension systems for a long time encouraged early retirement or failed to provide appropriate incentives to delay retirement. The general trend, also among companies, has been encouraging early exit routes rather than retaining older workers in employment. As a result, initiatives in support of workers aged 50+ were (and are) generally fragmented and limited to certain areas. Only recently, more emphasis has been put on measures intended to keep older workers in employment (Colombo, 2013).

While the processes to achieve an increase in retirement age started in the middle of the 1990s already, they were strongly opposed by trade unions (Colombo, 2013). Until the 31st of May 2011, the Italian Health Workers Public/Public Health fell into two broad categories (Lavelle, 2014):

- Men who retired after reaching their 35th year of service or when 60 years of age.
- Women who retired from 25 years of seniority onwards (according to personal needs) or when 55 years of age.

Both men and women could remain longer in service, on request, for a maximum of two years (for men after their 65th and for woman after their 60th birthday). These opportunities, however, were almost exclusively used by medical management (Lavelle, 2014).

Law 92/2012 (Law Fornero)

After a long and suspenseful awaiting and after months of discussions and shilly-shallying, on the 27th of June 2012 the Italian Parliament approved the Monti-Fornero reform of employment law which came into force on 18 July, 15 days after its publication on the Official Gazette which took place on 3 July with serial number 92/2012 (Baker & McKenzie, 2012). This law meant a historical break which will have considerable impact on the working lives of professionals. The 'Law Fornero' has substantially changed the parameters of access to pensions (Lavelle, 2014):

- For men: 42 years and 6 months of employment or 65 years of age (extendable up to 70 years for specific categories of workers)
- For women: 41 years and 6 months of employment or 60 years of age (a progressive increase of 'seniority' is foreseen each year, so that in 2018 the retirement age of all female workers will be at least 65 years).

Under these developments, the Italian health system has grown from a (predominantly female) working population that was never too old, to a perspective of a working population with a considerable amount of senior workers, without ever

having experienced the implications of their age on the organization of services. Moreover, healthcare institutions generally have two characteristics (Lavelle, 2014):

- A high proportion of part-time staff. The national average is 12%, but there are healthcare institutions where 20% of the working population is part-time staff and in certain professions – such as nursing – this percentage can rise up to 25%. The reason for the high percentage of part-time staff is that the workforce is predominantly made up of women, who also have to care for children or care for parental / family members who are ill or disabled.
- High proportion of personnel with limited work ability (LWA) due to chronic diseases or conditions of personal/family situations. The national average number of employees with reduced ability is 7%, but the distribution is very different among the professions, with the highest percentage found in nursing.

The increase in percentage of ageing working population is the largest in nursing. In 2002, the mean age of nurses was 38 years; this had increased to 42 years in 2012. In 2003, 12% of the nurses was 45 years or older, in 2014 this was 27% and this percentage is expected to increase to 50% in 2022 (Lavelle, 2014).

Over the last three years, it has become clear that there is a need to create working conditions that are compatible with the increase in retirement age and the resulting lower staff turnover, i.e. working conditions focused on an aging working population (Lavelle, 2014).

Objective of the intervention

Create working conditions that that are compatible with the increase in retirement age and the resulting lower staff turnover, i.e. create working conditions focused on an aging working population.

Type of intervention

Various

Professional group(s) targeted

The ageing health workforce

Level of the intervention

Policy and organisational level

Area covered

Italy

Running time of the intervention

Measures aimed at the ageing workforce have been taken since the late 1990s, early 2000s, but have become much more important since the Law Fornero (92/2012) came into force in July 2012.

Key actions

Act No. 30/2003 (2003 Biagi reform)

The Act No. 30/2003 (Biagi reform) was driven by EU-related policy considerations and established new working arrangements intended to keep the over-50s in the labour market (Colombo, 2013).

- Work-entry contracts have replaced the old training and work experience contracts and address also unemployed over-50. Former training and work experience contracts had better employer taxation arrangements but they were related only to young people before 29. These new contracts are also related to over-50 unemployed workers.
- Job on call consists of the alternation of working periods with periods when the worker is available to work only if needed. This tool was not used a lot, mainly due to the poor attention given by the collective bargaining.

Other legislative actions introduced working conditions in support of older workers:

Financial law 2007

The yearly financial law in 2007 introduced job-sharing, a measure intended to allow older workers to leave the labour market gradually, and at the same time transfer their skills to younger workers, by working next to them. However it does not seem to be an official tool used by collective bargaining, but rather a staff management measure that is sometimes used by companies unilaterally and not systematically (Colombo, 2013).

Social and labour market aspects

Initiatives to raise awareness about the relevant role played by older workers have been implemented in the last ten years, and have been intensifying in the last years due to the economic crisis negative effects on older workers. These initiatives consist of the analysis and monitoring of over-50s' working conditions and social policies; they are promoted by the Ministry of Labour and they act as policy advice (Colombo, 2013).

Organisational level (planned actions)

Based on the Law 92/2012 (Law Fornero) which meant an increase in pension age, it became clear that the Italian health system has grown from a working population which was never too old, to a perspective of a working population with a considerable amount of senior workers, without ever having experienced the implications of their age on the organization of services. The work that has been planned to support employment and retention of staff has been fruitful (Lavelle, 2014):

- Medical area: excluding doctors with advanced age and/or limited work ability from working night shifts and activities of the operating room/endoscopic room and assign them to daytime activities both in hospital and in surgery.
- Area of non-medical healthcare:
 - o Nurses and support staff: to assign to day-time activities (outpatient clinics, Day Hospitals, Day Surgeries), moving first from intensive care units or intensive nursing care platforms (as geriatrics or orthopaedics units) and excluding them from night shifts or night calls. Also for

- nurses, assignation to intermediate services (pathology laboratory, radiology, sterilization unit...) or assignation to the support staff as education services, quality improvement unit, clinical governance unit, safety and risk management unit, occupational safety unit or programs.
- Technical radiology: moving from activities on heavy machines (Computerized Tomography, Magnetic Resonance...) and from surgical/interventional radiology (angiography, coronary angiography, stenting) to daytime routine activities for internal patients or outpatients (diagnostic on thorax, bones, abdomen, sonograms, check after hospital discharge).
 - Lab technicians: they could be moved from emergency areas (night and day-time shifts, emergency) or moved from microbiology, virology, cytology, molecular biology or cells (that require a manual fine-tuning and prolonged attention in each test) to day-time duties, using simpler technologies and more automated technologies.
- Administrative area:
- For non-managerial staff: assignment to offices/tasks of lesser responsibility.
 - For leadership staff: the attribution of responsibility in the area of back-office and not the production or direct contact with customers / suppliers or users of services.

Implementation strategy

No information could be retrieved.

Organisational framework

No information could be retrieved.

Facilitators and barriers

The adoption of the 2003 Biagi reform and other measures aimed at supporting the older work force in Italy followed after a long confrontation between the government and the unions (social partners) (Colombo, 2013).

In Italy, the 'cultural idea' to encourage early retirement is very strong and hampers the introduction of measures aimed at supporting the ageing workforce and keeping people longer in employment.

The general idea, among pension systems and companies, still is to encourage early exit routes rather than retaining older workers in employment. The process of changing this idea takes time.

Finances

No information could be retrieved.

3. Results of the intervention

No information could be retrieved.

References

Baker & McKenzie (2012). The Reform of Italian Employment Law (92/2012): a practical overview. Available at: <http://www.lexology.com/library/detail.aspx?g=9ab9c7b6-ba7b-4b3e-8a75-cae72bdad0aa> (July 11, 2012).

Colombo, S. (2013). Italy: The role of governments and social partners in keeping older workers in the labour market. EurWORK European Observatory of Working Life.

Lavelle, T. (2015). Answers to email questions Recruitment and Retention study.

Appendix 8.4. Case report 8.4

Topic 8. Providing supportive working environments for the ageing workforce

Case 8.4. Life Stage Policy, Aalborg University Hospital, Denmark



Research methods applied:

Desk research: December 2014 – January 2015

1. Summary of the intervention –Life Stage Policy, Aalborg University Hospital, Denmark

Dimension of interest	Categories/description
Objective of the intervention	Retention
Type of intervention	Education Regulation Personal and professional support
Professional group(s) targeted	Senior hospital staff of 58 years and older
Level of intervention	Policy and organizational level
Type of organisation	Hospital
Kind of services provided by organisation	Secondary and tertiary care in almost all medical specialisations.
Size of organisation	Large (> 6,500 employees and > 900 beds)
Area covered	Aalborg University Hospital provides highly specialised care for 640,000 inhabitants, regional functions for 490,000 inhabitants and basic hospital functions for 250,000 inhabitants.
Intervention period / duration of intervention	The Livsfasepolitik was introduced in October 2008. There is no expected end date.
Key actions	The regional Livsfasepolitik is a broad framework and is implemented based on specific needs of individual organisations. At Aalborg University Hospital, this includes opportunity for less demanding tasks, reduction of working hours, reorganization of work.
Financial investment	No information could be retrieved.
Implementation strategy or processes used	The Livsfasepolitik is developed at regional policy level. It is a top down initiated measure. At Aalborg University Hospital, a working group developed a guideline on how to use the Livsfasepolitik policy. Individual hospital departments have developed specific instructions for their senior staff.
Personnel investment	Relatively low for implementing the policy. However, it should be noted that the policy may affect staff (i.e. replacement of shifts for colleagues who may benefit from Livsfasepolitik policy).
Outcome measures of the intervention	At the Occupational and Physical Therapy Department, only a limited number of employees use the opportunities in the department's policy for seniors.

	There is a greater need for long-term disease arrangements.
--	---

2. Rich description of the intervention

Case under study

The Livsfasepolitik [in English: Life stage policy] introduced by the region Nordjyllands [in English: Northern Jutland] as implemented at Aalborg University Hospital.

Establishment of the Livsfasepolitik [Life stage policy]

In October 2008, the region Nordjyllands in the north of Denmark introduced its Livsfasepolitik.

Objective of the intervention

The Nordjylland region recognises that during different life phases, different needs and requirements are expected of the workplace. The Livsfasepolitik [Life stage policy] is aimed at ensuring that organisations act according to these different needs and requirements. Hence, the purposes of the Livsfasepolitik are (Region Nordjylland, 2014):

- To create attractive workplaces where there is opportunity for individual consideration in order to attract, motivate, develop and retain employees.
- To ensure a good balance between work and leisure activities for the benefit of both employees and workplace.
- To take into account the diversity and multiplicity of staff
- To ensure flexible task performance and appropriate work organization.
- To ensure that North Denmark Region is an inclusive workplace that focuses on the possibilities to support individual employees in all stages of life; whether employees with children, seniors, employees with relatives with serious diseases or other urgent problems, part-time employees or full-time employees.
- To ensure open dialogue based on mutual interest and respect for the wishes of both the employee and the workplace.
- To ensure a gradual experience and knowledge transfer between younger and older employees.
- To ensure that requirements for challenge, development and well-being fit as far as possible with each employee's current life situation.
- To ensure continuous skill development throughout employees' working lives.

Based on this regional Livsfasepolitik, Aalborg Hospital established a framework on how to create attractive and flexible jobs so as to meet the individual employee's life situation whilst at the same time taking into account the work site best interests (Aalborg Universitetshospital, 2012).

Type of intervention

The implementation of the Livsfasepolitik policy in Aalborg University Hospital combines elements of regulation, personal and professional support and education.

Professional group(s) targeted

The Livsfasepolitik is a general policy, not aimed at a specific professional group. In Aalborg University Hospital, the policy is 'translated' to apply to all senior staff (> 58 years) in the hospital.

Level of the intervention

The Livsfasepolitik is developed at regional policy level by the Region Nordjylland, hence it is a top down initiated measure that is imposed on individual organisations (Flensburg Jensen et al., 2011).

Area covered

Aalborg University Hospital handles highly specialised regional functions for approximately 640,000 inhabitants, including parts of the Central Denmark Region, regional functions for approximately 490,000 inhabitants and basic hospital functions, except for certain elective procedures, for approximately 250,000 inhabitants (Aalborg University Hospital, 2015).

Kind of services provided by Aalborg University Hospital

Aalborg University Hospital is the largest hospital in the North Denmark Region. It is also northern Jutland's largest employer, with approximately 6,500 employees. It has 929 beds. Aalborg Hospital caters for all medical specialisations with the exception of Dermatovenereology, clinical pharmacology and psychiatry (Aalborg University Hospital, 2015).

Running time of the Livsfasepolitik

The Livsfasepolitik was introduced in October 2008 by the region Nordjyllands. There is no expected end date.

Implementation of the Livsfasepolitik at Aalborg University Hospital*Regional Livsfasepolitik*

The Livsfasepolitik [Life stage policy] is developed at regional level by the Region Nordjylland. Hence, it is a top down initiated measure (Flensburg Jensen et al., 2011). The life stage policy is formulated very broadly. The region's sectors and local MED-committees (mergers between cooperation and health & safety committees) may draft local agreements and guidelines, as long as they are consistent with the broad outlines of the policy. Guidelines are aimed at implementing the policy, but can for example offer explicit practical advice on how the policy relates to individual jobs or specific situations (Region Nordjylland, 2014).

Implementation at Aalborg University Hospital

At Aalborg University Hospital, departmental managers are supposed to use the broad Livsfasepolitik policy as directive and further develop it in accordance with the local conditions (Flensburg Jensen et al., 2011). Hence, a working group under the sector MED-committee at Aalborg University Hospital has developed a guideline on how to use the Livsfasepolitik policy. The guideline is targeted at managers at Aalborg University Hospital and aims to offer a framework on how the hospital can ensure attractive and flexible jobs which meet both the needs of the employees' individual life

stages as well as the needs of the hospital. Hence, among others, the guideline describes various options in relation to schemes for senior staff (Aalborg Universitetshospital, 2012).

Implementation at Departments

Below, we discuss how the Department of Occupational Therapy and Physiotherapy and the Department of Nuclear Medicine at Aalborg University Hospital have implemented the Livsfasepolitik in their Departments.

Occupational Therapy and Physiotherapy Department at Aalborg University Hospital

The local MED-committee in Occupational Therapy and Physiotherapy at Aalborg Hospital wished to have an additional instruction for seniors employed in the Occupational Therapy and Physiotherapy Department. Hence, in cooperation with the hospital working group on this issue, a consultant from the Salary and Personnel Office, and in consultation with employees of the Occupational Therapy and Physiotherapy Department, a specific instruction "Instructions for Seniors employed in Occupational and Physical Therapy Department" was developed. This should help to provide the employees to retain links to the department while they make the gradual transition to third age (Aalborg Universitetshospital, 2014).

The "Instructions for Seniors employed in Occupational and Physical Therapy Department", Occupational Therapy and Physiotherapy Department, Aalborg University Hospital

The "Instructions for Seniors employed in Occupational and Physical Therapy Department" is aimed at all Department employees older than the age of 58. The instruction offers the opportunity for individual employees to ask for an individually composed senior agreement, if desired (Aalborg Universitetshospital, 2014).

Employees can ask for a senior agreement for:

- for a limited time
- permanent

The employees have the opportunity to end the agreed senior agreement. Management on the other hand cannot terminate a permanent senior agreement (Aalborg Universitetshospital, 2014).

The "Instructions for Seniors employed in Occupational and Physical Therapy Department" provides instructions for (Aalborg Universitetshospital, 2014):

- Senior Conversation:
 - o The direct leader/manager of the employee of 58 or older offers him/her a senior interview in order to discuss the employee's wishes, opportunities and needs in relation to senior relevant topics. The conversation has a long-term perspective.
 - o Senior conversation will then be an integral part of the development conversation or can be arranged as needed.
- Work organization, including work function, job content and working hours
 - o It is possible for the employee to change his occupation / job description, to fit the individual's resources.

- It is possible for the employee to conclude an agreement on amended working hours, for example in the form of changing meeting times, a weekly day off, etc.
- Work at weekends and on Holidays
 - It is possible to completely or partially be deleted from the work in the weekend and on holidays / rescheduled working hours.
- Education / competency
 - There is still the opportunity to desire and seek both professionally and personally relevant courses / training.
- Job development
 - It is a shared responsibility between employee and manager / colleagues to consider and discuss whether the employees have specific skills that can also be used in new functions such as coordinator, trainer, training for new recruits, academic resource person.

Senior policy on the Department of Nuclear Medicine (NM), Aalborg University Hospital

The senior policy was implemented at the Department of Nuclear Medicine (NM) at Aalborg University Hospital to retain employees in the department by creating attractive conditions for the benefit of the individual, but also for the benefit of the department. This is done by offering employees aged 58 and older (Aalborg Universitetshospital, 2013):

- opportunity for less demanding tasks
- reduction of working hours
- reorganization of working
- leave
- good working environment and working
- further education and training

Frames for age management in the Department of Nuclear Medicine (Aalborg Universitetshospital, 2013):

- the economic base must be found within the department's budget
- self-financing
- creation of senior posts is an option and not a right
- agreed arrangements must be general, although must take the individual as point of departure
- agreements must be known
- the purpose of each agreement must be clear and well-founded

Advantages of the senior policy (Aalborg Universitetshospital, 2013):

For the Department:

- retention of dedicated and qualified staff
- retention of knowledge and experience to disseminate to new and younger workers
- satisfied employees
- possibility of temporary compensation

For the employee:

- reconciliation of work and private life

- more satisfying and manageable work
- a smoother transition to retirement

Facilitators in the running of the intervention

The "Instructions for Seniors employed in Occupational and Physical Therapy Department" are considered a success by the Department. The policy works as a valuable guideline – and it is possible to use it in a very creatively and individually oriented way. Employees talk to managers about their specific wishes, for example reduced working hours, and the managers consider whether or not it is possible to accommodate the request. Since the implementation of the life stage policy, only small modifications in terms of reformulations have been made and the ward expects the policy to remain (Flensburg Jensen et al., 2011).

Barriers in the running of the intervention

An unintended negative result of the "Instructions for Seniors employed in Occupational and Physical Therapy Department" has been that some employees regard the new opportunities as a right and not as a possibility. This perception can be a barrier for both the collegial collaboration and the service. For instance, the policy encourages employees to join their children when they start school. However, if a team consist of many parents whom all feel they have the right to join their child, it will influence the care provision on the ward as well as the other employees in a negative way. Moreover, young employees without a family might feel overseen, because the policy will not specifically benefit them. For example they might feel that it is unfair that people with children always have first priority, when it comes to the planning of vacation, since their vacation has to match the vacation of the children (Flensburg Jensen et al., 2011).

Finances

No information could be retrieved.

Conditions for replicability

To implement a 'life stage policy', it is important that the employees who can benefit from such a policy, i.e. the older employees, maintain their feeling of responsibility towards the collective and the aim and service of the ward. In other words, a life stage policy requires that the managers work on the culture and attitudes in the department and use conflict management in the daily work (Flensburg Jensen et al., 2011).

3. Results of the intervention

"Instructions for Seniors employed in Occupational and Physical Therapy Department"

The ward manager at the Occupational and Physical Therapy Department has the impression that only a very limited number of senior employees use the opportunities in the department's policy for seniors. In her perception senior employees are not interested in specific senior policies, since there is no difference in the needs or competences between young and senior employees. Instead of age, it is diseases – primarily depression and physiological diseases e.g. cancer – among the employees, which requires specific policies. Therefore, a more commonly used policy is the conical or long-term disease arrangement. Hence, the hospital's occupational and physiotherapy department does not have any plans to further develop its policy for senior staff (Flensburg Jensen et al., 2011).

References

Aalborg Universitetshospital (2012). *Livsfasepolitik på Aalborg Sygehus*. Region Nordjylland: Aalborg Universitetshospital.

Aalborg Universitetshospital (2013). *Seniorpolitik på Nuklearmedicinsk Afdeling (NM), Aalborg Sygehus*. Region Nordjylland:Aalborg Universitetshospital:Klinik Diagnostik:Klinisk Fysiologi og Nuklearmedicin.

Aalborg Universitetshospital (2014). *Instruks for seniorer ansat i Ergoterapi- og Fysioterapiafdelingen, Aalborg Sygehus*. Region Nordjylland:Aalborg Universitetshospital:Klinik Akut:Fysio- og ergoterapi.

Aalborg University Hospital (2015). *Aalborg University Hospital English*. Available at: <http://www.aalborguh.rn.dk/Service/English> (accessed: 14-01-2015).

Flensborg Jensen, M. C., Jensen, P. H., & Friis, K. (2011). *D.4.2. National report: Denmark - Report on organisational case studies*. Available at: http://www.aspa-eu.com/aspa_deliverables.htm.

Region Nordjylland (2014). *Livsfasepolitik*. Available at: <http://www.rn.dk/Om-Region-Nordjylland/Strategier-og-politikker/Personalepolitikker/Livsfasepolitik>. Date last modified: 03-03-2014.