# Recruiting and Retaining GPs

## A Perspective from the Top of the World

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# Background

Recruitment and crucially retention of general practitioners (GPs) in rural places is a challenge internationally.[1] It is a vast subject, with many facets. Some of the main reasons for the difficulty in recruiting and retaining doctors include; geographically long distances to the closest hospital, heavy work load and professional isolation.[2] An additional thread to the tapestry is that half of medical graduates are now women.[3] This change has correlated with an increase in demand for more part time work and flexible careers from both men and women[4] which exacerbates difficult working conditions. Social factors shown to influence reasons to stay in a location are; spouse satisfaction, good schooling, shopping and social opportunities.[5] As in any job, there is a need for locum workers and gap fillers for doctor absences and planned leave. However GP practice personnel consisting of mainly locums and having a high rate of turn over, creates disruption for patients and ultimately results in lower standards of care provision. Increase in continuity of care by doctors is associated with lower mortality rates.[6] It is essential that there are GPs wherever there are people as they form the bedrock of the health service globally.[5,7]

Coming from the Scottish Highlands and having experienced several rural GP placements throughout medical school, I appreciate that this is a complex problem with significant consequences. The Highlands are a similar size to the northernmost county in Norway, Finnmark[8,9] However, the Highlands are more densely populated, with 240, 000 inhabitants[8], compared to Finnmark (75, 000).[9] Therefore I was interested to observe the situation and strategies being used in Finnmark, in the Arctic, to combat difficulties in recruiting and retaining GPs at the top of the world.

Looking at this from a Norwegian perspective, there has been change in the structure and role of GPs in Norway in recent years. In 2012, there was a shift in the job remit with GPs taking on more responsibility for the treatment and follow up of patients[5] and also (supposedly) having fewer patients.[10] This means that primary care needs to be strengthened to take on this increase in workload. This takes the shape of adequate numbers of GPs and supporting medical staff.[10] The political aspects central to this issue of recruiting and retaining health personnel, are beyond the remit of this project.

In 2018, 3875 students in total studied medicine in Norway and 3279 Norwegians also studied medicine abroad.[10] The students who train abroad have less emphasis on rural general practice.[10] Therefore, the aim is not only to educate young doctors in Norway so they have a good grasp of general medicine, but also that they have adequate rural medicine exposure and see that it is an attractive career option.

In order to collaborate and share ideas on how to recruit and retain healthcare personnel, an international project: “Recruit & Retain- Making it work” (RRMiW) was developed (2015-2019). This was building on an earlier collaboration project, “Recruit and Retain” (2012-2014). RRMiW involved teams in Norway, Scotland, Canada, Iceland and Sweden. The collaboration of academics has developed: The Making it Work Framework for Rural

Remote Workforce Stability ("The Framework"). See Fig.1.[11] It is to be applied not only locally to the rural community but also regionally and nationally. The Framework is explained in the following section.

## Framework

The Framework consists of nine steps that are grouped together under three headings "Plan", "Recruit" and "Retain". It also contains five separate key elements for success. This Framework is not intended to work in a linear step by step fashion but to be a long-term dynamic process of reform.

The Framework facilitates a holistic approach, not only including the individual recruit, but their family, the community, other colleagues and future healthcare personnel. This is designed to create a desirable professional and social environment, to encourage the recruit to stay for a longer period of time. Retention allows quality care and essential services being provided for the inhabitants of rural and remote areas.

Although this Framework could be applied to recruitment of many professionals (e.g teachers), the following explanation of each section will be from a primary healthcare perspective.


**Figure 1.** The Making it Work Framework for Rural and Remote Workforce Stability[11]

## Plan

This part of the Framework includes actions to be taken locally and nationally to ensure that the population's needs are assessed and that healthcare provision is delivered accordingly. In order to make service provision relevant to the community being served, its needs have to be assessed. This is thinking specifically about the rural context as often national services have been modelled from urban sources and are not sustainable in a rural area. In fulfilling this need, job satisfaction will also be greater and will contribute to a more stable workforce. Regular revision of the population's needs and alignment of services to those needs should allow for tailored, cost effective but optimal health care to each unique community. Instead of vacancies being filled by any applicant in desperation, it should be recognised that working in this setting requires an attitude of adaptability and commitment to obtaining and maintaining the skills required for rural practice. Recruits with these qualities should be targeted and there has to be teaching opportunities in place to enable them to further their education.

## Recruit

The aim of this section of the Framework is to gain the right recruits, provide them with adequate information to help them move to a new community and make them feel welcomed. Moving to a remote community, potentially with a family, is a big decision. Therefore to make this an informed choice and a positive decision, there should be an emphasis on sharing information. This should include readily available, honest information for all aspects of life and work in the local area e.g schooling, number of co-workers, available housing and an accurate climate report etc. Local community engagement is essential. Their input should be sought during the whole process of planning, and recruiting and retaining new doctors. Local design of service provision creates achievable goals that are more likely to be engaged with and fulfilled. This values the locals and may help contribute to a satisfied, attractive community that welcomes incomers. This welcome includes the whole family of the new doctor being provided for and assured that there is a high quality of life in the local area. A specific challenge in this area that is important to overcome is assisting spouses to be informed of work opportunities and social groups available.

## Retain

The final section encourages support and training for current and future professionals. It is well recognised that a healthy and positive working environment is very important for work productivity and also for staff retention. Through supporting team cohesion, the local personnel could share ideas, learn from each other and have influence over the running and organisation of the workplace including new recruit options. In order to have safe and competent health care provision, relevant professional development options are required, as

mentioned previously. This education ideally should be delivered locally, from professionals who have grasped the specific issues that can arise in remote and rural practice. Education breeds confidence and competence which then in turn improves the whole quality of not only the patients', but also the doctors' experience. It also serves as a deterrent to social isolation, promotes excellence in becoming generalist experts and gives the opportunity to display pride in the beautiful rural surroundings in which the recruit may work. Training future professionals by engaging with medical students throughout their learning is important independent of whether they become GPs or not. It allows the opportunity for them to have a good experience in a rural setting, experience the specialty for themselves and harbour a professional working appreciation of GPs if they pursue a career in secondary care.

## Objective

The aim was to assess how "The Framework" was received by doctors, local managers, recruiters and others that attended the "Recruit & Retain- Making It Work" conference in Norway, Scotland, Iceland, Canada and Sweden. Also, to use rural general practice in the Highlands in Scotland and Finnmark in Norway as examples to relate the Framework to.

# Method

## Study Setting

This study is based on research from the National Centre for  Rural Medicine (NSDM.) This department makes up the Norwegian team of the RRMiW project and is part of the Department for Community Medicine at The University of Tromsø – The Arctic University of Norway.

In addition, in order to gain insight into rural practice in Finnmark, five smaller towns and GP practices in; Vadsø, Nesseby, Tana, Karasjok, and Kirkenes were visited over the elective period.  See fig. 2

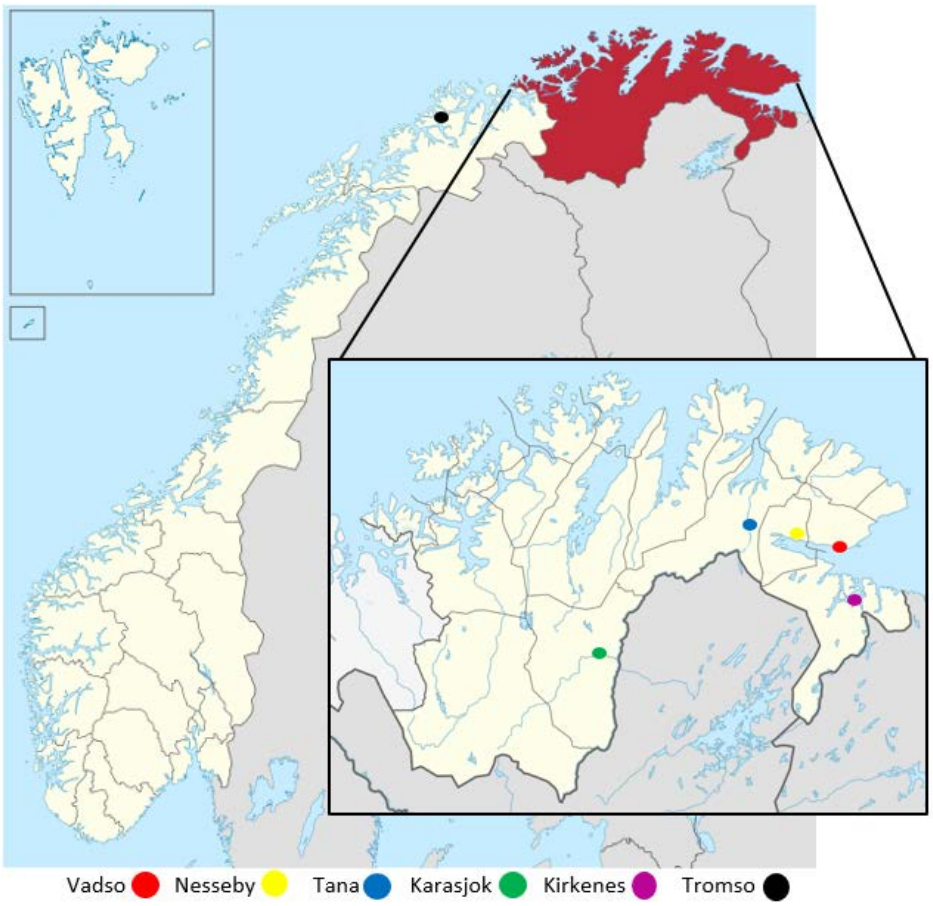


**Figure 2**.  Map of Finnmark showing towns visited

## Study design

The survey was developed (see Appendix 1) with help from the NSDM team the week before the final RRMiW conference, where the Framework was released. Each international partner in the RRMiW collaboration had their own conference on the same day and they were informed about the survey 4-5 days before. All the nine steps in the Framework were included in order to gain participants' overall impression. A satisfaction scale was

used as an easy and efficient way to gauge opinion. See fig. 3. Participants were asked to rank each statement with how strongly they agreed or disagreed.

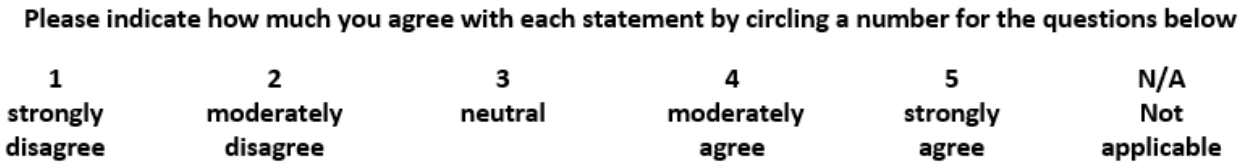


**Figure 3**. Satisfaction scale

Four background questions were asked including: age, gender, occupation and if they were from a rural or urban background. These were kept general in order to maintain anonymity. The questionnaire was kept simple and broad. It was also important that it did not take long to complete in order to maximise response rate.

An online version of the survey on "SurveyMonkey"[12] was made accessible through a link to enable participation from equivalent conferences happening simultaneously.

### Data collection

The Norwegian conference attendees were informed from centre stage about the questionnaire during the second half of the conference and physical questionnaires were placed on their tables. There was a follow up e-mail two days after the conference to the Norwegian participants containing the link. Two weeks later a further email was sent to all the conference attendees asking them to fill out the questionnaire if they had not done so already.

The link to the survey was sent to the organising representatives in the four other participating countries the day before the conference and also two weeks after the conference, with a request for it to be sent to the full email list of their conference attendees.

Only 19 questionnaires were completed at the conference and 41 responded to the online survey. This gives a total of 60 responses.

## Ethical considerations

It was deemed that no ethical approval was required for this project as it does not involve patients, health conditions or any identifying features of personnel.

# Results

Raw data is collected. See Appendix 2. There was a total of 60 participants.

The overall response rate of the questionnaire was disappointing considering the potential of about 100 participants in each of the five countries.

After further email investigation, it transpires that Scotland and Iceland did not send the survey to their conference participants. The Canadian and Swedish teams did send out the survey, which leaves us to presume we have data from three countries: Norway, Canada and Sweden.

There was a broad range of professionals that attended the conferences, according to the survey. 28.3% were clinical doctors and students, 26.7% local managers, 1.7% national managers, 15% researchers and 28.3% other professionals. This included those with more than one job title. 65.5% of attendees were from a rural background and 34.5% were from an urban background. See Appendix 2.

Below is a summary of results in a table which makes comparison possible. See Fig. 4 Each Framework statement is in the left column and it is horizontally followed by three graphs, each of which include all the participants of the survey. See fig. 5 First is how strongly they agree or disagree with the importance of the Framework statement. Secondly how strongly they agree or disagree that they are already doing this step and lastly how strongly they agree or disagree that this step is achievable. On the Y axis, percentage of survey participants is shown.

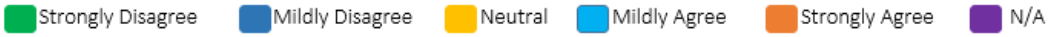


**Figure 5**. Key

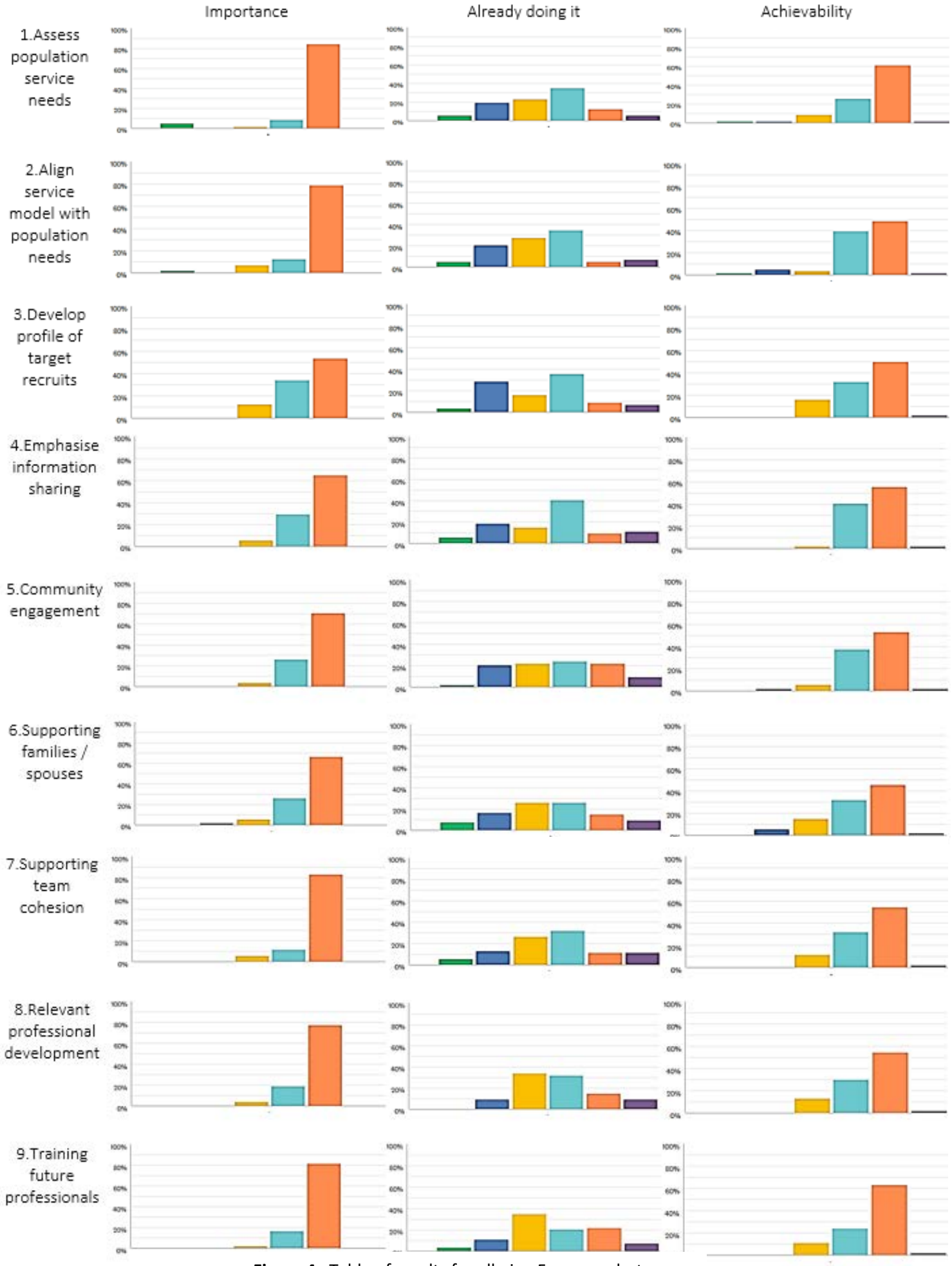


**Figure 4**. Table of results for all nine Framework steps

There is a common general trend between all of the Framework questions when looking at the graphs. There is a strong positive representation for agreement of importance and achievability but a less positive overall response for already doing it. There is also more agreement with importance than achievability. There is a wider spread of responses to the application of the Framework question.

The following results were obtained by adding together the responses in percentages for strongly and mildly agree and likewise strongly and mildly disagree. See Appendix 2. When adding the percentages for strongly agree and mildly agree for each Framework statement, it appears that the most important to conference participants is to train future professionals (98.15%). When adding together the strongly disagree and mildly disagree percentages, it appears that the least important is assessing population service need (5.17%). The participants thought they were currently best at information sharing (50%) and worst at developing a profile of target recruits (32.14 %.) The most achievable is to emphasise information sharing (96.3%) and the least achievable is to align service model with population need (6.89%).

# Discussion

The overall impression from the survey responses is positive and all nine Framework steps are received well but this would be expected at these three international "Recruit & Retain - Making it work" conferences. All the participants at the conferences had taken time off work, the Canadian conference could be attended by video link and the Norwegian participants had all travelled to Tromsø. The participants chose to attend these academic organised conferences, which posed no financial gain to either them or the organisers. It can be suitably deduced that the participants will have approached this questionnaire in light of their individual experiences with enthusiastic critical thinking. The spread of results across the question of currently doing a Framework step indicates honest answers. Each Framework step will now be discussed.

## 1. Assess population service needs

As one of the first questions in the survey, responses could be affected by this and be more enthusiastic compared to subsequent questions.[13] This theory is already reflected in participant numbers dropping from 60 for the very first question in the survey to 58 for this question. However it is contradicted by the finding that this first Framework question is found to have the lowest overall vote for importance. 84.48% strongly agreed that it is important which was found to be lower than the rest.

Assessing population service needs has been recognised as increasingly important since the 1980s[14] so may be more obvious and ingrained into the thinking of conference participants. GPs assess their patients' needs and demands on an individual basis every day and make professional decisions accordingly. A privilege of general practice globally, which was highlighted by the Norwegian "Fastlege" or family doctor approach, is that making this assessment of your patient can often be easier than without this continuity in patient- doctor relationship. Years of knowledge including their home and family life as well as their previous state of health can inform these decisions.

However, the Framework goes beyond this, to whole local population need, which may not be accurately represented by individual patients.[15] Formal assessment requires qualitative and epidemiological enquiry into unmet healthcare needs. The consequences should be a change in priority; economically, clinically and ethically.[15] Although this is essential for building a health service only 47.37% are currently doing it. This response could reflect a lack of knowledge of what steps are formally being taken, a lack of skills and resources in carrying out assessment[14] and a reluctance to add to an already overworked workforce.[16]

## 2. Align service model with population need

This step was deemed the least achievable with 6.89% of responses strongly and mildly disagreeing with its achievability. In contradiction, this step also has a higher achievability score with more people strongly and mildly agreeing with its achievability than six other Framework steps. This data can be easily influenced by a small number of responses as the total number of respondents was only 58 for this question. These other steps have fewer negative responses and higher neutral responses. Therefore there is not much significance in this result.

After assessing the local communities' specific health service needs, as discussed previously, the provision should be tailored and its effectiveness measured regularly.

As an example, Vadsø is the capital of Finnmark, with a population of 6.5 thousand and is located 171 kilometres away from the nearest hospital in Kirkenes (3.5 thousand). This is a similar geographical situation to Caithness General Hospital, Wick and Raigmore hospital, Inverness, in Scotland. In Vadsø many different services and multidisciplinary professionals are represented such as dialysis, phototherapy, occupational therapy, physiotherapy, cancer and diabetic nurses etc. This is a good example of service provision at point of contact and may represent alignment with population need.

## 3. Develop profile of target recruits

Personality and career choice has long been an assumed association.[17] My personal experience, is that secondary schools in Scotland encourage students to take a personality quiz before leaving school to attempt to give the student an impression of what career could be suited to them. Medical specialties also hold to personality stereotypes[18] however studies show that medical student personality and choice in medical specialty are linked.[19] Studies also show that non-surprisingly rural GPs share characteristics, such as confidence in the face of uncertainty, high curiosity, self-directedness and enjoy a degree of excitement.[20] This is a different profile from urban GPs as rural practice involves a wider job remit including procedures for example.[20]

32.14% of participants said they strongly or mildly disagreed that they were currently focusing recruiting energy at a target profile. This may come from a perspective of unwillingness to "narrow" the field of potential applicants when the requirement for doctors is huge.

Therefore, emphasising the importance of a profile for recruits, including characteristics and skills, may allow students and doctors to be successfully recruited and retained even if they have not had much exposure to rural medicine. This ultimately widens the field for potential recruits and does not only focus on people from a rural background.

## 4. Emphasise information sharing

Found to be considered both the most achievable (96.3%) and the most currently successfully performed (50%) step, this is a positive result. In the north of Scotland, a study showed that 48% of GP trainees reported that a blog with videos and experiences of primary care in the north positively influenced them to choose their location.[21] Small changes and comparably little effort in this well practiced domain of media usage could have large results if done well. Social media platforms, websites, videos, email but also importantly personal conversation are all tools to allow easy access and encourage potential new doctors to ask questions.

## 5. Community engagement

It is well illustrated by the graph showing participants currently doing this step that there is a very broad response with almost equal answers for mildly disagree (20.37%), neutral (22.22%), mildly agree (24.07%) and strongly agree (22.22%). Therefore the conclusion to be drawn from this response is that there may be a wide range in confidence and engagement with this part of the Framework. This concept is key to the whole Framework but also to health care as a profession. Stemming from patient involvement in their own care, this broader involvement of their family, the general public and other professionals is well documented as improving care, health service and inequality.[22]

The community can also fill an important role in recruiting and crucially in retaining doctors by actively helping integrate them and their families into the community. Community involvement has shown to be most effective and outcomes more sustainable when the community identify a need themselves and seek help from an external source rather than vice versa.[23] Therefore practically, public meetings could be held, members' opinions actively encouraged and good dialogue maintained throughout the process of recruiting and retaining health personnel.

## 6. Supporting families / spouses

This step is the second least achievable with 5.66% mildly disagreeing that it is achievable. However this finding is potentially surprising as it is a step which may come naturally to small rural communities.

As established, difficulty in retaining GPs is multifactorial. However, family and spouse factors are amongst the most common.[24] This can even be the case for families from rural backgrounds who have experienced several different rural communities.[24]

Early difficulties that communities and recruiters should be aware of are problems integrating into the community (as previously mentioned), childcare and schooling, housing and housing maintenance.[25] Support

offered to the family will have to change over time as new challenges are uncovered and support needs change. Studies have indicated that support groups for spouses of GPs, local and regional networking, and support for time out and leave have been beneficial.[25]

## 7. Supporting team cohesion

There were no significant findings for this step. Results show the pattern common to all Framework steps of: high importance and high achievability but more spread for participation. Cohesion, meaning the act of forming a united whole, recognises team members' personal attraction to the team and the task.[26] Studies show that this can be encouraged by small team sizes, similar attitudes, accurate feedback, success in adversity and good communication.[27] Communication is not only an important factor for allowing a cohesive team to be built but also an influence on job satisfaction.[28] A culture of co-operation will likely make a new employee feel more relaxed and more inclined to stay.

As an example, the doctors from Tana and Nesseby, two smaller towns in Finnmark meet together every Thursday morning. They take turns in leading a discussion on a chosen subject, finding educational material or a previous case to share. Not only does this promote continuous learning but it involves the single GP working in Nesseby and encourages a team environment.

Consistent and regular education not only in medical aspects but also in team work has been strongly recommended for healthcare professionals to promote similar attitudes.[26]

## 8. Relevant professional development

This was voted the second most important step with 96.36% strongly and mildly agreeing that it is important. Building on knowledge and grasping every learning opportunity is essential to practicing safe, high quality medicine and meeting the needs of patients.[29] Although having always been a lifelong commitment for a physician, methods may need constant revision to fit individual requirements and local capacity.

As an example of one form of professional development, training in emergency medicine with simulated patients occurs every month in the city Alta, Finnmark. Nurses and ambulance staff are included and a range of acute scenarios are completed. Training is usually during working hours, maximising accessibility to staff. Practicing in their local environment with their own equipment and colleagues is beneficial and may make feedback and evaluation easier.[30]

## 9. Training future professionals

This final aspect of the Framework was shown to be the most important to conference attendees with 98.15% mildly and strongly agreeing that it is important. This comes hand in hand with the previous Framework step. Another Norwegian example of educating doctors, is a mandatory group for GP trainees which meets once a month. This group consists of several trainees from different practices around Finnmark with a more experienced qualified GP taking a facilitating role. The aim of these groups is to discuss and contribute equally around cases in order to educate each other. Similarly to the previous example, this promotes social engagement, motivates and encourages knowledge and allows the sharing of experiences. Informal comments from these group participants indicate that they are a valued aspect of training and may increase the likelihood of recruitment and retention.

## Limitations of study

This survey had a relatively low response rate considering the conference participant number. In the survey there was not an option for asking country of origin for the participant, which was an oversight. In retrospect it would have been very useful to know how many from each country were involved. More time should have been allowed to prepare involvement with the international partners. For example, a video call before the conferences could have boosted participation and subsequently the response rate. There should also have been more allotted time for introduction and explanation to the conference participants. The questionnaire is only accessible to professionals who have attended the conference and learnt about the frame work. Therefore the responses are not representative of all people involved in recruiting and retaining of doctors.

## Strengths of study

To our knowledge this is the first study of its kind. The Framework has never been formally evaluated before. It looks at responses from professionals across multiple disciplines and promotes personal reflection.

## Conclusion

The main findings of this report are that every Framework step was well received, perceived as relevant, important and achievable. In addition there is plenty scope for every step to be improved upon, in order to increase the likelihood of recruiting and retaining doctors in rural communities. Collaboration between countries is valuable and there is much to be learnt from taking examples and comparing the unknown to the known.

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# Appendix 1

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## What do you think about the "Recruit & Retain Framework"?

This questionnaire is part of a final year medical student elective project, from the University of Aberdeen, Scotland. It will also serve as feedback for the Recruit & Retain – Making it Work project. Please be assured your answers will be kept confidential and that you do not have to participate in this study if you do not wish to.

---

Please tick which category of work you fall into:

| Clinician/Student | Local Health manager | Researcher | Media | National manager |
|---|---|---|---|---|
| | | | | |

Is the area you live and work: Rural? ☐ Urban? ☐

Are you: Male? ☐ Female? ☐ Other? _____

Please tick which age group you fall into:

| <30 years | 30- 50 years | 50-70 years | >70 years |
|---|---|---|---|
| | | | |

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**Please indicate how much you agree with each statement by circling a number for the questions below**

| **1** **strongly disagree** | **2** **moderately disagree** | **3** **neutral** | **4** **moderately agree** | **5** **strongly agree** | **N/A** **Not applicable** |
|---|---|---|---|---|---|

Regarding step 1 of the frame work (Assess population service needs):

- This step is important 1 2 3 4 5 N/A
- We are already doing this 1 2 3 4 5 N/A
- This is achievable 1 2 3 4 5 N/A

Regarding step 2 of the frame work (Align service model with population needs)

- This step is important 1 2 3 4 5 N/A
- We are already doing this 1 2 3 4 5 N/A
- This is achievable 1 2 3 4 5 N/A

Regarding step 3 of the frame work (Develop profile of target recruits)

- This step is important 1 2 3 4 5 N/A
- We are already doing this 1 2 3 4 5 N/A
- This is achievable 1 2 3 4 5 N/A

**[Please turn over]**

Regarding step 4 of the frame work (Emphasise information sharing)

- This step is important 1 2 3 4 5 N/A
- We are already doing this 1 2 3 4 5 N/A
- This is achievable 1 2 3 4 5 N/A

Regarding step 5 of the frame work (Community engagement)

- This step is important 1 2 3 4 5 N/A
- We are already doing this 1 2 3 4 5 N/A
- This is achievable 1 2 3 4 5 N/A

Regarding step 6 of the frame work (Supporting families/ spouses):

- This step is important 1 2 3 4 5 N/A
- We are already doing this 1 2 3 4 5 N/A
- This is achievable 1 2 3 4 5 N/A

Regarding step 7 of the frame work (Supporting team cohesion):

- This step is important 1 2 3 4 5 N/A
- We are already doing this 1 2 3 4 5 N/A
- This is achievable 1 2 3 4 5 N/A

Regarding step 8 of the frame work (Relevant professional development):

- This step is important 1 2 3 4 5 N/A
- We are already doing this 1 2 3 4 5 N/A
- This is achievable 1 2 3 4 5 N/A

Regarding step 9 of the frame work (Training future professionals):

- This step is important 1 2 3 4 5 N/A
- We are already doing this 1 2 3 4 5 N/A
- This is achievable 1 2 3 4 5 N/A

Thank you very much for your participation!

# Appendix 2

| Category of Work? | Clinician / Student | Local health manager | Researcher | Media | National health manager | Participants who answered question |
|---|---|---|---|---|---|---|
| no. of votes | 17 | 16 | 9 | 0 | 1 | 60 |
| % of participants | 28.33 | 26.67 | 15.00 | 0 | 1.67 | |

| Area live and work? | Rural | Urban | Participants who answered question |
|---|---|---|---|
| no. of votes | 38 | 20 | 58 |
| % of participants | 65.52 | 34.48 | |

| Sex? | Male | Female | Participants who answered question |
|---|---|---|---|
| no. of votes | 30 | 28 | 58 |
| % of participants | 51.72 | 48.28 | |

| Age in yrs? | <30 | 30-50 | 50-70 | >70 | Participants who answered question |
|---|---|---|---|---|---|
| no. votes | 3 | 19 | 37 | 1 | 60 |
| % of participants | 5.00 | 31.67 | 61.67 | 1.67 | |

| Framework step 1 | Importance | Already doing it | Achievable |
|---|---|---|---|
| Participants who answered question | 58 | 57 | 59 |
| Strongly Disagree no. of votes | 3 | 3 | 1 |
| Strongly Disagree % of participants | 5.17 | 5.26 | 1.69 |
| Mildly Disagree no. of votes | 0 | 11 | 1 |
| Mildly Disagree % of participants | 0 | 19.30 | 1.69 |
| Neutral no. of votes | 1 | 13 | 5 |
| Neutral % of participants | 1.72 | 22.81 | 8.47 |
| Mildly Agree no. of votes | 5 | 20 | 15 |
| Mildly Agree % of participants | 8.62 | 35.09 | 24.42 |
| Strongly Agree no. of votes | 49 | 7 | 36 |
| Strongly Agree % of Participants | 84.48 | 12.28 | 61.02 |
| N/A no. of votes | 0 | 3 | 1 |
| N/A % of participants | 0 | 5.26 | 1.69 |

| Framework step 2 | Importance | Already doing it | Achievable |
|---|---|---|---|
| Participants who answered question | 57 | 58 | 58 |
| Strongly Disagree no. of votes | 1 | 3 | 1 |
| Strongly Disagree % of participants | 1.75 | 5.17 | 1.72 |
| Mildly Disagree no. of votes | 0 | 12 | 3 |
| Mildly Disagree % of participants | 0 | 20.69 | 5.17 |
| Neutral no. of votes | 4 | 16 | 2 |
| Neutral % of participants | 7.02 | 27.59 | 3.45 |
| Mildly Agree no. of votes | 7 | 20 | 23 |
| Mildly Agree % of participants | 12.28 | 34.48 | 39.66 |
| Strongly Agree no. of votes | 45 | 3 | 28 |
| Strongly Agree % of Participants | 78.95 | 5.17 | 48.28 |
| N/A no. of votes | 0 | 4 | 1 |
| N/A % of participants | 0 | 6.90 | 1.72 |

| Framework step 3 | Importance | Already doing it | Achievable |
|---|---|---|---|
| Participants who answered question | 56 | 56 | 56 |
| Strongly Disagree no. of votes | 0 | 2 | 0 |
| Strongly Disagree % of participants | 0 | 3.57 | 0 |
| Mildly Disagree no. of votes | 0 | 16 | 0 |
| Mildly Disagree % of participants | 0 | 28.57 | 0 |
| Neutral no. of votes | 7 | 9 | 9 |
| Neutral % of participants | 12.50 | 16.07 | 16.07 |
| Mildly Agree no. of votes | 19 | 20 | 18 |
| Mildly Agree % of participants | 33.93 | 35.71 | 32.14 |
| Strongly Agree no. of votes | 30 | 5 | 28 |
| Strongly Agree % of Participants | 53.57 | 8.93 | 50.00 |
| N/A no. of votes | 0 | 4 | 1 |
| N/A % of participants | 0 | 7.14 | 1.79 |

| Framework step 4 | Importance | Already doing it | Achievable |
|---|---|---|---|
| Participants who answered question | 54 | 54 | 54 |
| Strongly Disagree no. of votes | 0 | 3 | 0 |
| Strongly Disagree % of participants | 0 | 5.56 | 0 |
| Mildly Disagree no. of votes | 0 | 10 | 0 |
| Mildly Disagree % of participants | 0 | 18.52 | 0 |
| Neutral no. of votes | 3 | 8 | 1 |
| Neutral % of participants | 5.56 | 14.81 | 1.85 |
| Mildly Agree no. of votes | 16 | 22 | 22 |
| Mildly Agree % of participants | 29.63 | 40.74 | 40.74 |
| Strongly Agree no. of votes | 36 | 6 | 30 |
| Strongly Agree % of Participants | 64.81 | 9.26 | 55.56 |
| N/A no. of votes | 0 | 6 | 1 |
| N/A % of participants | 0 | 11.11 | 1.85 |

| Framework step 5 | Importance | Already doing it | Achievable |
|---|---|---|---|
| Participants who answered question | 54 | 54 | 53 |
| Strongly Disagree no. of votes | 0 | 1 | 0 |
| Strongly Disagree % of participants | 0 | 1.85 | 0 |
| Mildly Disagree no. of votes | 0 | 11 | 1 |
| Mildly Disagree % of participants | 0 | 20.37 | 1.89 |
| Neutral no. of votes | 2 | 12 | 3 |
| Neutral % of participants | 3.70 | 22.22 | 5.66 |
| Mildly Agree no. of votes | 14 | 13 | 20 |
| Mildly Agree % of participants | 25.93 | 24.07 | 37.74 |
| Strongly Agree no. of votes | 38 | 12 | 28 |
| Strongly Agree % of Participants | 70.37 | 22.22 | 52.83 |
| N/A no. of votes | 0 | 5 | 1 |
| N/A % of participants | 0 | 9.26 | 1.89 |

| Framework step 6 | Importance | Already doing it | Achievable |
|---|---|---|---|
| Participants who answered question | 54 | 54 | 53 |
| Strongly Disagree no. of votes | 0 | 4 | 0 |
| Strongly Disagree % of participants | 0 | 7.41 | 0 |
| Mildly Disagree no. of votes | 1 | 9 | 3 |
| Mildly Disagree % of participants | 2 | 16.67 | 5.66 |
| Neutral no. of votes | 3 | 14 | 8 |
| Neutral % of participants | 5.56 | 25.93 | 15.09 |
| Mildly Agree no. of votes | 14 | 14 | 17 |
| Mildly Agree % of participants | 25.93 | 25.93 | 32.08 |
| Strongly Agree no. of votes | 36 | 8 | 24 |
| Strongly Agree % of Participants | 66.67 | 14.81 | 45.28 |
| N/A no. of votes | 0 | 6 | 1 |
| N/A % of participants | 0 | 9.26 | 1.89 |

| Framework step 7 | Importance | Already doing it | Achievable |
|---|---|---|---|
| Participants who answered question | 53 | 53 | 53 |
| Strongly Disagree no. of votes | 0 | 3 | 0 |
| Strongly Disagree % of participants | 0 | 5.66 | 0 |
| Mildly Disagree no. of votes | 0 | 7 | 0 |
| Mildly Disagree % of participants | 0 | 13.21 | 0 |
| Neutral no. of votes | 3 | 14 | 6 |
| Neutral % of participants | 5.66 | 26.42 | 11.32 |
| Mildly Agree no. of votes | 6 | 17 | 17 |
| Mildly Agree % of participants | 11.32 | 32.08 | 32.08 |
| Strongly Agree no. of votes | 44 | 6 | 29 |
| Strongly Agree % of Participants | 83.02 | 11.32 | 54.72 |
| N/A no. of votes | 0 | 6 | 1 |
| N/A % of participants | 0 | 11.32 | 1.89 |

| Framework step 8 | Importance | Already doing it | Achievable |
|---|---|---|---|
| Participants who answered question | 53 | 53 | 53 |
| Strongly Disagree no. of votes | 0 | 0 | 0 |
| Strongly Disagree % of participants | 0 | 0 | 0 |
| Mildly Disagree no. of votes | 0 | 5 | 0 |
| Mildly Disagree % of participants | 0 | 9.43 | 0 |
| Neutral no. of votes | 2 | 18 | 7 |
| Neutral % of participants | 3.77 | 33.08 | 13.21 |
| Mildly Agree no. of votes | 10 | 17 | 16 |
| Mildly Agree % of participants | 18.87 | 32.08 | 30.19 |
| Strongly Agree no. of votes | 41 | 8 | 29 |
| Strongly Agree % of Participants | 77.36 | 15.09 | 54.72 |
| N/A no. of votes | 0 | 5 | 1 |
| N/A % of participants | 0 | 9.43 | 1.89 |

| Framework step 9 | Importance | Already doing it | Achievable |
|---|---|---|---|
| Participants who answered question | 54 | 54 | 54 |
| Strongly Disagree no. of votes | 0 | 2 | 0 |
| Strongly Disagree % of participants | 0 | 3.70 | 0 |
| Mildly Disagree no. of votes | 0 | 6 | 0 |
| Mildly Disagree % of participants | 0 | 11.11 | 0 |
| Neutral no. of votes | 1 | 19 | 6 |
| Neutral % of participants | 1.85 | 35.19 | 11.11 |
| Mildly Agree no. of votes | 9 | 11 | 13 |
| Mildly Agree % of participants | 16.67 | 20.37 | 24.07 |
| Strongly Agree no. of votes | 44 | 12 | 34 |
| Strongly Agree % of Participants | 81.48 | 22.22 | 62.96 |
| N/A no. of votes | 0 | 4 | 1 |
| N/A % of participants | 0 | 7.41 | 1.85 |

| Table of Summary | Most important (%) | Least important (%) | Most doing it (%) | Least doing it (%) | Most Achievable (%) | Least Achievable (%) |
|---|---|---|---|---|---|---|
| Step 1 | 93.10 | 5.17 | 47.37 | 24.56 | 85.44 | 3.38 |
| Step 2 | 91.23 | 1.75 | 39.65 | 25.86 | 87.94 | 6.89 |
| Step 3 | 87.5 | 0 | 44.64 | 32.14 | 82.14 | 0 |
| Step 4 | 94.44 | 0 | 50 | 24.08 | 96.3 | 0 |
| Step 5 | 96.3 | 0 | 46.29 | 22.22 | 90.57 | 1.89 |
| Step 6 | 92.6 | 2 | 40.74 | 24.08 | 77.36 | 5.66 |
| Step 7 | 94.34 | 0 | 43.4 | 18.87 | 86.8 | 0 |
| Step 8 | 96.36 | 0 | 47.17 | 9.43 | 84.91 | 0 |
| Step 9 | 98.15 | 0 | 42.59 | 14.81 | 87.03 | 0 |