NIHR | National Institute for Health and Care Research

Journals Library

Check for updates

Health and Social Care Delivery Research

Volume 13 • Issue 34 • September 2025

ISSN 2755-0079

‘Come and work here!’ Qualitative research exploring community-led initiatives to improve healthcare recruitment and retention in remote and rural areas

Louise Locock, Andrew S Maclaren, Zoë Skea, Lorraine Angell, Jennifer Cleland, Topher Dawson, Alan Denison, Christina Dobson, Rosemary Hollick, Peter Murchie, Diane Skåtun and Verity Watson

DOI 10.3310/DJGR6622

NIHR | National Institute for Health and Care Research

Health and Social Care Delivery Research

Check for updates

Extended Research Article

‘Come and work here!’ Qualitative research exploring community-led initiatives to improve healthcare recruitment and retention in remote and rural areas

Louise Locock,[1*] Andrew S Maclaren,[2] Zoë Skea,[1] Lorraine Angell,[3] Jennifer Cleland,[4] Topher Dawson,[3] Alan Denison,[5,6] Christina Dobson,[7] Rosemary Hollick,[8] Peter Murchie,[9] Diane Skåtun[10] and Verity Watson[10]

[1]Aberdeen Centre for Evaluation (formerly Health Services Research Unit), University of Aberdeen, Aberdeen, UK
[2]Institute of Applied Health Sciences, University of Aberdeen, Aberdeen, UK
[3]Patient and public involvement representative
[4]Medical Education Research and Scholarship Unit, Nanyang Technological University, Singapore
[5]Institute of Medical Sciences, University of Aberdeen, Aberdeen, UK
[6]NHS Education for Scotland, Forest Grove House, Aberdeen, UK
[7]Population Health Sciences Institute, Newcastle University, Newcastle-Upon-Tyne, UK
[8]Aberdeen Centre for Arthritis and Musculoskeletal Health (Epidemiology Group), University of Aberdeen, Aberdeen, UK
[9]Academic Primary Care Research Group, University of Aberdeen, Aberdeen, UK
[10]Health Economics Research Unit, University of Aberdeen, Aberdeen, UK

[*]**Corresponding author** louise.locock@abdn.ac.uk

Published September 2025
DOI: 10.3310/DJGR6622

This report should be referenced as follows:

Locock L, Maclaren AS, Skea Z, Angell L, Cleland J, Dawson T, *et al.* ‘Come and work here!’ Qualitative research exploring community-led initiatives to improve healthcare recruitment and retention in remote and rural areas. *Health Soc Care Deliv Res* 2025;**13**(34). https://doi.org/10.3310/DJGR6622

Health and Social Care Delivery Research

ISSN 2755-0079 (Online)

A list of Journals Library editors can be found on the NIHR Journals Library website

Health and Social Care Delivery Research (HSDR) was launched in 2013 and is indexed by Europe PMC, DOAJ, INAHTA, Ulrichsweb™ (ProQuest LLC, Ann Arbor, MI, USA), NCBI Bookshelf, Scopus and MEDLINE.

This journal is a member of and subscribes to the principles of the Committee on Publication Ethics (COPE) (www.publicationethics.org/).

Editorial contact: journals.library@nihr.ac.uk

This journal was previously published as *Health Services and Delivery Research* (Volumes 1–9); ISSN 2050-4349 (print), ISSN 2050-4357 (online)

The full HSDR archive is freely available to view online at www.journalslibrary.nihr.ac.uk/hsdr.

Criteria for inclusion in the *Health and Social Care Delivery Research* journal

Manuscripts are published in *Health and Social Care Delivery Research* (HSDR) if (1) they have resulted from work for the HSDR programme, and (2) they are of a sufficiently high scientific quality as assessed by the reviewers and editors.

HSDR programme

The HSDR programme funds research to produce evidence to impact on the quality, accessibility and organisation of health and social care services. This includes evaluations of how the NHS and social care might improve delivery of services.

For more information about the HSDR programme please visit the website at www.nihr.ac.uk/explore-nihr/funding-programmes/health-and-social-care-delivery-research.htm

This article

The research reported in this issue of the journal was funded by the HSDR programme or one of its preceding programmes as award number NIHR133888. The contractual start date was in March 2022. The draft manuscript began editorial review in November 2023 and was accepted for publication in April 2025. The authors have been wholly responsible for all data collection, analysis and interpretation, and for writing up their work. The HSDR editors and production house have tried to ensure the accuracy of the authors' manuscript and would like to thank the reviewers for their constructive comments on the draft document. However, they do not accept liability for damages or losses arising from material published in this article.

Published by the NIHR Journals Library (www.journalslibrary.nihr.ac.uk), produced by Newgen Digitalworks Pvt Ltd, Chennai, India (www.newgen.co).

Abstract

Background: Recruitment and retention of healthcare staff in rural and remote areas is a significant problem for the National Health Service. Some communities have experimented with initiatives to support recruitment and retention, but these actions are often ad hoc and undocumented.

Objectives:

1. To explore the experiences of remote and rural community members and organisations of trying to attract healthcare staff and their families.
2. To map local context and describe initiatives they have undertaken to improve recruitment.
3. To understand how community initiatives have been received by those staff and families who have been attracted to work and live in a rural area as a result.
4. To assess which initiatives seem to have been more or less successful and why.
5. To provide resources for other communities and the National Health Service based on this learning.

Design and setting: Qualitative case studies, three in Scotland and two in England. A case description of each site was developed, and interviews were analysed thematically.

Documentary framework analysis of published job adverts for remote and rural healthcare posts.

Participants: Case studies: 22 individuals, including community members, healthcare practitioners and family members, took part in interviews and focus groups.

Job adverts: 270 from *British Medical Journal*, and National Health Service Scotland websites for general practitioner and general National Health Service vacancies.

Results: Case studies: communities engaged in a range of activities, such as making promotional videos, social media campaigns, help finding accommodation and informal social integration efforts. They drew on multiple local 'assets' to encourage healthcare staff to move to the area, including showcasing beautiful local landscapes; outdoor activities; a safe, cohesive community for children; and high quality of life. Often a small number of people drove these efforts. While this worked well in some communities, the burden of responsibility could be unsustainable, and not all communities have people with the necessary skills and time.

There was less focus on retention than recruitment. Where this worked well, it relied on informal networks of key individuals who created social links for incoming families.

Communities struggle with the absence of some key assets, including housing; schools; employment opportunities for family members; cultural activities.

Job adverts: different emphases on job details, place and wider area. Only 18/49 advertisers (of 189 approached) reported positive outcome in terms of appointments. We suggest greater use of photographs and place descriptions in future advertisements.

Limitations: This is a small exploratory study. Sampling was constrained by the small number of eligible communities and people involved. Planned ethnographic fieldwork was impacted by the COVID pandemic.

Conclusions: Successful recruitment and retention need to focus on the whole person and family, not just the job. There is an important role for communities to play, but communities cannot be expected to solve all recruitment and retention problems. Central and regional government and the National Health Service could work in supportive partnership with communities at an earlier stage, benefiting from their local contextual knowledge and energy.

We recommend further longitudinal ethnographic research into retention and a health economics study of the cost-effectiveness of National Health Service job adverts.

Study registration: This study is registered as researchregistry7518.

Funding: This award was funded by the National Institute for Health and Care Research (NIHR) Health and Social Care Delivery Research programme (NIHR award ref: NIHR133888) and is published in full in Health and Social Care Delivery Research; Vol. 13, No. 34. See the NIHR Funding and Awards website for further award information.

Contents

List of tables

List of boxes

List of supplementary materials

Report Supplementary Material 1	Focus group consent form
Report Supplementary Material 2	Interview participant information sheet
Report Supplementary Material 3	Topic guide for interviews
Report Supplementary Material 4	Focus group participant information sheet
Report Supplementary Material 5	Interview consent form
Report Supplementary Material 6	Protocol

Supplementary material can be found on the NIHR Journals Library report page (https://doi.org/10.3310/DJGR6622).

Supplementary material has been provided by the authors to support the report and any files provided at submission will have been seen by peer reviewers, but not extensively reviewed. Any supplementary material provided at a later stage in the process may not have been peer reviewed.

List of abbreviations

ABCD	asset-based community development
AHP	allied health professional
ANP	advanced nurse practitioner
BMJ	*British Medical Journal*
CAWH	Come and Work Here
CIC	community interest company
CSO	Chief Scientist Office, Scotland
GMC	General Medical Council
GP	general practitioner
HCP	healthcare professional
NCRHC	National Centre for Rural Health and Care
PI	principal investigator
PPI	patient and public involvement
QoL	quality of life
SRMC	Scottish Rural Medicine Collaborative
SRUC	Scotland's Rural College
WHO	World Health Organization

Plain language summary

What was the question?

Public contributors on a previous project about recruitment and retention of medical staff in remote and rural areas alerted us to actions that local communities can take:

- to attract healthcare workers to take up posts in their area
- to encourage them to stay once they arrive.

These local actions are largely undocumented, so we set out to investigate what local communities were doing to attract or retain healthcare workers, with two public coinvestigators.

What did we do?

We conducted case studies in five local communities, three in Scotland and two in England. We spoke to community members, healthcare staff and family. We also analysed a sample of remote and rural job adverts, looking at what they do to make local areas appealing.

What did we find?

Communities drew on a range of local 'assets' to help attract and retain healthcare staff and their families. These included beautiful local landscapes; outdoor activities; a safe and cohesive community for children; high quality of life and work-life balance; skills of local people (e.g. those with marketing and design experience, photographers and filmmakers). Often, a small number of people drove these efforts.

There was less focus on retention. Where this worked well, it often relied on informal social networks of key individuals who created social links for incoming families to integrate them into community life.

Communities struggle with the absence of some key assets, including housing (both cost and availability, particularly in tourist areas); schools, notably secondary schools; employment opportunities for other family members; cultural activities.

What does this mean?

Successful recruitment and retention needs to focus on the whole person and family, and social integration to the community, not just the job. More active use can be made of community skills, knowledge and energy to support this.

Scientific summary

Background

Recruitment and retention of healthcare staff in rural and remote areas is a significant and growing problem for the NHS and a persistent policy issue. Much research in this area has focused on the motivations and background of practitioners themselves and the organisation of work. There has been less focus on the experiences of people living in remote and rural communities and what they themselves have done to help to attract staff. Some communities have experimented with initiatives to promote their area; to get involved in the recruitment and selection process; and to welcome and integrate new health professionals and their family members into local life. These community-led initiatives are often ad hoc and undocumented, particularly around retention.

This project was prompted by the public research partners on another study on rural medical workforce led by the principal investigator (PI) Locock [Chief Scientist Office, Scotland Health Improvement, Protection and Services Research (HIPS) 19/37]. They talked to us about both formal recruitment initiatives, but also small informal acts designed to make new doctors and their families feel welcome and integrated. This new research was, therefore, designed with our public partners, aiming to capture this learning and share it with other communities as a basis for potentially developing recruitment and retention strategies of their own.

Aim

To improve recruitment and retention of healthcare practitioners in remote and rural areas.

Objectives

1. To explore the experiences of remote and rural community members and organisations of trying to attract health-care staff and their families to their area.
2. To map local context and describe initiatives they have undertaken to improve recruitment and retention.
3. To understand how community initiatives have been received by those staff and families who have been attracted to work and live in a rural area as a result.
4. To assess which initiatives seem to have been more or less successful and why.
5. To provide resources for other communities and the NHS based on this learning.

Methods

This was a qualitative study, based on five case studies, three in Scotland and two in England. In addition, we collected and analysed a sample of job adverts for remote and rural NHS posts across the UK. Ethical approval for the study was granted by the University of Aberdeen School of Medicine Ethics Review Board.

Given our focus on what communities in different parts of the country can do to attract and retain healthcare staff, a case study approach offered the most appropriate way to gain a rounded understanding of local action in context.

Theoretical framing

The study was informed by 'asset-based community development' (ABCD), which can be summarised as an approach which aims to strengthen communities by recognising, identifying and harnessing existing assets. Asset-based

approaches seek to understand what strengths, assets and resources lie within communities, often unrecognised, which may be brought together to find locally led solutions to community problems. Such assets may be individual and collective and include place-based assets as well as institutions and social networks.

Our approach was also informed by geographical theories of place and migration studies. This has led us to adopt a more place-and-person-based approach to understanding healthcare workers' career choices, rather than a purely professional or job-focused approach. The shift in language in our findings from 'recruitment and retention' to 'moving and staying' reflects these theoretical influences.

Data collection

Case studies

Potential case studies were identified purposively in an initial mapping phase, through a combination of searching for media reports, snowballing through the research team's professional networks and suggestions from our advisory panel and patient and public involvement partners. Our key criteria were that the community should be in a remote or rural area and should have been actively involved in leading efforts to recruit and/or retain healthcare workers. As expected, this resulted in a very small sampling pool.

Our final sample comprised a mixture of remote coastal/highland locations and islands. Fieldwork took place between April 2022 and February 2023.

In each case, a lead contact was identified and contacted by the lead researcher (Andrew Maclaren) or the PI (Louise Locock). This lead contact was asked to identify other local community members who may have been involved in local recruitment and retention initiatives, and healthcare workers who had been attracted to come and work in the community. From these participants, we used snowball recruitment to reach family members, other healthcare workers and other local residents with an insight into our topic. The number of participants per site was determined by relevance and the nature of local action, rather than a target number per case. A total of 22 participants took part across the 5 sites. We also included in the analysis an interview conducted for a previous study with a general practitioner (GP) in one of our sites. This had been consented for secondary analysis.

Job adverts

Between July and December 2022, a total of 270 job adverts for posts in remote and rural areas of the UK were collected by the PI (Louise Locock), using a monthly trawl of three sources: the *British Medical Journal* (*BMJ*) job adverts site www.bmj.com/careers (covering GPs and secondary care doctors), the NHS Scotland GP jobs website www.gpjobs.scot and the NHS Scotland jobs website https://jobs.scot.nhs.uk (covering secondary care doctors, dentists, nurses, midwives, allied health and care professionals). We e-mailed 189 named recruitment contacts for the adverts collected, to ask how many applications they received and whether they were able to appoint someone.

Analysis

Case studies

Throughout the study, the whole research team was involved iteratively in analysis. Transcripts (and selected job adverts) were circulated in advance of monthly team meetings and discussed at the meeting to start identifying themes and forming a view of the 'story' behind each case. Similarly, we shared extracts with the advisory panel and the lay panel to gather multiple perspectives on the data.

Drawing on these whole team discussions, transcripts were analysed thematically. Coding drew on both ABCD principles, as well as theories of place and migration, and inductive coding from the data.

Supporting this process was the development of a detailed, holistic case description for each site, which drew not only on the interview and focus group data but also on observational field notes. This enabled us to interrogate commonalities and differences across cases.

Job adverts

These were analysed using a thematic framework analysis approach, identifying the different assets that adverts drew attention to, their use (or not) of pictures and video, the balance and ordering of details about the job itself/professional practice versus the location as a place to live. In developing the framework categories, we worked particularly with our public advisory panel. We sent them a subsample of adverts and then held a meeting to invite their reflections on what 'assets' had struck them and how they responded to the differing styles of adverts. At their suggestion, we also held one focus group with medical students nearing the end of training to explore their reactions to different types of adverts.

The framework we developed was both deductive, in looking for assets that we already expected to be important, and inductive as new themes were identified.

Research findings

Case studies

Community-led recruitment action in our case studies was often borne out of an initial period of frustration and tension with local NHS authorities, arising from a failure to fill a vacancy or decision to close a practice. Typically, community members felt that the NHS needed to take a more proactive approach, but they often felt their suggestions were not listened to or were actively dismissed. Lack of genuine communication was a common theme.

Occasionally, we heard that community members suspected that failure to recruit was being used as an excuse to reorganise service provision. Community members were concerned that decisions were taken without sufficient awareness of their impact on the health of local people or the wider sustainability of their community.

From these initial stand-offs and sense of powerlessness, events went in varying directions, with some communities taking back control and running their own recruitment campaign and some negotiating to work jointly with the NHS.

The types of initiative we observed included:

- Stakeholder campaign groups
- Contributing to job adverts
- Promoting the area as a good place to work
- Making a video
- Social media campaigns
- Collaborating with neighbouring practices
- Help with sourcing housing and practice buildings
- Organising or contributing to pre-application visits
- Sourcing job opportunities for partners
- Social navigation and buddying – introducing new people to local activities, clubs
- Informal social integration

Communities drew on a range of local 'assets' to encourage healthcare staff and their families to move to the area. These included showcasing beautiful local landscapes; outdoor activities; a safe and cohesive community for children; and high quality of life and work–life balance. People assets included the skills of local people (e.g. those with marketing and design experience, photographers and filmmakers).

Often, a small number of people drove these efforts. While this worked well in some communities, it placed a substantial burden of responsibility on a few people, which could be unsustainable and could cause tension within the community. Local people may be well placed to inform NHS recruitment campaigns, but not all communities have

people with the skills, time and willingness to take on such roles, and shifting all the labour from NHS to community would not be realistic.

There was less focus on encouraging people to stay (retention) than on recruitment. Where this worked well, it often relied on informal social networks of key individuals who created social links for incoming families to integrate them into community life.

We identified a number of ways in which communities took steps to encourage new healthcare staff to stay. The period between appointment and taking up post could be an important window to identify family needs and interests and make some useful introductions. This could include supporting partners to find employment, contacting schools and looking for housing, but also simple acts of friendship. In some cases, people were invited for a pre-arrival visit, perhaps to a social event, such as a New Year's party.

There were examples of well-networked local people making a point of inviting newly arrived people to join clubs, choirs and sports activities, arranging coffee and dinners, and local parents forming relationships with new families with young children through schools and playgroups.

These actions may be small, informal acts that people barely recognise as 'acts' at all. While some participants recognised them as intentional and planned, those taking such steps often saw them as just normal, everyday, neighbourly actions one would do for anyone moving to the area.

One staff participant reflected on the importance of key individuals as social engineers or navigators in making connections. They also proposed the idea of a 'social passport' – gathering information about the interests of the person and their family and providing them with a list of social opportunities in the area – and a welcoming committee to ensure all the burden did not fall on just one person and that actions were co-ordinated and sustainable.

At one extreme, however, some community participants did not seem to have actively considered retention at all. After all the labour which had gone into recruitment, some simple things which might have aided retention were overlooked.

Communities struggle with the absence of some key assets, especially housing (both cost and availability, particularly in tourist areas); schools, notably secondary schools; employment opportunities for other family members; cultural activities.

Job adverts

Our thematic analysis of the job adverts covered the following themes:

- Job or place? Which comes first?
- Landscape and natural environment
- Outdoor pursuits
- Photos and videos
- Connectivity
- Family, schools, housing
- Culture
- Humour and tone
- Nature of team and job
- Other incentives

Our analysis suggests that more use could be made by some advertisers of photographs and place descriptions. Some adverts dwelt at length on aspects of wider life in the area, some touched on it more briefly and some focused entirely on the job details, with no reference to the value of place. The use of humour was particularly striking in a few cases, and both our public advisory group and focus group with medical students suggested this could appear unprofessional and off-putting.

The results from contacting advertisers to ask if they managed to recruit were disappointing. Of the 45 that replied, only 18 reported making an appointment from the advert. The majority said they had not been able to recruit, in some cases getting no applicants at all, or had only managed to recruit through some other route, such as persuading a locum to stay on.

Conclusions and implications

Our findings demonstrate that there is an important role for communities to play in both recruitment and retention. In remote and rural areas where the NHS is struggling to recruit, they could more proactively invite community members to the table to devise jointly a campaign which showcases the things which that community knows to be its main attractions.

Addressing the lack of available and affordable housing for key workers in remote and rural areas is a fundamental issue for the governments of the four nations of the UK. The Scottish Government has recently responded to the issue of rural housing by committing to publish a Remote, Rural and Islands Housing Action Plan by 2026 and establishing an Affordable Housing Initiative for key workers in rural areas.

Retention is a neglected issue. Socially, it is supported by an actively welcoming community, with key individuals who go out of their way to help someone forge links and take part in local social activities. The formation of a community stakeholder group could help formalise this and reduce reliance on the goodwill and energy of individuals. Professionally, there could be benefits in a 'buddying' system, perhaps with someone from a different rural community, to whom they can talk about the challenges of remote and rural practice and life and gain tips for navigating their new context.

Recommendations for research

1. There is scope for further research with new campaigns to test our findings.
2. We would particularly recommend further research into retention. We would suggest conducting longitudinal ethnography within a range of remote and rural communities which have recently recruited new staff and observing over time how these staff fare and how the relationship with the wider community unfolds.
3. In terms of NHS job advertising, there is scope for a health economics study of the cost-effectiveness of adverts of different styles and platforms.
4. We also recommend a qualitative evidence synthesis of published articles on community involvement in recruitment and retention.

Study registration

This study is registered as researchregistry7518.

Funding

This award was funded by the National Institute for Health and Care Research (NIHR) Health and Social Care Delivery Research programme (NIHR award ref: NIHR133888) and is published in full in Health and Social Care Delivery Research; Vol. 13, No. 34. See the NIHR Funding and Awards website for further award information.

Chapter 1 Background and literature

Context and research objectives

Recruitment and retention of healthcare staff in rural and remote areas is a significant and growing problem for the NHS and a persistent policy issue. Much research in this area has focused on the motivations and background of practitioners themselves and the organisation of work. There has been less focus on the experiences of people living in remote and rural communities and what they themselves have done to help to attract staff. Some communities have experimented with initiatives to promote their area; to get involved in the recruitment and selection process; and to welcome and integrate new health professionals and their family members into local life. These community-led initiatives are often ad hoc and undocumented, particularly around retention; there is potential learning for other communities that remains untapped.

This project was prompted by the public research partners on another study on rural medical workforce led by the principal investigator (PI) Locock [Chief Scientist Office, Scotland (CSO) HIPS 19/37]. They talked to us about both formal recruitment initiatives, but also small informal acts designed to make new doctors and their families feel welcome and integrated. One example was a local councillor finding someone for the relative of a new general practitioner (GP) to play Scrabble with. This new research was, therefore, designed with our public partners aiming to capture this learning and share it with other communities as a basis for potentially developing recruitment and retention strategies of their own.

Aim

To improve recruitment and retention of healthcare practitioners in remote and rural areas.

Objectives

1. To explore the experiences of remote and rural community members and organisations of trying to attract healthcare staff and their families to their area.
2. To map local context and describe initiatives they have undertaken to improve recruitment.
3. To understand how community initiatives have been received by those staff and families who have been attracted to work and live in a rural area as a result.
4. To assess which initiatives seem to have been more or less successful and why.
5. To provide resources for other communities and the NHS based on this learning.

Background and rationale

Inequalities in health and health care in remote and rural areas

There is strong evidence that people living in remote and rural areas find it difficult to access quality health care, with negative consequences for health.[1–4] Inequitable access to appropriate healthcare professionals (HCPs) in remote and rural areas can compound and amplify the negative health effects of other inequalities and issues such as low income, lack of transport, social isolation, comorbidities and poor health.[5] For example, evidence shows that people with cancer in remote and rural communities in Scotland have worse health outcomes than better connected areas.[6] People with cancer living on islands or more than an hour's drive from a specialist centre on average start treatment sooner than those living within 15 minutes' drive and yet they are significantly more likely to die in the first year after treatment than those living closer by.[7] A study using British registry data found that people with axial spondyloarthritis (a long-term

inflammatory joint condition) living in rural areas reported a greater impact of their disease on their ability to work than their urban counterparts, after adjustment for age, sex and local area deprivation.[8]

As Murchie *et al.* (2019, p. 1) note, 'hard evidence is lacking for what causes poorer outcomes in rural populations', but lower access to services is a probable factor, which in turn influences whether people get timely referral; diagnosis; ongoing support for long-term conditions; and post-discharge rehabilitation support.[6] In addition, rural services may depend more on locum or agency staff, affecting continuity of care and raising costs.[9]

Recruitment and retention of the healthcare workforce is essential to maintain access to services and provision of care but is a persistent challenge for health services. Innovative approaches to healthcare delivery help with access to care (e.g. telehealth, virtual consultations, visiting support from specialty services, upskilled multidisciplinary team members) but are insufficient: communities need doctors.[10] When compared with their urban counterparts, doctors practising in remote and rural locations may be described as 'extended generalists'.[11] They often carry a heavier workload and higher level of clinical responsibility across a wider range of clinical services than urban doctors, in relative professional isolation.[12] When a local GP retires or a small hospital cannot attract enough staff, the reduced availability of local health care can impact the wider sustainability of remote communities, making it harder to attract families to live and work in the area.[13] Vacancies which cannot be filled may simply disappear; remaining staff 'get by' with fewer colleagues and may reduce the services they offer.

A Nuffield Trust report for the National Centre for Rural Health and Care (NCRHC) in England notes that there are some unavoidable additional costs of providing services in rural and remote areas across the UK, but that funding allocation adjustments for health inequalities and unmet need tend to result in funds being targeted primarily to urban areas.[14] This means there are proportionately fewer NHS staff per head of population in rural areas. A previous study for the NCRHC reported that there may be up to 45% fewer NHS workers per head in the most rural areas.[10] The Chief Medical Officer for England's annual report for 2021 on health in coastal communities reports that despite such communities having an older, more deprived population, they have 14.6% fewer post-graduate medical trainees, 15% fewer consultants and 7.4% fewer nurses per patient than other areas.[15] Already-stretched remote and rural services can ill afford the additional pressures caused by unfilled vacancies.

Before the COVID-19 pandemic, Public Health Scotland reported that vacancy rates for GPs in the Western Isles were the highest in the country in 2019 (15.2%).[16] The highest vacancy rates for consultants are generally in health boards with a more rural profile. The workforce update for the quarter ending 31 December 2022 from NHS Education Scotland continues to show that the highest medical and dental vacancy rates are in the more remote and rural boards, with Shetland the highest (39%), followed by Western Isles (25.1%), Orkney (17.4%) and Highland (14.5%).[17]

A recent review of the consultant appointment process in Scotland found that 42% (n = 306) of interview panels for consultant posts had to be cancelled in 2022 for lack of applicants.[18] The data show that the recruitment challenge is greatest in remote and rural areas. In NHS Western Isles all six panels were cancelled, and four out of six in NHS Highland. Both NHS Highland and NHS Borders had a cancellation rate of 63%, compared to 29% in NHS Greater Glasgow and Clyde.

A BMA Scotland report in 2019 highlighted that NHS-reported figures 'indicate that the true vacancy rate is almost double the official NHS ISD figures' (p. 4).[19] The Royal College of Physicians (2019) census of consultant appointments showed that in rural areas of England, only 13% of advertised consultant vacancies were filled at the time of the census.[20]

National GP recruitment figures for Scotland also show that for every year since 2014, the number of ST1 GPs recruited in Scotland has been less than the planned places.[21] This indicates that the challenge to recruit and retain is something that will continue into the future with depressed numbers of GPs in training.

United Kingdom vacancy figures for other healthcare professions analysed by type of area are harder to come by, but similar concerns are reported for nursing[22] and allied health professions, with a particular shortage of radiographers in

rural Scotland (Scottish Government 2019).[23] NHS Shetland had the highest vacancy rate for allied health professionals (AHPs) overall (16.1%) in the last quarter of 2022.

Our fieldwork took place at a time of major and continuing change in healthcare provision in remote areas. Greater connectivity and technical infrastructure are changing both the nature of consultations and the availability of prompt specialist back-up to rural practitioners. The COVID-19 pandemic has accelerated the implementation of digital solutions which may help compensate to some extent for workforce shortages. Anecdotal reports of increased population-level interest in moving away from the city following the pandemic may lead to more healthcare staff considering a move to rural locations – but may also increase pressure on stretched local health services.

Given existing disadvantages,[14] it is reported that the pandemic has disproportionately affected health care in remote and rural areas, which may face a steeper climb to recovery than urban trusts and boards.[24] They have seen larger drops in activity than their urban counterparts, longer increases in waiting times, more vacancies and reliance on temporary staffing and a worsening financial position.

Review of literature

Existing evidence on recruitment and retention interventions

The problem of recruitment and retention of the healthcare workforce in remote and rural areas is not new. The Dewar report of 1912, commissioned to examine the adequacy of health care in the Highlands and Islands of Scotland, noted a range of issues affecting doctors' employment.[25] These included low pay, transport and communication difficulties in remote areas, problems obtaining suitable housing, inability to take holidays and lack of post-graduate training. Furthermore, it concluded that 'no matter affecting the welfare of the people of the Highlands and Islands is more urgent that the provision of an adequate supply of trained nursing' (p. 16). One hundred years on this list of issues feels sadly familiar; during the course of this and our previous study, many participants have observed to us that the same issues are repeatedly identified, yet never fully resolved.

Considerable research has been undertaken internationally on factors affecting rural recruitment and potential interventions, and it is a long-standing World Health Organization (WHO) priority.[2,3,26,27] In preparing this chapter, a literature search was conducted in March 2023, using the following terms:

Remote or rural
Recruitment or retention
Workforce

We also conducted a refined search with the term 'community' added to look specifically for literature on community-based interventions.

This search found several recent systematic reviews,[28–33] a review of reviews,[34] longitudinal cohort studies[35,36] and numerous scoping reviews.[37–41] This body of research has focused mainly on health service organisation and practitioners themselves (especially doctors and, to a lesser extent, nurses, pharmacists and other AHPs): what attracts or deters them from applying for rural jobs, what professional support and development they need and whether exposure to rural practice during training improves recruitment and retention. Much of the work in this field has been led by Australia, Canada and the USA; considerably, less has been rooted in the context of the UK health system. This is an issue because, as the WHO notes, context matters.[3] A Nuffield Trust working paper on acute care in remote areas concludes that solutions from other countries may not always work in a UK context and that multiple strategies across organisations are likely to be needed.[42]

One recent systematic review has focused on European medically underserved areas (or GP 'deserts').[33] This included 25 studies, of which 6 were from the UK. Consistent with other international reviews, all the interventions identified fell within the following categories: education, professional and personal support, financial incentives and regulation. However, only 10 of the 25 publications directly evaluated the effectiveness of the interventions described. The

authors note the difficulty of establishing causality when GPs' decisions are influenced by so many factors beyond the intervention (including personal preference and upbringing).

Systematic reviews of the international literature on remote and rural healthcare workforce solutions generally indicate that many recruitment and retention strategies are based on little definitive evidence. Being born or brought up in a rural area remains the strongest predictor of career intention, and extensive rural placements during training may also help, but combining several strategies is most likely to be effective.[35]

The evidence for financial incentives and coercive strategies from systematic reviews (e.g. offering 'golden hellos' and requiring people to spend some time post qualification in rural placements) is also mixed. One review found that coercive interventions were associated with comparatively lower rural retention than interventions involving less coercion.[30] Although another review found mixed evidence for financial incentives, the authors note that these may be more likely to work in tandem with other factors, such as a remote and rural upbringing.[33] They also highlight the potential importance of salary differentials in international recruitment, for example, higher salaries in countries in Western Europe attracting GPs from Eastern Europe to fill vacant posts. While this may be at least a temporary solution for the receiving country, it risks creating new underserved areas in the country of origin.

In their recent review of reviews of recruitment and retention interventions, Esu *et al.* conclude that there was little evidence on the effectiveness of different interventions. They note that measures which combined incentives with obligations to work in rural and underserved areas had some success, but that healthcare workers were likely to relocate once they had fulfilled the necessary obligations. Recruiting rural students and offering rural placements also seemed to improve both recruitment and retention, but that the absence of a control group in most studies made it difficult to reach firm conclusions on effectiveness.[34]

A recent updated review from WHO, looking specifically at retention, also concluded the strength of evidence in most international studies was low or very low;[27] a Nuffield Trust report comes to a similar conclusion for UK-based evidence.[42]

Previous studies in the UK context (including by coinvestigators Cleland, Watson and Skåtun) have also highlighted themes raised in the international literature, such as the importance of rural birthplace, and concerns about professional and/or personal (social) isolation.[43–45] The issues may be different for doctors at various life and career stages. A study of GPs and hospital doctors aged over 50 years led by co-applicant Cleland indicates the importance of sustainable workload and support to keeping people in post.[46] At the same time, findings from our recent CSO-funded study suggest doctors late in their career may seek out new challenges in rural and remote areas, and relish the opportunity to practise more generalist medicine, at a time when they are less tied for family reasons to a particular place.[47] Much of the focus of existing recruitment research has focused on attracting newly qualified staff; understanding what may draw or keep experienced late-career clinicians to remote areas has received less research attention.

In short, there remain many gaps in knowledge nationally and internationally about how best to attract new people from diverse backgrounds to remote and rural areas – and how to keep them there.

The impact of community

The influence of the community in attracting and integrating a healthcare worker and their family is regularly identified as important across a range of settings.[28,29,36,48,49] One study investigated how recent GP graduates in Australia would define their ideal rural practice.[50] While aspects of the job itself are important, new doctors also looked for features such as child care, good schools and partner employment opportunities, as well seaside or countryside attractiveness.

Spouses/partners and children may thus be as much the target of community recruitment and retention initiatives as practitioners themselves,[10,13,51] ultimately contributing to a community's social capital[52] and potentially furthering community sustainability.[53,54] There is limited international work on spousal perspectives, and again, mostly focused on Australia and the USA.[55–58]

A number of studies have measured 'community attractiveness' or features of the community that are associated with better or worse recruitment/retention.[59] These place-based differences may or may not be amenable to change or intervention. The Community Apgar Questionnaire was developed in rural Idaho to measure the assets and capabilities of rural communities related to physician recruitment and retention and identify which factors are most important for a community with limited available resources to address.[60] The scoring system features 50 items across 5 domains (geographic, economic, scope of practice, medical support, hospital and community support). The geographic domain, in particular, includes place-related features, such as recreational opportunities, spousal satisfaction, schools, shopping, housing, social networks and general perception of the community.

Sense of place, place attachment and belonging

Closely linked to the importance of community is a wider literature, particularly from rural studies, about migration and sense of place. This place and migration literature does not feature routinely in applied research on recruitment and retention, which has tended to focus chiefly on job characteristics, professional training, financial incentives and the individual's professional needs and aspirations. As Mandal and Phillips put it, 'Although the importance of social connection or belonging is a long-established source of well-being, such information has not infiltrated the dialogue or action on physician retention in rural areas' (p. 1).[61] In a recent scoping review, Gillespie *et al.* argue that although sense of place, place attachment and belonging-in-place have been identified as relevant concepts for healthcare recruitment and retention, 'there is limited information regarding operationalisation of these concepts within health workforce studies' (p. 1).[41]

A migration lens shifts the focus from the job to the person, the family and the place; Cosgrave (2020) argues for a 'whole-of-person' approach to retention.[62] Elsewhere we have argued that reconceptualising 'recruitment and retention' as 'moving and staying' better captures this more holistic understanding of what motivates people to take up a post in a remote or rural area – and, importantly, what keeps them in place once they get there.[63] This finds a parallel in Cosgrave's Australian framework of 'Attract-Connect-Stay',[64] and Pierce's description of the process of social worker retention in Canada as 'coming here', 'being here' and 'staying here'.[65] Staying (retention) is often the poor relative in much of this research. Even if recruitment interventions show some success in getting people to apply, the effect may be short-lived, and greater research focus on what encourages people to stay is needed.[34]

Mandal and Phillips examine the importance of a 'sense of belonging' for retention of physicians in the circumpolar region and note that it requires reciprocity between physician and community. They argue that:

> *A physician's sense of belonging, arising from that emotional need for social connectedness, is built via bilateral active efforts at community engagement, reciprocity, social integration of family and workplace collegiality. (p. 1)*[61]

They also note that a sense of belonging is likely to be the main reason why rural birthplace predicts likelihood of rural practice – for these people, the sense of belonging does not need to be worked on in the same way, since migrating to a rural practice is more like 'coming home'.

Hollick *et al.* note how interactions with both patients and place shape staff experience of providing care in remote areas – sometimes positively, but sometimes also generating negative feelings.[8] Sirili *et al.* explore how different communities in rural Tanzania either accommodated or rejected new healthcare workers.[66] While some provided a warm, welcoming reception, sought to integrate new staff into local life, and help them overcome practical and administrative challenges, others exhibited a lack of trust and suspicion of incomers that led to staff feeling isolated and eventually leaving.

The importance of an 'engaged community' is noted in the WHO reviews on retention.[3,27] Indeed, the WHO's most recent report highlights the need for a 'whole of society' approach to the issue of recruitment and retention.[3] Community and stakeholder engagement are key to this whole of society approach. There is some limited international research that has considered community activism,[67] including the development of community-led action plans[68,69] and community education and support[70] in relation to recruitment and retention. But, more commonly, research has focused more on the perspectives and preferences of healthcare workers themselves than on the experiences of communities, and what they have done, or could do, to help attract and integrate those workers.

One study has examined the development of action plans in two contrasting remote communities.[69] Despite the different context, the action plans were similar and included forming a liaison committee of stakeholders, developing information packages for prospective applicants, forming a welcome process to help doctors and families settle in, addressing housing issues, sponsoring a medical student to spend time in the community and considering partners' education and employment needs.

As Urquhart suggests, communities have important local knowledge to inform successful interventions, and their involvement in the process fosters a sense of ownership for helping to integrate new doctors and their families. She also notes their role in making their community an attractive place to be.[71]

Within the UK, some communities have experimented proactively with various initiatives to:

- promote their local area as a place to live and work
- get involved in the recruitment/selection process
- scout dual career move opportunities
- welcome and integrate new health professionals and their family members into local life, for example, inviting them to join societies and clubs.

Some of these initiatives have received national attention; some, particularly around retention, take place under the radar. In both cases, actions taken by local communities in the UK to enhance recruitment and retention of health workers have not been systematically studied and remain at the level of anecdote. These community-led initiatives have been the focus of our study reported here.

As a more detailed example of the kind of campaign which we have investigated, we include below a brief description of a new community recruitment initiative launched in the UK after our fieldwork period had ended, and which received widespread media attention.

The Lostwithiel example

The small community of Lostwithiel in Cornwall faced a dilemma as one of the two partners in their local practice headed towards retirement. Adverts in the usual medical journals and NHS websites had not managed to recruit anyone. The remaining partner approached a local community interest company (Really Lovely Projects) to help launch an eye-catching campaign. In February 2023, a video was released with members of the community singing a pop song with humorous lyrics about their desperate need to find a new GP, featuring their common ailments, but also showcasing the landscape and history, leisure activities and social groups, the presence of a rail station, and places to eat and have coffee. Hundreds of local people from all walks of life took part in creating the video, including butchers, schoolchildren, pharmacy staff, firefighters and even the local vicar popping up behind the altar. The video was accompanied by a website with further information about the post, an interview with the remaining GP partner, and material about the quality of life in Lostwithiel, including photos, links to local shops, estate agents and schools.

Engaging proactively with local media resulted in BBC Radio Cornwall featuring an item about the making of the campaign in early February. The story was then picked up later in the month by national broadcast and print media when the video was released.

It is, of course, too early to tell, at the time of writing, what the outcome will be in terms of retention, but it is a perfect example of how one community has harnessed a range of local assets in its bid to attract a GP.

Summary

Recruitment and retention of healthcare workers in remote and rural areas remains a challenge for health services across the world and may be one factor leading to inequalities in health outcomes. The systematic review evidence for various interventions to address recruitment and retention issues is mixed.

Previous qualitative research has shown that healthcare workers' decision-making about whether to take up a post in a remote or rural area is not simply about the job itself, but it is affected by a complex mix of personal, familial and social factors and attitudes towards place. Evidence about retention is less well developed, but existing literature points to the importance of community engagement and social integration in forming a sense of attachment to place.

This study focuses on what action communities can take to encourage healthcare workers to move to their area, and to encourage them to stay once they have arrived, particularly examining the range of community-based assets they can draw on.

Chapter 2 Methods

Methodology

This was a qualitative study, based primarily on five case studies, three in Scotland and two in England. In addition, we collected and analysed a sample of job adverts for remote and rural NHS posts across the UK. Ethical approval for the study was granted by the University of Aberdeen School of Medicine Ethics Review Board.

Given our focus on what communities in different parts of the country can do to attract and retain healthcare staff, a case study approach offered the most appropriate way to gain a rounded understanding of local action in context.

Theoretical framing

The study was informed (but not driven) by 'asset-based community development' (ABCD), which can be summarised as an approach which aims to strengthen communities by recognising, identifying and harnessing existing assets.[72] Asset-based approaches seek to understand what strengths, assets and resources lie within communities, often unrecognised, which may be brought together to find locally led solutions to community problems. Such assets may be individual and collective and include place-based assets as well as institutions and social networks.

The ABCD was developed in the 1990s by Kretzman and McKnight in the USA, to counter what they identified as a predominantly needs-based, deficit model of analysing economically and socially failing communities. This deficit model, they argue, could lead to residents starting to see themselves as fundamentally deficient, as victims unable to change the course of their lives and their community's future. It could also lead to fragmented efforts by a range of state and voluntary organisations to intervene. Instead, they argued, communities should be supported to identify their own strengths and help themselves.

We do not seek to apply the asset-based approach uncritically; as others note, it can be viewed as a neoliberal project, placing the burden back on individuals and communities to address their own problems, and masking or justifying cuts in welfare services as 'empowering local people'.[73] It may also serve to further reinforce inequalities in already underserved areas. We, therefore, see it as a critical analytical lens rather than a normative prescription.

Nonetheless, ABCD offers a useful analytical framework to consider what assets local communities are drawing on in recruitment and retention initiatives, how they present these to potential candidates and what both other communities and national policy-makers can learn and borrow from their experience. Assets can be broadly understood – anything from the beauty of the natural landscape to local people with skills in marketing or photography; community clubs and social groups; transport links; schools and housing; employment opportunities for partners.

'Community' means different things to different people. We adopt the broad definition developed in the context of participatory public health by MacQueen *et al.* of 'a group of people with diverse characteristics who are linked by social ties, share common perspectives, and engage in joint action in geographic locations or settings' (p. 1929).[74] In practice, this can mean a village, island or small remote town, where some health care is based.

Our approach is also informed by geographical theories of place and migration studies as explained in our background section. This has led us to adopt a more place-and-person-based approach to understanding healthcare workers' career choices, rather than a purely professional or job-focused approach. The shift in language in our findings from 'recruitment and retention' to 'moving and staying' reflects these theoretical influences. Furthermore, as the WHO has argued, these decisions are not simply individual but require a 'whole society' understanding.[3]

Team characteristics

A key aspect of this study has been the interdisciplinarity of the team, which included health services research and medical sociology (Louise Locock, Zoë Skea and Christina Dobson); human geography (Andrew Maclaren); medical education (Jennifer Cleland and Alan Denison); public partners from rural Scotland and England (Topher Dawson and Lorraine Angell); clinical academics in primary and secondary care with experience of remote and rural practice (Peter Murchie and Rosemary Hollick); and health economists with interests in labour force issues (Diane Skåtun and Verity Watson).

The study was directly inspired by public partner comments during our previous study of medical recruitment and retention.[47] Their input shaped our research questions, design and analysis.

Lead researcher Andrew Maclaren had already led the fieldwork on that study and had completed a geography PhD on ageing in rural communities, which complemented the more health service-focused perspective of other members of the team. Both our public and clinical partners helped root the study in the reality of rural life and remote practice, constantly prompting us to interrogate our assumptions and definitions (e.g. what is 'remote'?) (see *Public involvement*).

Sampling, recruitment and data collection

Case studies

Potential case studies were identified purposively in an initial mapping phase, through a combination of searching for media reports, snowballing through the research team's professional networks and suggestions from our advisory panel and patient and public involvement (PPI) partners. Our key criteria were that the community should be in a remote or rural area and should have been actively leading efforts to recruit and/or retain healthcare workers. As expected, this resulted in a very small sampling pool. We identified three sites in Scotland and three in England (though recruitment difficulties meant we later reduced the number of English case studies to two – see *Changes to the protocol*). This reflects the messy reality of fieldwork, where plans have to be flexed to take into account local contexts and recruitment challenges. A fourth site in Scotland was considered but discounted, because although the community was involved, the NHS appeared to be the leading partner.

Our final sample comprised a mixture of remote coastal/highland locations and islands. Fieldwork took place between April 2022 and February 2023.

In each case, a lead contact was identified and contacted by the lead researcher (Andrew Maclaren) or the PI (Louise Locock). This lead contact was asked to identify other local community members who may have been involved in local recruitment and retention initiatives, and healthcare workers who had been attracted to come and work in the community. From these participants, we used snowball recruitment to reach family members, other healthcare workers and other local residents with an insight into our topic. The number of participants per site was determined by relevance and the nature of local action, rather than a target number per case. A total of 22 people took part across the 5 sites. We also include in the analysis an interview from our previous study of doctors' decision-making about remote and rural working with a GP from one of our sites. This interview had been consented for secondary analysis.

We anticipated that given both COVID and the remoteness of the sites, most fieldwork would be conducted online. We had hoped to conduct one initial site visit to each site, but several sites told us they would actively prefer not to host a site visit, because they were still keen to avoid introducing the risk of COVID infection into their isolated communities. We had planned to conduct an initial focus group during these site visits; we attempted to organise these online, but in the event, a combination of small numbers and difficulty co-ordinating dates meant that only one online focus group took place. A few interviews were able to be conducted face-to-face later in the fieldwork period, particularly in the two English sites which were slower to recruit. The lead researcher was eventually able to visit both English sites and one Scottish site.

Potential participants were sent an information sheet and a copy of the consent form in advance (see *Report Supplementary Materials 1* and *2*) and offered an opportunity to ask any questions before the interview or focus group. Before the focus group, the researcher organised a brief online conversation with each of the participants individually to test equipment and obtain recorded consent. At the beginning of the focus group, the researcher reconfirmed with the participants that they still gave consent to participate.

At the beginning of individual interviews online, the researcher read out each statement on the consent form and asked the participant to confirm verbally they agreed with each statement. This was recorded as part of the audio-recording and included in the transcript. Where interviews were able to take place face-to-face, a signed written consent form was obtained.

Interviews used an open and exploratory style, following the outline included in *Report Supplementary Material 3*. Interviews and the focus group were recorded using a digital audio-recorder and transcribed verbatim by professional transcribers. All transcripts were stored on a password-protected university-shared drive and anonymised before use (see also *Anonymising sites*).

Some participants fell into more than one category of participant; for example, during the course of one interview, it quickly became apparent that someone who had been invited to take part as the partner of a HCP was also a part-time healthcare worker, so the researcher adjusted questioning accordingly to include both experiences. This reflects the reality of remote communities, where people often fulfil multiple paid and voluntary roles.

As part of a previous study, we had already collected interviews with doctors in Scotland, some of which were linked to the case study sites. These were already consented for secondary analysis, and one was added to the data set.

Job adverts

Between July and December 2022, a total of 270 job adverts for posts in remote and rural areas of the UK were collected by the PI (Louise Locock), using a monthly trawl of 3 sources: the *British Medical Journal* (*BMJ*) job adverts site www.bmj.com/careers (covering GPs and secondary care doctors),[75] the NHS Scotland GP jobs website www.gpjobs.scot[76] and the NHS Scotland jobs website https://jobs.scot.nhs.uk (covering secondary care doctors, dentists, nurses, midwives, allied health and care professionals).[77]

We took the decision to limit the search for non-medical posts to Scotland on pragmatic grounds, given the numbers involved. Even with this decision, the non-medical jobs constituted 43% of the adverts identified.

Adverts which occurred in more than one search were generally excluded, unless the advert looked distinctively different (e.g. a GP vacancy in Scotland might appear on both the *BMJ* search and the GPjobs.scot search with different content). Adverts which appeared in successive months with identical text were excluded; some which reappeared after a gap were reincluded. (Interestingly some still showed the old closing date and were very obviously a repeat advert.) Some showed no closing date at all, stating that the vacancy remained open until the right candidate was found. One county had an ongoing open advert for any GP wanting to come and work there, which appeared alongside adverts for specific practices in that county. Both these categories were included only once.

A recurring theme in our study is exactly what we mean by terms such as ‘remote’, ‘rural’, ‘semi-rural’, ‘accessible rural’. GPjobs.scot is the only site which explicitly categorises posts using such terms; for the other sites, we conducted a keyword search for ‘rural’ and sifted the results. (Early attempts to use ‘remote’ as a keyword were abandoned as it became apparent it yielded many unrelated hits focusing on ‘remote consultation’, and otherwise seemed duplicative of ‘rural’.)

Deciding which adverts to include, therefore, required a degree of geographical interpretation. As one example, Stranraer, a town in west Scotland with high levels of socioeconomic deprivation, has a population of just over 10,000, which tips it officially into the category of ‘other urban’ (settlements of 10,000–124,999 people). But given its coastal location, if the population were a few hundred lower, it would be categorised as a ‘very remote town’ (settlements of between 3000 and 9999 people and with a drive time of over 60 minutes to a settlement of 10,000 or more – in this

case, Ayr or Dumfries). By contrast, a village in Surrey or Kent might be described as rural but might be considerably better connected.

Importantly, however, this was not intended to be a quantitative analysis, and we were not aiming to be exhaustive in terms of numbers. Rather, the aim was to identify an information-rich purposive sample to illuminate the range of ways in which communities are presented when competing for job applicants, what features are highlighted as attractive community assets and what is sometimes absent. Each advert was, therefore, assessed for its relevance bearing these conditions in mind.

It is, of course, impossible to attribute the NHS's success or not in filling a post simply to the design of the advert. As will be evident in our discussion of findings from the case studies, and from our previous publications focusing on doctors' career choices,[63,78] the decision to move to a remote or rural post comes from a confluence of multiple personal and family considerations, of which the advert itself may form only a small part. Different people will be more or less attracted by different advert styles. It is also worth noting that during the period of our fieldwork, NHS Highland was running a generic recruitment campaign, 'Aim High, Aim Highland', which may have influenced decision-making.

However, in June and July 2023, we also sent out 189 e-mails to named recruitment contacts from the adverts for whom we had a valid e-mail address, to ask how many applications they received and whether they were able to appoint someone. While this cannot prove whether a particular type of advert 'works' or not, it did provide some interesting additional information. A total of 43 replies were received.

In response to a suggestion from our PPI panel, we also organised an online focus group in early August 2023 with three medical students nearing the end of their training, recruited through the University of Aberdeen, to discuss examples of job adverts and how they felt about the tone and content of different adverts. This was facilitated by a medical student intern. Participants were sent the participant information sheet and consent form in advance (see *Report Supplementary Materials 4* and *5*). They returned copies of the consent form, and their consent to participate was confirmed at the start of the meeting. Ideally, we would have liked to hold a focus group with qualified doctors, but this was not possible within the remaining time frame of the grant, given that this would have required new research and development approvals to recruit through the NHS.

Analysis

Case studies

Case study analysis can be used to explain, describe or explore the topic of interest in the everyday contexts in which events take place.[79] This exploratory, naturalistic form of enquiry does not set out to test a hypothesis; the primary focus is on describing and explaining what is happening, why and how within a given context. Crowe *et al.* identify three epistemological stances towards case study analysis: 'critical (questioning one's own and others' assumptions), interpretivist (trying to understand individual and shared social meanings) or positivist', though these can be combined.[80] Our analysis has taken a largely interpretivist approach, attempting to understand both individual perspectives and social relationships and dynamics within each case, and how social meanings are shared or disputed. Alongside this, we have adopted a critical stance in focusing on power relationships, and the influence of the wider political context which may not be consciously reflected in interview accounts. We may draw tentative conclusions on 'what works' from a more positivist perspective – though we were always conscious that recruitment and retention are rarely settled once and for all. What seems to be successful at one point in time may crumble as the situation changes, and, indeed, even in the course of our relatively short fieldwork period, we were able to observe shifts in service provision.

Throughout the study, the whole research team was involved iteratively in analysis. Transcripts (and selected job adverts) were circulated in advance of monthly team meetings and discussed at the meeting to start identifying themes and forming a view of the 'story' behind each case. Similarly, we shared extracts with the advisory panel and the lay panel to gather multiple perspectives on the data.

Drawing on these whole team discussions, the case study interview and focus group transcripts were analysed thematically. A coding framework was developed by the lead researcher (Andrew Maclaren) and research fellow (Zoë Skea) in discussion with the PI (Louise Locock) and applied to the full data set by Andrew Maclaren. Coding drew on both ABCD principles, as well as theories of place and migration, and inductive coding from the data.

Supporting this process was the development of a detailed, holistic case description for each site, which drew not only on the interview and focus group data but also on observational field notes written by Andrew Maclaren and what we knew publicly from each case, in the form of publicly available newspaper articles, reports, campaign videos and, in some cases, presentations given about their experience.

This enabled us to interrogate commonalities and differences across cases. For confidentiality reasons (see *Anonymising sites*), we cannot share these individual site descriptions publicly, but they are woven into our thematic reporting. As an example, the role of highly active key individuals is a common theme across sites, but the dynamic of their relations with other local actors differs substantially from site to site, and this is something we explore in the findings.

Adopting an interpretivist approach, as Sheard has recently and powerfully argued, involves moving towards a more creative telling of 'the story',[81] beyond 'reporting data' and line-by-line coding. She notes that Broom describes interpretive analyses as 'moving backwards and forwards between broader disciplinary and cross-disciplinary conceptual ideas . . . in relation to the newly collated data', seeking 'an explanation of what is going on with your data, rather than merely summarizing it'.[82] This resonates strongly with our repeated reflections in team meetings to arrive at our own shared meaning, drawing on the unique knowledge of our public team members and our interdisciplinary backgrounds in geography, sociology, health services research, primary and secondary care research and practice, medical education and health economics.

We strongly support Sheard's 'bold new vision' as she argues:

> *Empiricist gatekeeping is encouraging an oversimplification of the complexity resident in many qualitative health research studies. This is to the detriment of interpretative or theoretical advances because rarely can these be generated based on verbatim accounts of what participants explicitly vocalised during an interview or focus group. We need a bold new vision with strident defence of interpretive qualitative analysis, which does not aim to be subdued by the rigid demands of quantitative empiricism or conservativism. (p. 9)*[81]

Job adverts

Job adverts were analysed using a thematic framework analysis approach, identifying the different assets that adverts drew attention to, their use (or not) of pictures and video, the balance and ordering of details about the job itself/professional practice versus the location as a place to live. In developing the framework categories, we worked particularly with our public advisory panel. We sent them a subsample of adverts and then held a meeting to invite their reflections on what 'assets' had struck them and how they responded to the differing styles of advert.

The framework we developed was both deductive, in looking for assets that we already expected to be important (such as transport links, the natural environment or local schools), and inductive, as we identified additional local assets that were not anticipated (such as tone and the use of humour or mention of communal coffee breaks and regular cake). The framework was then applied to the whole data set by one researcher (Zoë Skea), in discussion with the PI (Louise Locock).

Responses from advertisers contacted were added to the framework, including both whether or not they had recruited, and free text from respondents talking about their experiences of trying to recruit.

The focus group transcript was analysed thematically, drawing on the asset framework.

Again, however, as with the case studies, our analysis moves beyond the immediate framework to create an overarching narrative about the whole data set.

Developing a library of examples

As a practical output from the study, we assembled a list of ideas and examples, drawing both on our case studies and wider media reporting and grey literature, to help other communities think what actions they might be able to take (see *Appendix 1* and https://learn.nes.nhs.scot/73640).

Anonymising sites

By their very nature, the communities which have agreed to be part of this study are small and close-knit; some Scottish islands have a population between 100 and 200 people. Some of the case studies have received a degree of media or policy attention, resulting in a trail of identifiable newspaper articles, presentations and social media posts. Often, key individuals have been prominent in local campaigns, but their role may sometimes have been controversial. Describing in any detail the communities involved, or their current pattern of healthcare provision, would thus make it potentially easy to identify which places we are referring to and by extension which individuals have shared their views. These views might, on occasion, have been critical of the community or other individuals and were shared confidentially.

Our ethics approval requires us to anonymise the data as far as possible. For this reason, we have opted not to include even anonymised case descriptions, though, as noted above, we compiled these for the purpose of comparative analysis. Instead, we present findings thematically, looking both at the many commonalities and also at divergent experiences and tensions. We do not attribute interview quotations to particular sites, nor do we identify the number of interviews at each site, giving only a total across the study.

In some quotations from interviews, we have omitted a few potentially identifying details, for example, when people talk about their or their neighbours' occupations, or local industries or leisure activities, to enhance anonymisation.

Ethics approval

This study was granted ethics approval by the University of Aberdeen School of Medicine Research Board, SERB/2021/10/2186. All recruitment was community-based, and we did not recruit through the NHS. Adverts collected were all available publicly on recruitment websites.

Changes to the protocol

Inclusion of doctors: in our original protocol, we had anticipated that we would have sufficient data on doctors' perceptions from interviews already conducted as part of our previous CSO-funded study (which were consented for secondary analysis). However, we applied for an amendment to include new interviews with doctors.

Number of case studies: we had originally planned to conduct three case studies in England but changed this to two. Despite promising initial contacts and an insightful informal discussion with a key informant in one of our proposed areas, we were unable to recruit participants. This may have been partly because although the local doctor recruitment campaign seemed to have some success initially, further problems arose. In the end, no individual doctor moved to or stayed in that area. As a result, people may have been reluctant to go on the record.

Contacting job advertisers: a further change to the protocol was to add that we would use details included in publicly available job adverts to contact job advertisers to enquire whether an appointment was made and what their experience of recruiting had been.

Focus groups: a final minor amendment was made to include focus groups with medical students nearing the end of training, to discuss their reactions to different styles of job adverts. In the event, there were only enough participants for one focus group.

Study duration: this was extended by 5 months to 31 October 2023, at no cost, to accommodate the appointment of the lead researcher to a new post at the beginning of 2023 and allow additional time for analysis and writing up.

The final protocol is available as *Report Supplementary Material 6*.

Public involvement

As noted earlier, this study was directly inspired by comments from public advisers on a previous study in Scotland. One of those people became a coinvestigator (Topher Dawson), along with another public partner from England (Lorraine Angell), and the other chose to become a member of the steering committee for this study and join in PPI group discussions. The whole project was therefore built around the need to reflect local community perspectives and potentially help other communities with ideas they could try in future. Reflections on PPI are included in our final discussion chapter.

Reporting checklists

In writing this report, we have drawn on the 21-item 'Standards for Reporting Qualitative Research' and the Guidance for Reporting Involvement of Patients and the Public 2 short-form guide for reporting public involvement.

Chapter 3 Job adverts for remote and rural posts

In this chapter, we report findings from our thematic analysis of our sample of NHS job adverts, responses from advertisers who responded to our request for information about their recruitment and findings from focus groups with medical students nearing the end of training.

Our data were drawn from: the *BMJ* job adverts website (primary and secondary care doctors),[75] the NHS Scotland GP jobs website[76] and the NHS Scotland general jobs website (covering secondary care doctors, dentists, nurses, midwives, allied health and care professionals).[77]

Over the 6 months of data collection from July to December 2022, we gathered 270 job adverts, shown in *Table 1* by job type and location within the UK. 'Other medical' includes secondary care and public health posts.

Adverts ranged from a couple of short paragraphs of text describing the post, with perhaps (though not always) a few details about the location, to lengthy and elaborate descriptions of both the post and the local community, sometimes with photographs of local scenery, links to further information and videos about the community. These topics will be explored in sections below. First, we reflect on the nature of the three different advertising platforms.

Comparing the advertising platforms

The three platforms offered quite different templates for advertisers. The NHS Scotland GP jobs website, for example, usually included a street map of the location and a descriptor, such as 'remote rural', 'accessible rural' or 'rural small town', using official Scottish Government classifications, but did not feature other visuals, such as photographs. Some practices added links to more visual information, such as a YouTube (YouTube, LLC, San Bruno, CA, USA) video, the practice Facebook [(formerly) Facebook, Inc., (currently) Meta Platforms, Inc., Menlo Park, CA, USA] page or illustrated documents.

By contrast, the wider NHS Scotland jobs website routinely included photos, but these were drawn from a bank of 'stock photos', mostly of clinical staff doing their job and interacting with patients. As a result, adverts for different professions in different areas might feature identical or similar photos, with occasional variation to illustrate, for example, social work or midwifery posts. Occasionally, when a job involved travelling around remote locations, there might be a picture of someone getting out of a car in a rural location, but photos of natural landscape without people did not feature. Again, however, some adverts linked to further information and videos to supplement the basic advert.

The *BMJ* jobs website, covering medical jobs in primary and secondary care, appeared to offer advertisers greater flexibility of format, including the opportunity to include photographs within the main advert (though not all advertisers used this feature). *BMJ* adverts may feature tabs for both 'job details' and 'company'; some advertisers used this additional 'company' feature to add considerable additional information about both job and place, including additional photos of landscape, local architecture and facilities. It is interesting, within the context of a state-funded health service, that the website uses the word 'company'. While, of course, some private and international providers might advertise through the *BMJ*, a word such as 'organisation' might be more generally relevant.

Cost is undoubtedly part of the explanation for variation. Advertising a GP vacancy on the NHS Scotland GP jobs website is free, whereas *BMJ* adverts costs several hundred pounds. However, the generic NHS Scotland jobs website,

TABLE 1 Job adverts by type and location within the UK

Type of post	GPs Scotland	GPs rest of UK	Other medical Scotland	Other medical RUK	Nursing/AHP/social care/ dental Scotland	Total
Numbers	57	57	24	15	117	270

which is also free, does include photographic material. The reason why NHS Scotland has enabled the inclusion of photographs on one and not the other is unclear.

The NHS Scotland GP jobs website refers potential advertisers to a guide produced by the former Scottish Rural Medicine Collaborative (SRMC; www.recruitmentsupport.scot.nhs.uk/advertising/), which strongly recommended the use of links to video content and strong visuals, though it did not mention photos.[83] Adding the ability to include photos could be a relatively low-cost intervention to increase the visual appeal of GP adverts in Scotland.

However, the SRMC guide also reported experience that the *BMJ*, despite the expense, has been the best route for attracting doctors to Orkney, particularly those in later career stages. They suggested this was because of its wide reach, including among older doctors, which may be enhanced by having a print distribution as well as online. Given that our findings from the case studies and our previous research suggest that people were not actively looking for a remote or rural job before applying, casting the advertising net as wide as possible would seem sensible.[63] This is also supported by some of the responses from advertisers (see further below).

We turn now to a thematic analysis of the adverts, focusing on how the jobs are presented and which community 'assets' are invoked and covering the following themes:

- Job or place? Which comes first?
- Landscape and natural environment
- Outdoor pursuits
- Photos and videos
- Connectivity
- Family, schools, housing
- Culture
- Humour and tone
- Nature of team and job
- Other incentives

Job or place? Which comes first?

The online advertising guidance produced by SRMC included the following recommendation:

> *Include some information about the local community and the rural environment, but do this after you've described the job. You are advertising a job – tell them about the job!*

Members of our public advisory group (which included a retired GP) broadly agreed with this and suggested it could look unprofessional and off-putting if there were too much initial emphasis on leisure and lifestyle. They contrasted two examples in particular (from different parts of the UK). The first example, from Somerset, starts with extensive information about place, quality of life (QoL), outdoor pursuits, transport and schools, before moving on to talk about the job and the team (*Box 1*). Although the second example from Jersey (*Box 2*) also touches on place early on, our public advisers felt it struck a better balance. Importantly, the very first point is directly about the job and the expertise the practice is looking for.

BOX 1 Part-time salaried or partner GP, Somerset, *British Medical Journal*

Somerset is attracting GPs from cities and other areas across the UK to make the most of what the county has to offer.

Cheddar is more than its world-famous cheese, still aged within the caves of the Gorge.

An attractive market town situated just off the A38 and M5 surrounded by the Cheddar Gorge with its historic caves. It offers an unrivaled [*sic*] quality of life while having great road links to Bristol, Exeter, Bath and London with Bristol international airport on our doorstep.

If you are into fitness, outdoor pursuits, the Cheddar reservoir is a popular destination for water sports fans, birdwatchers, walkers and cyclists. Cyclists can also begin the Strawberry Line cycle ride in Cheddar heading North West towards the main line at Yatton.

The schools in Cheddar and surrounding areas are happy places to study and have fantastic results.

This is an exciting opportunity to join a dedicated team.

A high standard of patient care, with good patient access and continuity is our utmost priority together with the work-life balance of our GPs and staff.

While only being 19 miles from the vibrant city of Bristol, with its irrepressible creative spirit and, of course, the world-famous balloon festival, Cheddar remains a semi-rural village.

Cheddar Medical Centre has 3 GP partners and 4 salaried GPs. One GP is moving abroad and therefore is looking for a new GP partner/salaried GP.

Some facts:

- 8100 patients and growing
- Training practice
- Personal lists
- Daily catch ups over coffee
- Semi-rural and rural area
- High QOF achievers
- Good CQC rating (outstanding in some areas)

We do things a little differently in Somerset: we have an active and supportive LMC and you will be welcomed into a well-supported learning environment where professional development is actively encouraged: the Somerset GP Educational Trust can meet all your educational needs.

Forget the chaos and breathe the clean air!

BOX 2 Full-time salaried GP, Jersey, *British Medical Journal*

Are you a GP interested in female health, looking for an exciting career opportunity? St Martin Surgery might have the role for you!

Imagine waking up a short distance from stunning beaches and coastlines. You could be enjoying a dip in the sea, or pottering around St Helier, exploring boutique shops and highly rated restaurants. With low crime rates and a choice of exceptional schools, Jersey is the perfect place to raise a family; alongside, easy connections to the UK, life in Jersey could be just what you're looking for!

We are looking to employ a full-time salaried GP who will fit our ethos; fun, hardworking and patient-centric, while maintaining a good work-life balance. We encourage work in different spheres of medicine. We are made up of 2 partnered GPs, working 6–8 sessions each. We offer a generous financial package, which we would discuss with any suitable applicants.

Our little surgery in the rural Parish of St Martin has expanded rapidly since we opened our doors. We are passionate about looking after our staff and take great pride in continuity of care and developing close relationships with our patients.

In common with many rural job adverts, these examples juxtapose opposites to imply candidates can have 'the best of both worlds', for example, pairing information about local QoL with easy travelling distances to bigger places, and being hardworking but also having good work-life balance. (Other adverts paired terms such as 'modern' or 'forward thinking' with 'traditional'.)

We note, however, that our qualitative findings suggest some applicants are indeed more attracted to location than to job, and many of the adverts in our sample did put early emphasis on 'why here' rather than 'why this job'. The difficulty for advertisers is anticipating how their advert will land with different audiences. It may be that healthcare workers who are already disposed to the idea of a rural job or have not thought about it one way or the other might find a pitch about place more eye-catching than a description of job tasks. Potentially, an approach such as example 2 covers both bases, with succinct information about the job but quickly followed by a sense of place and lifestyle. However, we should stress that there is no right or wrong answer, and examples used here and in subsequent sections are intended for illustration of varied approaches rather than criticism.

Other job adverts dwelt at some length on the nature of the job first; of these, some gave equal weight to information about place, while others covered it only briefly. In the *BMJ* example in *Box 3*, for a salaried part-time GP post in rural Wiltshire, the advert includes just one embedded sentence about place, 'We are an easy commute from Bath with potential for a perfect blend of city and country life'.

BOX 3 Salaried part-time GP post in rural Wiltshire

We are a friendly, well established and growing semi-rural training practice based south of Bath, offering a supportive environment and with an ethos for a high standard of patient care. We are an easy commute from Bath with potential for a perfect blend of city and country life.

Main duties of the job

As a salaried GP you will manage a caseload and deal with a wide variety of health needs in a primary care setting working individually and as a team, to ensure a high standard of care for all registered and temporary patients as you carry out the associated clinical and administrative duties.

Overview

We seek to preserve the best of traditional family practice with a willingness to adapt and modernise to ensure a continuing high standard of care to patients with a sustainable work environment.

- GMS Practice list size 11,000
- Four partners, eight salaried GPs, one ANP
- Three First Contact Physiotherapists, Health Connector, Paramedics, Network Pharmacist and pharmacy technicians
- Purpose built main surgery in Beckington, modern branch surgery in Frome Health Centre
- Dispensing at main site
- EMIS web across both sites
- Established training and teaching Practice
- Potential input at local Community Hospital
- Shared network cover of enhanced access; additional pay or time in lieu offered
- Medical indemnity paid and subscription for Bath Education Trust
- Part of Mendip PCN
- Individual mentoring offered
- Competitive salary, increasing with experience in the first 5 years

At one end of the spectrum, there were a few adverts which did not mention anything about place at all. More commonly (but by no means exclusively), these tended to be for nursing, midwifery or AHP roles. It is possible that NHS recruiters expect the applicant pool for such posts to live reasonably locally already, in which case they would need less persuasion about the attractiveness of the area. However, our case studies include examples of advanced nurse practitioners (ANPs) seeking a change to a more rural life, and other non-medical adverts explored below include plenty of information about place, including attractive videos.

Medical examples included adverts for a surgical research fellow in rural Scotland and a salaried GP in rural Wales with no mention of place at all, and a consultant anaesthetist advert in rural Scotland in which place was described only briefly on a second page. Yet other adverts for secondary care posts gave considerable attention to place, including this for a consultant general surgeon in Oban (*Box 4*):

BOX 4 Consultant general surgeon post in Oban

The area is of one of outstanding natural beauty. The town of Oban is a tourist and commercial centre for the West of Scotland and the Isles. The port town has ferry links to the islands of Mull, Iona, Islay, Coll, Tiree, Colonsay and Lismore. There is plenty of opportunity for enjoying leisure pursuits, including yachting, canoeing, walking, climbing, cycling and fishing. There is a strong culture of traditional music and dance in Argyll. It's a great place to bring up a family with good local schools and reasonable property prices. Oban provides the advantage of a high quality of life in a rural setting with access to the main centres of Glasgow, Stirling and Perth all within 2 ½ hours travel time.

Landscape and natural environment

The beauty of the local area is one of the most obvious assets to feature in many remote and rural adverts. Adverts commonly invoked images of mountains, sea, beaches, forest and open country, wildflower meadows and opportunities to see wildlife. However, the extent of description varied widely.

A *BMJ* advert for GPs across Somerset (*Box 5*) includes the following extensive description:

BOX 5 Generic advert for general practice in Somerset

> Somerset has so many surprises waiting to be unwrapped. Those who live here have discovered many hidden gems, the wildflower meadows, beach waterfalls, ancient wells, unique carvings and underground reservoirs. Think of Somerset and what comes to mind – the things you know such as delicious strawberries, authentic Cheddar cheese and thirst quenching cider. What is lesser known is the fossil hunting on local beaches, miles of mountain biking, a network of footpaths and Byways for walking and horse riding across the County including on the Quantocks, a designated Area of Outstanding Natural Beauty, and discovering the beauty of the beaches and coastal paths.

Similarly, a *BMJ* advert for a contract GP in Scotland (*Box 6*) states:

BOX 6 Contract GP Carradale

> Carradale is on the stunning west coast of Scotland, situated on the Kintyre Peninsula (overlooking Arran) with beautiful scenery, golden sandy beaches, hills, lochs, and the relaxing atmosphere which the area has to offer. There are several golf courses, a variety of water sports, photography, archaeology, wildlife, vibrant music culture, seafood, gin and whisky distilleries.

Often, comments about landscape were embedded in a list of multiple assets, such as the above example. Another advert (*Box 7*) for a GP in Western Scotland (NHS Scotland GP jobs website) provides a similar list:

BOX 7 General practitioner in Western Scotland

> There is a great family and outdoor lifestyle to be enjoyed here with wonderful scenery and beaches on our doorstep, two championship golf courses, a swimming pool, cinema, flights to and from Glasgow, a bus service daily to and from Glasgow and a summer ferry link to Ayrshire.

Understandably, advertisers are often trying to cram a lot of material into a limited word count, but our PPI panel commented that occasionally adverts sounded almost desperate in their enumeration of place-based assets. (In the light of findings from contacting advertisers, described further below, the PPI panel were probably correct to detect a degree of desperation.)

Outdoor pursuits

Closely linked to the natural environment is the opportunity for an outdoor lifestyle. Adverts included references to walking, hill walking and climbing, mountain biking and cycling, skiing and snowboarding, golf, fishing, wild swimming, surfing, kayaking/canoeing, sailing, birdwatching, dog-walking, safe outdoor play for children and just being 'in nature'. These assets were often featured in accompanying videos. For example, in one video (*Box 8*), a GP already working in the area commented (with perhaps unguarded honesty):

BOX 8 General practitioner post, Lochgilpead (quotation from YouTube video transcript)

> *I think if you like outdoor life and outdoor living, then it's really good. So I'm quite happy running by the hills, walking around with a dog, which is great. I think if you didn't have any outdoor pastimes or anything like that it might be fairly isolated*
>
> www.youtube.com/watch?v=zrd-sp1Y22w (accessed 20 November 2024).

Photos and videos

As noted above, not all adverts included photos, sometimes because they were placed on a free advertising platform which did not include visual components or permitted only stock photographs. Where tailored photos were able to be included, these ranged from pictures of NHS premises – not always very inspiring – to pictures of beautiful scenery, seaside and harbours, village scenes, people taking part in outdoor pursuits, attractive local buildings and historic monuments (such as churches and Hadrian's Wall). In some cases, these were quite artistic compositions, for example, the sun setting over the sea, or snowy mountaintops.

Videos might be specially created for the job in question, or they might be generic videos used whenever that location was trying to recruit. Some were NHS-produced, and some community-produced. An example of the latter is the following video about Oban, made by a local walking company which also runs a video marketing business, 'proudly supporting our NHS': https://youtu.be/SjxX2VS-JKQ (accessed 20 November 2024)

This is an unusual example in terms of content, as it features no words (apart from an initial text screen with a greeting in Gaelic), and is entirely focused on place. It features drone and other footage of landscape, food, cycling and walking, fireworks but nothing about NHS services or jobs. It is also a good example of a local asset, in terms of video marketing expertise right on the doorstep. Not every remote or rural location will have access to such professional skills in the community.

More commonly, videos made to accompany NHS job adverts include a mixture of NHS staff interviews or pieces to camera talking about the job and the team/team culture applicants would be joining, footage of NHS facilities and people at work and shots of local landscape and attractions. Some further video links are included in the 'library of examples' (see *Appendix 1*).

Connectivity

Under the theme of connectivity, we looked for mentions of transport options, ease of accessibility and journey times to nearby destinations, and digital connectivity (e.g. Wi-Fi).

Many adverts emphasised how close they were to towns and cities. One advert for a GP on the west coast of Scotland practice mentioned being '90 miles from Glasgow, 35 miles from Oban'. This glosses over the fact that to get to Oban, there is only one road, and it takes over an hour to drive, while the nearest station with connections to Glasgow is also over an hour's drive away.

It is, of course, understandable that advertisers want to emphasise connectivity rather than lack of it. A number of island adverts referred to regular ferry services, omitting to mention that they may not run every day of the week or that they are likely to be cancelled in bad weather.

In some cases, descriptions of connectivity went so far as to suggest that there was no need to live in the location, for example, suggesting living in a nearby town or city and commuting to the practice or hospital would be feasible (*Box 9*).

BOX 9 General practitioner partner, Wales

> We have excellent local schools but some of the GPs live in Shrewsbury and Wrexham and there are excellent accessible private schools.

An advert for rotational GP locums (*Box 10*) encouraged people to think further afield, which might appeal to people with a particular set of values and preferences.

BOX 10 Rotational GP locum, Orkney

> Rotational working allows practitioners to live on island or as far away as South Africa, with blocks of time to work elsewhere; Primary Care in their areas, hospitals or even refugee camps. The best of both worlds?

But most seemed to aim to tread a line between the 'get away from it all' rural idyll and access to more urban life.

Digital connectivity might include professional aspects, such as telemedicine links to major hospitals and virtual appointment systems, but also how/whether the local community as a whole had good digital services. While access to fibre and radio broadband has increased rapidly in remote areas, some areas remain underserved. However, we found no mention in our sample of the quality of local broadband quality.

Family, schools, housing

As our qualitative findings suggest, moving to a remote area is often not just an individual decision but may involve partners and other family members, though the extent to which advertisers reflected this in their materials varied.

This extract from Royal Cornwall Hospitals Trust (*Box 11*) offers an illustration of the way advertisers might present assets relevant to wider family life:

BOX 11 Consultant Eldercare Physician, Cornwall

> We are offering you not just the opportunity to work with us but also the benefits of working in the beautiful county of Cornwall for you and your family:
>
> - The surrounding countryside is renowned for its spectacular rural and coastal scenery. Cornwall offers an outstanding quality of life and many opportunities for outdoor pursuits, with its sailing waters, surfing beaches and rugged coastal country routes for walking and cycling and equestrian activities.
> - Cornwall is a food haven with an unprecedented growth in high quality restaurants and family orientated leisure facilities.
> - The pace of life is gentle and community spirit is abundant with many villages having their own identity and take pride in caring for their surroundings.
> - Schools are of high quality often comprising of small class sizes where children thrive.
>
> Do you have a partner and family who would relocate with you? If so, then please contact us as we have a variety of employment opportunities within the hospital and would be happy to discuss this with you.

Quality of life for children and a safe, healthy environment for them were a common theme. Schools also featured prominently in many adverts, with some referring to Office for Standards in Education, Children's Services and Skills inspection results and some also mentioning private schooling in the area. These family factors are important not just for recruitment but also for retention. Some participants in our previous study reported staying in a remote and rural setting precisely because of their children's schooling and friendship groups, despite the fact that they found the job itself not that satisfactory.[47]

The above advert was very unusual in suggesting the employer might also be able to help with jobs for partners or other family members (albeit only within the hospital sector). The likelihood, or not, of partners being able to find employment in a new, restricted job market is a theme in our qualitative case study findings and is something that both communities themselves and local public services could potentially help address.

Housing is another factor which we know, from case study findings and previous research, can play a decisive role in healthcare workers' decision-making. As with employment opportunities for partners, however, housing was rarely mentioned in job adverts. Occasionally, adverts mentioned that the area had 'reasonable property prices', 'a wide diversity of housing' or 'a reputation for excellent properties' but very little about support with finding housing. One advert for a salaried GP on the Island of Hoy, Orkney, stated that accommodation was provided (but with no further detail); this was a role for part of the year only (enabling people to locum elsewhere or volunteer abroad for the rest of

the year), making accommodation particularly important. Another advert for a mental health nursing post stated the availability of 'newly refurbished accommodation to rent'.

By contrast, one advert for an ambulance technician notes that the requirement to follow shift patterns, including unsocial hours and on-call working from home, means that candidates will be 'required to secure accommodation within a reasonable distance', 'Before commencing the employment'. Although the advert goes on to say this will be discussed at interview, it is unclear whether help locating accommodation would be provided.

Culture

We took a broad approach to defining 'culture', looking for examples, including theatre, cinema, restaurants, history, museums and galleries, shops and local tourist attractions. An advert for a GP in Kilcreggan, Argyll, was one of the more extensive examples (*Box 12*):

BOX 12 General practitioner, Kilcreggan

> Kilcreggan has its own pharmacy, cafe, small shop and a great pub which serves fantastic food, a supermarket is available in nearby Rosneath. The area also has the well rated Knockderry Hotel. Garelochhead at the top of the Peninsula has a petrol station and cafe. Helensburgh (15 miles away) has two supermarkets and a wide range of independent shops/cafes/restaurants and a cinema.

As in the case of Kilcreggan, frequently, adverts alluded to cultural assets available within travelling distance rather than in the immediate vicinity. One advert for a GP in Somerset refers to the 'irrepressible creative spirit' of Bristol (19 miles away) and its 'world-famous balloon festival', as well as the proximity of Cheddar and its 'world-famous cheese'.

In another GP advert, 'newly fashionable Bruton' showcases a range of assets of its own: 'Bruton is a bit of a one off, even more so than every Somerset town, with first class eateries and restaurants, fine shops, local artistic ventures'. An advert for a GP in a remote part of Dumfries and Galloway makes reference to nearby Wigtown, 'the famous town of many bookshops'.

In an advert for a consultant physician, Orkney is described as 'an archipelago of beautiful islands with a deep cultural heritage, a gentle warm welcome and a resourceful community'. Hosting the Island Games in 2025 is mentioned, along with music, art, drama and a range of festivals, as well as 'history, ranging from World Heritage Neolithic sites to World War 2'.

Humour and tone

While the great majority of adverts could not be described as funny, some used flashes of humour. One example was for a GP vacancy in Dumfries and Galloway, with the opening line 'Father Ted needs a Dougal, Jack has left Craggie Island!!' The advert then goes on to explain that 'We are looking for a GP to join our small friendly & supportive team, due to a partner's retirement'.

This was one of the examples we discussed with our public advisory panel, who had reservations about the overt humour, and felt it risked appearing unprofessional. They also raised the point that 'Father Ted' was a TV sitcom which first aired 27 years ago. They felt this might make it meaningless to a younger generation of GPs, or might suggest they would be joining a practice with mostly older colleagues. Although the rest of the brief advert talks conventionally of work-life balance, practice premises, a patient-centred approach and professional and educational links with two neighbouring practices, members of the PPI panel were concerned that the opening might be enough to put people off applying.

Another advert, from rural Wales, used considerable amounts of humour, in an exceptionally long advert (running to five pages in a word document). This included comments such as 'it is sometimes rather a relief to be out visiting as the journeys are so beautiful' and 'while a cow or two might hold you up briefly queues are very rare and usually commented on in Facebook'.

Most other examples of humour were brief and uncontroversial – for example, commenting on the quality of the fresh-ground coffee available at the practice, or joking about the damp weather on the west coast of Scotland: 'we are a close, supportive team and always aim to meet for coffee which will often be enjoyed on our rooftop terrace. Scotland is renowned for its excellent weather after all'. In the same advert, good working relationships were highlighted, 'but all that camaraderie is forgotten when it comes to Musical Chairs on the Christmas night out'.

Aside from humour, other aspects of tone were noteworthy, varying from a strictly factual description of the work to a romantic appeal to change your lifestyle: 'Do you ever dream of driving to work on quiet roads, alongside a beautiful Scottish sea loch?' The use of questions such as 'do you ever dream . . . ', or inviting people to 'imagine', were common devices.

The five-page Welsh example mentioned above took a conversational tone, describing at length the empathy of collegial relations within the practice, including naming their 'amazing practice manager', and the close-knit relationship with the community. Two extracts (*Box 13*) illustrate this tone.

BOX 13 General practitioner, Wales

We have a very supportive patient population who not only regularly donate to support what we can offer but actually throughout COVID remained staunchly positive about us and what we were doing; understanding when we had no staff and the presents of cakes, tea, chocolate, wine was as appreciated as the many heartfelt comments.

Too good to be true?

Working in the NHS nowadays is inevitably stressful and with all the arrangements in the world things can happen. What we make sure of is that no one is ever dealing with too much alone – if the days goes pear-shaped, we all step in to help whether that's helping another Doctor, a nurse, or the Pharmacist.

If something is not right or something goes wrong for a patient, we look at it together, try and work out what happened and then work out what we think might be better or what we all need to learn. Nobody comes to work to make a mistake and there for the grace of God go all of us and that is how we approach problems.

On the more positive side we enjoy making things work better for patients both as their advocates in secondary care, working with our local health board for funding to improve what we can do here and developing all our skills and interests, so we stay sane and enjoying what we do as much as possible.

We like getting together; we like partying; our yoga class run by our ANP kept the senior partner sane through COVID. Lunchtime walks are a regular and evening paddleboarding and canoeing are very amusing. Bike trips and hill walking helped burn off the calories after the Macmillan cake making fundraising was rather too successful.

There are a couple of good practice parties in the year but many more informal evenings across and within the teams which are widely shared (and often laughed at). Our children and their friends support the practice and get good training in throwing a party and cocktail making among other vital skills.

This lengthy advert does seek to engage with potential applicants at an emotional level and certainly gives a strong impression of what it would be like to live and work there. At the same time, the 'Too good to be true?' subheading is noteworthy. There is perhaps a risk, in trying to 'sell' the practice and the place, of overselling and overclaiming and beginning to sound a little desperate.

Nature of team and job

The above extract is one of the more extreme examples of how advertisers sought to present the nature of the working environment as an asset to attract people to a particular place. However, other adverts also frequently commented on the ways that remote and rural practice differs from urban practice, and how small teams work and live closely together, and often socialise together. Work-life balance, strong team cohesion, continuity of care and the opportunity to practise in a more holistic way were all commonly mentioned. One job advert in rural Scotland described the role as 'relatively stress-free job with plenty of variety', for example.

Unsurprisingly, the potential downsides of remote practice – for example, the stress of being left to manage everything alone, finding it difficult to get cover for time off or feeling professionally or socially isolated – rarely featured or were given a positive spin which might appeal to people looking to extend their skills (*Boxes 14* and *15*):

BOX 14 General practitioner rotational locums, Orkney

> Spice up your regular GP skills with the challenges of pre-hospital emergency care while waiting for helicopter evacuation. Emergency care training, with standardised equipment and protocols is provided.

BOX 15 Advanced nurse/paramedic practitioner, Skye

> The role of the Advanced Practitioner is dynamic and it is essential that skills are maintained in order to offer a safe and sustainable service to the community, as a consequence there will be opportunities to work in other locations and learn new skills.

We were struck by how often we saw claims to be a 'forward-thinking' practice in GP adverts, for example, 'we are a dynamic and forward-thinking team with a wealth of clinical and leadership experience'.

Occasionally, a practice would instead describe itself as 'traditional' (e.g. 'we are a small, semi-rural practice with a traditional family doctor approach'), but the exact words 'forward-thinking' appeared over and over again. Advertisers face a dilemma of wanting to present themselves as modern, up to date and innovative, while, at the same time, appealing to those seeking a chance to get back to greater generalism and continuity of care: 'we are a forward thinking practice, striving to deliver excellent continuity of care to patients in our community'.

Other incentives

In addition to the range of community 'assets' presented across the job adverts, several adverts also described a range of other incentives relating to the job itself. Sometimes these incentives were financial in nature [e.g. funded relocation schemes; golden 'Hellos', competitive salary, medical defence subscription, annual General Medical Council (GMC) fees, free membership to various reward and benefit platforms, excellent pension, etc.], whereas sometimes they related more to workload issues (e.g. promoting no out-of-hours/weekend work, protected training time, reduced administrative burden, very light or no home visit/nursing home commitment, low patient-to-doctor ratio, flexible working with consideration of term time, paid sabbatical, generous annual leave package, etc.). Other job-related incentives included reference to individual mentoring or buddying, car lease and Cycle to Work schemes and even the opportunity to work with the ski patrol and mountain rescue service. One GP practice offered 'free membership to our reward and benefit platform "Perkbox" with access to a range of discount deals and perks'.

Recruitment outcomes

Where valid e-mail contact information was still available, we attempted to contact job advertisers to ask (1) whether an appointment had been made and (2) how many people were shortlisted. E-mails were sent to 189 advertisers, and we received 45 responses. The results were disappointing, both in terms of the number of responses received and the story they told.

Of the 45 responses received, only 18 responded to say that an appointment had been made as a result of the advert. Of these, two were GPs and the rest were AHPs. While a few of these appeared to have been straightforward appointments, replies sometimes revealed a more complicated story. In one case, the appointment did not work out because the person was less experienced than expected, and the postholder was leaving after a short time in post. Several respondents highlighted the lack of experience among applicants as an issue; one respondent had shortlisted three midwives after a year of advertising, but the two senior applicants withdrew, one because of 'inability to secure accommodation in the area (we live in a high-level tourist area and prices are too expensive)' and one because they could not offer as many hours as the employer wanted. The more junior applicant was appointed, but changes had to be made to the responsibilities of the post to allow for lack of experience. This advertiser noted that applications for jobs in their area had improved when they put out a short promotional video about working there.

By contrast, one of the advertisers who had been unsuccessful had tried opening up the vacancy to less-experienced staff to no avail.

> *We have had difficulty recruiting for a number of years, we have reviewed the banding and opened it up to new graduates at Band 5 offering for them to gain the capabilities of a Band 6 clinician within 2 years to support career progression. This did not attract applicants that were new graduates, we have reworded the advert several times, highlighting opportunities of a career in a remote and rural location.*
>
> *Specialist podiatrist*

A different strategy which had worked for some was to make the post more senior. For example, a Community Mental Health Worker post was regraded to a higher band requiring a degree in Child and Adolescent Health. This generated strong interest, where the previous post had attracted none. Another advertiser had just recruited an experienced and previously retired member of staff who was having to reactivate their professional registration, and noted that actually getting someone in post can take 3–6 months. This was echoed by an advertiser who had appointed an overseas applicant to a qualified social worker post: 'Visa and sponsorship were required – it is a very long process and the person has still not started'. This contrasted with two other posts which were quickly filled by local residents, which required no professional qualification.

A further four advertisers told us that after many fruitless attempts, they eventually managed to recruit a GP through their own networking channels, by persuading a locum or a trainee to stay on, using word of mouth locally or using the services of a head-hunter. There was evidence in advertisers' responses that people they recruited had not necessarily been looking for a job until they were made aware of the vacancy.

> *We finally appointed a GP to this post [. . .] but it wasn't as a result of the advert. We had absolutely no interest to our advert [. . .] This GP was appointed as was working as a locum in the area when she was made aware of our vacancy.*
>
> *Salaried GP*

This suggests those recruiting to rural and remote posts may need to be receptive to and proactively seek connections with potential applicants rather than hoping that the advert will be enough to attract them. They may also need to consider alternative strategies to maintain services, such as upskilling nursing staff, recruiting physician associates, employing rotational locums, considering merging with neighbouring practices (if geographically feasible).

Indeed, one advertiser, using a rotational approach, commented:

> *Generally speaking we have few problems in appointing GPs to our practice. We are looking for experienced GPs to work 24/7 in shifts lasting usually 3–4 weeks for 13–17 weeks a year. There seem to plenty of doctors in their 50s or 60s who find this very attractive compared with continuing in traditional practice.*
>
> *Salaried GP*

Of the remaining 23 replies, 5 told us either they did not know the outcome or the vacancy remained unfilled. Eleven reported explicitly that they had received no applications at all, and two said they had applicants, but no one was suitable for shortlisting. Three had shortlisted but did not appoint, and a further two reported that the only appointable

candidate had withdrawn. One of these reported that other applicants 'were very much new graduates with no experience and our ability to support and develop newly qualified staff from abroad is extremely limited' (audiologist).

One respondent noted that online interviewing since the pandemic had made things harder.

> *I think the restriction of virtual interviewing (although entirely required during the pandemic) which continues today makes recruitment more difficult, the individual doesn't get the opportunity to come to [the area], have a look around and meet the team.*
>
> *Specialist podiatrist*

This advertiser even reported that they had been 'ghosted' mid-interview by one candidate and that they had people applying without the essential professional qualifications.

Of course, it is possible that it was mostly those who had failed to recruit who felt prompted to reply to our request for information. However, while we cannot assume that the responses were representative of all attempts to recruit to remote and rural posts, they were reflective of issues experienced in our case study sites. In their responses, some commented on the ongoing challenges faced around recruitment and retention of HCPs and expressed frustration at the apparent lack of interest in their job adverts. In the examples below, the nature of the post is included in brackets after the comment:

> *Sustained staffing is perhaps the greatest challenge we face. From our advert [. . .] we did not receive any applications.*
>
> *Consultant physician*

> *We very regularly have no applicants these days. Used to get 6 to 8 minimum.*
>
> *Community staff nurse*

> *Most applicants have withdrawn when researching partners' job availability, housing, family commitments, there have been a few applicants we have been unable to shortlist.*
>
> *Specialist podiatrist*

> *We had no applicants. Repeatedly. We also advertised the same post as a consultant or staff grade locum and got no applicants.*
>
> *Consultant psychiatrist*

> *I have been part of multiple community initiatives, filming videos and using social media. They are great for reaching multiple people, but they have not affected number of applicants, or the Islands are portrayed as an idyll where in fact it can be challenging to work in such small communities.*
>
> *Senior community staff nurse*

The comment about unrealistic representations of the rural idyll is particularly noteworthy and is something to which we return in the conclusion.

Focus group summary

We conducted one focus group with three medical students nearing the end of their training, facilitated by a fourth medical student who worked with us as a summer intern. We shared with them a subset of the adverts we had discussed with our public advisory group. The students confirmed the reservations of our public advisory group that humour could be off-putting. While the students appreciated that advertisers were trying to sound approachable and conversational, this was generally not the tone they expected from a job advert, and none of them had heard of the sitcom 'Father Ted'. They were unsure on occasion whether some comments in an advert were factual or rather an attempt at sarcastic humour. Participants questioned the appropriateness of humour in describing what they saw as serious work.

They strongly prioritised information about the job itself as the thing that would make them keep reading. Two of the three participants were considering whether they might want to work in a rural area eventually, but despite this, they were not drawn to lyrical descriptions of place. They argued that descriptions of a community needed to appeal to as wide an audience as possible. One participant commented, for example, that adverts which included phrases such as 'If you are into fitness, outdoor pursuits' could be off-putting for anyone who did not see themselves as 'into fitness', yet who could still appreciate a rural setting. This is not to say that they did not want to see any information about place but, rather, that they wanted to see a brief and factual description, after key facts about the job.

In discussion, they acknowledged that at their early career stage, the content/duties of the job itself, the salary and the training opportunities were key factors affecting their decision; whereas if they were further into their careers, they might have different priorities around settling down with their family or moving to a particular type of place in late career. As new entrants to the medical job market, they know they will be moving regularly from job to job, hence the lower priority attached to place.

One aspect of place which was very important to them, however, was accommodation. Particularly, when anticipating several job moves, knowing there would be somewhere to live was a vital piece of information missing from most of the adverts they saw.

Finally, they reflected on the visuals of adverts. They felt photographs were important and could tell them more succinctly than text what a place looked like. They also recommended inclusion of a map, given that both UK and overseas applicants may have little knowledge of where a place is just from the name. An eye-catching layout was something to which they felt advertisers needed to pay more attention.

Conclusions

While many adverts include plenty of detailed information about the community and the lifestyle, our findings suggest some places may not be realising the full potential of local assets. One relatively simple change would be to provide more visual images, either in the advert itself or – if that is too costly or not possible on the advertising platform – in a linked website or document. There were several examples of materials that could be reused for different vacancies, or generic adverts, such as the Somerset-wide advert for GPs or the video from Oban running alongside individual vacancies.

Tanaka argues that the twin purposes of advertising – to inform and to persuade – are not of equal importance; rather, persuasion is the primary goal.[31] Unsurprisingly, most advertisers sought to present an optimistic and attractive picture of the local area and the job. Moments of authenticity or realism about the possible disadvantages of living and working in rural and remote areas were rare. As one of our advertisers hinted, however, overemphasis on the 'rural idyll' can have unintended consequences, attracting people to apply without their fully realising what life will be like. Crafting an effective 'sales pitch' without exaggerating or being misleading is a difficult balancing act.

The decision as to how much prominence to give to place versus job characteristics is another balancing act for advertisers. Findings from our previous research with doctors working in remote and rural posts suggest that place is indeed a crucial factor, and that family needs and preferences for a place to live are influential.[63] This is not to say that job is not also important but might suggest that adverts which make little, or no mention of, place could miss a potential audience. Yet our medical student focus group participants, at their earlier career stage, prioritised job characteristics.

Another juggling act for advertisers is getting the tone 'right', while accepting that there can never be a single right answer, and different styles of adverts will be more or less appealing to different people.

Goddard characterises adverts as 'attention-seeking devices' (p. 9).[84] Foley and Karlsson note that 'advertising often finds itself in complex situations in which modest advertisements risk being left unattended, whilst the bold or perplexing might be disliked or misunderstood altogether' (p. 99).[85] While careful use of humour may help an advert stand out from the crowd and give potential applicants a more personal feel for the place and the people with whom

they would be working, advertisers should be conscious that it can be off-putting. Similarly, enthusiasm for place is important but can risk tipping over into a pleading tone or a focus on one particular kind of lifestyle which may deter some applicants.

As noted earlier, our analysis of advertiser responses to our enquiries cannot prove one way or another whether the advert per se was the deciding factor in recruiting or not recruiting. However, the fact that most of the small number of responses received told us that no one had been recruited or had even applied raises questions about the amount of NHS investment in advertising. To our knowledge, there has not been a cost-effectiveness analysis of different styles of adverts and different advertising outlets and how these relate to outcomes. When so much is spent on repeated and sometimes fruitless advertising, this could be a valuable piece of health economics research to take forward.

The experience of advertisers who contacted us suggests that recruiting through informal local networks – encouraging locums or trainees to consider staying on – may sometimes have greater success than formal advertising. This speaks to the value of training placements as a way to give people a taste of rural and remote practice, and recruiting students from rural backgrounds, ensuring their perceptions are grounded in reality.

Chapter 4 Community action: identifying challenges and making the most of local assets

In this chapter, we describe the nature of the challenges faced by our case study sites and summarise the types of formal and informal actions that took place, and the assets and social relations that communities drew upon. These are then explored further in two subsequent chapters.

All our case studies took place in rural or remote coastal or island communities, characterised by sparse and dispersed populations, with limited road and transport links. Some communities had more facilities than others, in terms of health practice buildings as well as local shops, businesses and schools, along with varied digital connectivity. Some had taken community action to improve local Wi-Fi provision [e.g. a community interest company (CIC) to develop private radio broadband].

The degree of remoteness of a place in itself is an obvious common challenge to healthcare staff recruitment. However, as our public coinvestigators frequently reminded us, 'remoteness' is, to some extent, a subjective experience, and a well-networked community with good local services may not feel remote to those who live there. For example, some remote communities in Scotland provide services for a wide catchment area and have more services than might be expected for a place of that size, so they can 'feel' like somewhere larger:

> *I often compare [case study village] to [another village], which has a similar population, they are about 1800 but obviously it's very different in terms of the services and distances. . . . It's the services; there's a lot more in [case study village] than there is in [another village]. . . . I just feel that the locals are more open to the ideas of incomers taking part in the commercial life of the village and that has led to a great many successful businesses and prosperity flowing from the tourist industry. So maybe that's only speculation on my part but it's, that's why I think there's quite a fertile and a productive mixture of local and incomers.*
>
> *CAWH-18; community member*

While geographical remoteness may be a deterrent to some potential applicants for healthcare jobs, it can also be a selling point for the right applicant. Thus, several initiatives focused on showcasing the attractiveness of their community and the benefits of 'getting away from it all' to live and work in a beautiful natural environment. The family member of a GP explains below how the attractions of the place featured in their decision.

> *So, I suppose the things that attracted us was we got here – it's a beautiful place, and the community, the community were very welcoming, and we have a small child so it was easy to make friends and there was a nice group of mums and kids and a really good school and, yeah, that's what kept us around really, is the community. And the fact you can go to the beach after work.*
>
> *CAWH-19; family member*

As the above participant describes, the scenery and lifestyle were things that helped encourage them to move and also to keep them there. Staying was impacted by the community and the asset that welcoming communities can be. This reflects wider rural geographical scholarship, where close, tight-knit communities can be a positive thing. However, for HCPs, particularly those working in general practice, as we have attested elsewhere (Maclaren, 2022, personal communication), being known by and knowing the community can also be a challenge. The GMC, for example, recommend that doctors should 'wherever possible avoid providing medical care to yourself or anyone with whom you have a close personal relationship',[86] but in small rural communities, this is not necessarily possible and can be something that affects recruitment or retention of healthcare staff.

The nature of the local environment also raised some context-specific issues. Areas popular with tourists may benefit from the infrastructure that comes with tourism – for example, bars and restaurants, employment opportunities, better shops – whereas other remote communities might be less attractive to such tourism and so feel more economically depressed, with fewer resources and things to do. On the other hand, tourist areas in our sample suffered from high

house prices and second-home ownership. A lack of affordable housing was a persistent theme in all our sites. Indeed, in very small communities, a shortage of housing – affordable or otherwise – can mean that local people may spend the winter living in unused holiday lets and then, in summer, find other temporary accommodation, including tents and caravans. For many of our sites, local community lynchpins and word of mouth were often integral in finding places for healthcare workers to stay in both short- and long-term arrangements.

A report from Scotland's Rural College (SRUC) has recently documented the housing issues in very remote mainland Scotland and the Scottish islands.[87] They note that house price inflation has been greater in these remote areas than in urban contexts, driven by second-home ownership, and that high proportions of second and vacant homes are a persistent problem (13% in islands and 11% in very remote mainland locations, with up to a third of all housing stock taken up by second homes in the worst affected areas).

While limited transport links were a common challenge, there was considerable variation, with island communities at one end of a spectrum. Island communities might appear to be 'too small' to justify an on-island medical or nursing presence, but an occasional visiting service or expecting islanders to seek care on the mainland or a neighbouring island can be unreliable strategies given limited and fragile transport options. The SRUC report notes that even islands with an airport frequently experience higher rates of flight cancellations than other parts of the country, and that very remote mainland communities are heavily dependent on private cars, in the absence of public transport.[87]

Island communities in our study were dependent on ferries, which can be infrequent or have timetables that do not align with onward public transport. Ferry timetables are at the mercy of both the weather and commercial decisions about cancelling or withdrawing services. This affected both recruitment and retention and also underlined the importance of local care provision, given the difficulty of reaching the mainland. Participants described the importance of access to and continuity of care in preventing ill health, spotting issues arising before emergency treatment is needed, and supporting longer-term health outcomes, for example, proactively supporting people with long-term conditions. They also noted that the availability (or not) of regular health care was an important factor in wider community sustainability, specifically in encouraging people to stay living in a particular place.

The availability or lack of employment opportunities for other family members was another common theme, one which played out differently in the various sites. Smaller communities might have fewer job vacancies but benefited from close informal networks that enabled local people to recommend options to incoming families and put them in touch with prospective employers that might not be possible in bigger, more impersonal communities. The increase in teleworking and working from home, combined with availability of reliable high-speed internet access, certainly helped in some cases, and there were examples of partners continuing existing employment remotely, or, indeed, community members moving to an area because of increases in home/remote working even prior to the COVID-19 pandemic.

Similarly, schooling was more of an issue for some communities than others, particularly at secondary level. In our previous study of doctors' motivations and preferences with regard to remote and rural working, children reaching secondary school age was often a tipping point at which doctors and their families decided to move.[47] At the same time, small local primary schools could be a real asset for attracting healthcare staff with families. One family described how they stayed despite the job not being particularly satisfactory, because their young children had such a good school and friendship group.

Child care for younger children can also be a challenge, as one participant described:

> *The biggest compromise for us, as a family, is lack of childcare. We don't have family in the village, there is no outwith of school wraparound care, our daughter is in primary school. So throughout the whole time that my wife and I have been together, I've been fortunate that my employer in my previous career was incredibly flexible. Now I work for myself I've got complete flexibility, but we were both very career-driven. . . . It is the flexibility of my job now, my role now, my company, that enables us to stay here and raise a family.*
>
> *CAWH-12; family member*

Clearly, some of these challenges were not within the power of communities to address, for example, the presence or absence of a secondary school or, indeed, the availability of housing stock. Many solutions to issues experienced in rural communities, particularly around health care, need to come indirectly from other arms of government, local and national. Nonetheless, communities can showcase the assets they do have.

Some assets may be easier to recognise or describe than others, such as an excellent primary school or good shops and restaurants. Others may be more difficult to articulate, such as close, welcoming communities; the quality of a landscape or the wider phenomenological experience of living and working in that rural community; yet these aspects can often be the things that make people stay.

The types of initiatives we observed in our case study sites and the ways communities actively presented and used the assets available to them took on many guises and extended into more everyday social relations and connections that rural places are often seen to have. Community action and involvement in recruitment and retention can be roughly categorised as follows:

- Stakeholder campaign groups
- Contributing to job adverts
- Promoting the area as a good place to work
- Making a video
- Social media campaigns
- Collaborating with neighbouring practices
- Help with sourcing housing and practice buildings
- Organising or contributing to pre-application visits
- Sourcing job opportunities for partners
- Social navigation and buddying – introducing new people to local activities, clubs
- Informal social integration

These categories have formed the basis for our 'library of examples' (see *Appendix 1* and https://learn.nes.nhs.scot/73640), which draws on both our case studies and wider examples we have encountered during the course of research.

In our case studies, the spur to action was often a failure to recruit a HCP by the local NHS organisation and frustration from the local community with what they perceived as a lack of action and energy by the NHS organisation in pursuing the recruitment process. Sometimes they felt they had to work through a degree of conflict and hostile meetings to get to a point where they could work together, with the local NHS organisation accepting help and suggestions, and community members agreeing to support the NHS. One community described a tense public meeting, at which the community complained that the job advert 'was a miniscule thing about an inch big and it was really pathetic'. A local NHS manager told the community, 'Well, if you think you can do any better, you do it' and offered a small budget. A community member with a background in advertising took it on, and a local councillor talked about it in a radio interview, which led to national press coverage and attracted applicants.

In another community, the threat of a GP practice closing led to a well-attended protest march, but this evolved into the formation of a joint NHS and community working group. The community developed a video campaign which attracted considerable national attention and led to successful GP recruitment.

Communities drew on the expertise of residents with film and photography skills, design and marketing experience, and used connections and networks to raise awareness of the advertised post in the media. The following quotation describes another locally led example which led to national TV exposure:

> *So that's when we sort of came up with the idea of why don't we just create our own campaign around this? I've obviously got a background in doing this, so we just created a very simple campaign and deliberately made it to look like 'the yokels of [community] need a doctor', but we made little posters saying 'Wanted, GP!' or whatever, I can't remember what the wording was. I went round and took photos, as if we'd put the job adverts up in some of the most idyllic areas, with some turquoise sea in the background or gorgeous mountains in the background or whatever, and we first off sent them out as*

> *press releases to all the press contacts we had, but we also did an organic Facebook campaign. We didn't have any money for this so we couldn't do paid ads or anything, but we just did organic and basically I went and searched Facebook groups where I thought there was a correlation between doctors and the type of people we could imagine wanting to live in [community]. So we basically targeted outward bound type people, we targeted sailors, walkers, ramblers, I can't remember . . . I just went round as many of these groups on Facebook and posted a picture with a job ad and just said, 'If you know anyone who might be interested in this, please forward it on to them', it was as simple as that.*
>
> *CAWH-08; community member*

One community used the area's attraction as a tourist area to have a section in tourist promotion material to encourage visitors to think about potentially moving to the area for work. As a GP now working in that community said:

> *I'd always loved [community], since I moved up here it's been a happy place to visit and in my head I always thought this would probably be the place where I might want to work.*
>
> *CAWH-20; GP*

Communities might also get involved in interview panels, helping organise pre-application visits or preparing information packs for applicants.

> *Yes, we were involved in the interviews, and I just made a spreadsheet of each of the doctors, the medical qualifications, which I didn't know anything about, so we weren't really judging on that but just the status and what their interests were, just . . . I don't know if you'd be allowed to do that these days. Family etc. etc. etc. And then we went through that as a community council and chose, had a list of ones we thought were suitable to come here. . . . I think we did our list of preferences, and then we passed it on and then the candidates were invited to interview. And myself and the then chairman of the community council, we went to the interviews.*
>
> *CAWH-01; community member*

Organising visits, either as part of the application process or after someone had accepted a job, helped make applicants feel welcome and provided an opportunity for the community to establish their needs and interests to make the transition easier. This could include advising partners or other family members about local job opportunities, explaining the local housing market and introducing them to local schools. One GP recalled how proactive the community was in helping them look for accommodation:

> *I was really impressed with how helpful people were. So, for example, one of the GPs here goes along to the community council meetings and she was keeping them updated and she put the message out that [another new colleague] and I would need somewhere to stay and all sorts of things have come out of that, actually, and there's still things come up and the admin staff will say, 'have you seen this house is for rent?' That sort of thing is still happening. Maybe I was particularly impressed with the community council, because it seems to be very well functioning here . . . The place that I'm staying now . . . I think that probably was through the community council but you sort of forget after a while because it's word of mouth and all sorts of ways that messages get around and Facebook and yeah, so I'm not sure, I think it probably was through the community council, and em . . . yeah, certainly went and had a look round a couple of different places, and a friend also had connections with another friend. So it's been, yeah, a bit of the community council, a bit of word of mouth, and that's working about absolutely fine, for now – a little bit chilly! But it's fine!*
>
> *CAWH-20; GP*

At a more structural level, our case studies included examples of working with a GP practice in a neighbouring area to encourage them to take over a single-handed GP practice when the GP was retiring, community buy-outs of practice premises and finding properties or negotiating lower rents for incoming key workers.

In some instances, the initial recruitment campaign led to wider community engagement with the local NHS or GP practice to discuss other local healthcare challenges and how communities could help solve these issues.

> *We were invited to a meeting. Well, we were basically asked what we wanted and we said that we wanted to know the problems, 'Confidentially, we want to know the problems in our town and how we can help as a community'. And the ten*

> *of us, as representatives of our community, attended the meeting with all of the other service providers, including the ambulance service, child services, adult social care, our GP, the hospital, er, care companies – everybody to do with health and wellbeing, we invited them to a meeting. And it kind of went from there. Whereas, the NHS would come and say, 'Well, you know, nobody's using our health service correctly. They're just going straight to hospital with something where they should be going to the pharmacist'.*
> *So, we said, 'Well, let's re-educate them. Let's do a step-by-step guide . . . ' – which one of our team created, of how to use your NHS facilities. And it was, you know, the first step is, you know, see what's in your cupboard and use what's there. Second step is go to your pharmacy. There's a pharmacy scheme. The next step was go and make an appointment with your GP. The next step was 'Do I need to go to A&E?' And we worked with our pharmacy and schools on providing lots of information on how to use your NHS services correctly. And that reduced, I believe – I'm just trying to think off the top of my head – I think it reduced admissions to A&E by 25% and to the GP's surgery by 35%. So, it worked.*
>
> *CAWH-02; community member*

Although this was not directly related to recruitment or retention, alleviating pressure on services and reducing workloads could indirectly help encourage practitioners to stay.

In terms of retention, much of this was less about deliberate actions and more reflective of everyday life in tight-knit rural communities, where, in positive instances, people are welcomed and become part of a community through a cascade of social connections. In some of our case studies, this just happened informally through invitations to coffee or dinner, or to come along to a community activity, a playgroup or a sports club; whereas, in others, it was to some extent a more active and intentional process to help find people with shared interests. These examples are explored further in our chapter Social navigation: from moving to staying. Even in these more active cases, however, those involved tended not to think of what they did as an intervention as such but, rather, just what anyone would do.

> *I don't know how widely used it is, my father used to say if you did anything good, constructive or helpful for other people, and he was thanked for it, he would say, 'no, no, it's just enlightened self-interest', because he could see that in the future, it would be good if he'd done this and I guess for all of us to have skilled and happy and contented health staff in our area, that's enlightened self-interest. So I just feel if you put stuff into the social fabric of the area that you are in, it comes back to you and everybody else.*
>
> *CAWH-18; community member*

When prompted by a question about the amount of work involved in one particular community project, this person acknowledged it could be 'laborious'.

> *What it involved was persistence and going to meetings again and again and again and cultivating contacts and networks. So I guess that's the work of it, it's 'do I want to go to this bloody meeting?' That's the laborious part of it, but if you are kind of gregarious, like me, then it's also fun.*
>
> *CAWH-18; community member*

Yet we observed clear differences between sites, with some apparently paying little attention to helping newly recruited healthcare workers feel integrated. This would suggest that some communities in our sample had cultivated a more actively welcoming culture than others, and the norm of 'just what anyone would do' is not universal.

These initiatives relied on people as assets: people who would be willing to make connections to facilitate those who have moved to settle; willing to take on responsibility of helping with recruitment campaigns and the associated skills to augment a recruitment campaign, or meet with an NHS board and mediate relations between a community and NHS administration. Place was also invoked as an asset, where we see communities mobilising their attractive idyllic qualities, encouraging people to think about moving in local tourist information on a place, or as the backdrop to a recruitment campaign showcasing blue skies and sandy beaches.

In the next chapter, we go on to explore how community-led recruitment campaigns unfolded, the power relations involved and the distribution of labour and responsibility.

Chapter 5 Power, responsibility and labour

In our case studies, community-led action in our case studies to encourage healthcare workers to move to an area was often borne out of an initial period of frustration and tension with local NHS authorities, arising from a failure to fill a vacancy or decision to close a practice.

> *I think I was one of the more incredulous voices on the council saying 'hang on a minute', this is extraordinary, we're advertising – or a job is being advertised for, which – in one of the most beautiful places in the United Kingdom for what is probably the highest paid job on the island. And actually, you know, I know I've got other friends who are GPs elsewhere, and if you are a GP, in lots of places you are under phenomenal pressure, you've got tens of thousands of patients who you struggle to keep on top of the workload, and obviously in [community] you have a very small community. Now, there are obviously clearly other challenging issues that we've talked about but, to me, it looked like a very, very attractive offer. If I was doctor I'd be thinking 'well that would be an interesting option to pursue', so I was slightly amazed that we weren't getting anyone and I think part of that was just probably that the fact that the ad was just positioned in the wrong place.*
>
> *CAWH-08; community member*

Typically, community members felt that the NHS was not trying hard enough to recruit, and that a more proactive approach was needed, but they often felt side-lined and that their suggestions were not listened to or were actively dismissed. Communication problems and a lack of genuine two-way communication was a common theme, as this community member describes.

> *In 2015, I think it was, the life of the previous community council came to an end and not enough people stood for election and we had, we set up a [community] Healthcare group and we were trying to persuade NHS [organisation] to listen to us and do something about the situation, and it just wasn't . . . the plans were terrible, they were really awful. . . . They hardly paid any attention to us at all, we weren't a recognised body of any sort. So . . . a bunch of us put our names forward for the community council and they did start paying more attention then. We were a recognised body. And so that helped matters. But our argument has always been with the hierarchy, not with the people on the ground trying to do their jobs in very difficult circumstances. [The staff] were stuck between a rock and hard place.*
> *The internal communication in NHS [organisation] was appalling – it still could be, I don't know – but it certainly was atrocious and [laughs] I remember somebody in the housing association saying to me, 'I don't mind, I'll speak to the cat if it'll get the work done'. In the NHS you've got to go through layers and this one several layers up or several layers down. There's ways of doing things that just block everything, it stops the work getting done.*
>
> *CAWH-05; community member*

As the above extract illustrates, often people felt powerless as individuals, up against a large bureaucracy. In this case, they achieved a degree of collective power by standing for election to the community council (which was, in effect, revitalised because of the staffing crisis).

In the next example, a husband and wife from another community identified a combination of feeling powerless but also being landed with the responsibility as volunteers to do something themselves by a range of public bodies. Another common theme illustrated by this extract is the sense that NHS organisations were remote from the community and the realities of rural life.

> **Community member (husband):** *We get that a lot with the [name] council, with the [name] council: 'You do it'. That's not what we're here for, that's what you get paid for – we don't get paid, we're volunteers here. And we get that a lot with a lot of other things, highways, street cleaning . . . But with this, yes, communication was very lax from the [NHS organisation]. They were making decisions without consultation with anyone. I mean, to be honest, when they first said it, when we came out of that band hall, I thought, 'That's it, we're going to lose the doctor'. . . . We've got an ageing population in [community] and what the hell are they going to do?*
> **Community member (wife):** *We put all these arguments to the [NHS organisation] as well. No bus links, ageing population, people don't drive, we gave them the whole works but they kind of went, 'Oh well, dispersal'.*

> **Community member (husband):** *They said you can go to [name of town] surgery. How the hell are they going to get to [town] from [community]?*
>
> *CAWH-15 + 16; community members*

Another person from the same community also emphasised the lack of realism about transport challenges.

> *Now what? So 1500 hundred patients suddenly in a socially isolated rural demographic with just two buses a week, an expensive train that's unreliable. Taxis? Don't even think about it, you are starting in two figures straight away for a taxi to anywhere. . . . So we need a GP and it has to be in the village.*
>
> *CAWH-14; community member*

In a further case study site, the stand-off between NHS and community was only resolved through the intervention of a clinical manager, who recognised the value of listening to and involving the community.

> *I think if we didn't have him [Clinical Manager] go 'Do you know what? We need to think about what they're asking and what we can achieve by bringing them in' and opening his eyes . . . He was very respected within the NHS. . . . He talked everybody into 'Let's just have a meeting with them and see where it goes from there' – and eight years on, we're still having these fantastic meetings. But if it wasn't for him instigating it and saying, 'Let's go with it and see how far this goes'. But it's borne on trust. We had to trust them because we didn't – they had to trust us that we wouldn't go to the public and tell them, you know, the real bones of what the problems were and deliver it negatively. That was their caution. But we decided that we would work together on the comms. For me, there's still the biggest problem in the NHS is communication. And this is where communications are really important. And honesty within the NHS. We need to know where they're struggling, why are they struggling, how we can help them. And before, that wasn't there. We didn't have an understanding of the problems, so they need to be more open and transparent, and we'll work with them.*
>
> *CAWH-02; community member*

Occasionally, we heard that community members suspected that failure to recruit was not simply because of a lack of effort on the part of the NHS, but it was being used as a convenient excuse – or deliberate ploy – to reorganise service provision and save money, again often by people who the community felt did not have sufficient on the ground knowledge of the local context to appreciate the impact of their decisions on the health of local people or the wider sustainability of their community. Some questioned whether changes made would, in any case, save money or rather lead to new additional costs.

> *And they were trying to cut down the service and centralise everything and we resisted. And amazingly we got where we did. Even when [healthcare staff] were only coming over for the day, you lost continuity. . . . They didn't know the basics of the community, they'd know the one or two people that they were dealing with, but not everybody else. So if something came up, they wouldn't have any background on that person that a resident would have. It was, it was . . . it wasn't even efficient because people were having to, for example, stay overnight in hospital because there was nobody at home. And the lifeboat was getting called out, on a fairly regular basis, because if anything came up and somebody needed attention, there was nobody in place to say if it was serious or it could wait until the morning.*
>
> *CAWH-05; community member*

In the following example, the disagreement resulted in a challenge from the NHS to the community to do it themselves – echoing the 'you do it' phrase mentioned above (from a different case study site).

> *We did have a succession of locums and in the meantime the health authority were saying, 'Well we're just going to take the doctor away and we'll send somebody over a couple of days a week from [another community], so you won't have a doctor anymore', so that caused trauma and horror all round. . . . We had public meetings, and said that we weren't happy . . . But the health authority at the time was saying, 'Well you know, it's really difficult to get doctors and GPs, they don't want to come', blah, blah, blah. So during the course of one of the public meetings – there's another little bit to this because, when the job was advertised (and I think I kept copies of the advertisement, although of course it's all in*

> *the community council records) it was a miniscule thing about an inch big and it was really pathetic . . . So when we had another public meeting . . . we pointed out the fact that we didn't think that their campaign to get a doctor had been very good. By this time we had all these letters from all the other doctors and other health people saying [community] needed a doctor. So at the public meeting, I said that – 'what you've done is not good, it hasn't been good enough'. So [NHS Manager] said to me, or to us, 'well if you think you can do any better, you do it'.*
>
> *CAWH-01; community member*

From these initial stand-offs and sense of powerlessness, events went in varying directions, with some communities taking back control and running the campaign themselves, and some negotiating to exercise control jointly with the NHS. The NHS, meanwhile, could be a willing, grudging or absent partner. In one site, at the more community-driven end of the spectrum, after repeated fruitless advertising in an 'old fashioned medical profession journal' which 'almost has cobwebs', the community council mounted its own social media campaign. When asked if they got NHS permission to run their campaign, a community member commented:

> *I can't really remember, I'm sure we would have spoken to them about it saying 'Would you mind if we do this?' I think it was about as much as that, I think it was just out of politeness. It was basically me and [another community member], who you've spoken to. [She] has got a background in marketing, I've got a background in marketing, actually I don't know if [she] was on the community council but the two of us just saw the opportunity so we just ran with it. But we wouldn't certainly have done it without the permission of the community council, and that would have meant that the authorities were aware of it. But having said that, I think we just ran with it, there weren't any sign offs or anything like that, we basically went and did it.*
>
> *CAWH-08; community member*

Communities had differing levels of existing organisation they could tap into. Some already had well-developed and active community councils, as in the example above, which were able to step up and add healthcare recruitment to their priorities. In other cases, a specific action group was formed. In the extract below, a community meeting was held which led to the formation of such a group.

> *There was about sixty people that turned up and our local MP [name] chaired the meeting . . . And then there was ten people that stood and said that they would help . . . None of us really had a background in anything to do with the NHS – so we weren't nurses or doctors or anything like that. But we were really strong community voices that I think people respected. . . . It now has a more positive voice rather than being an action group – where it sounds like we're attacking the NHS. We've never actually done that. We just wanted the . . . the truth from . . . from them.*
>
> *CAWH-02; community member*

Action ranged from highly purposeful, intentional campaigns to something more emergent and serendipitous, or smaller actions to augment work done by the NHS, as illustrated in the previous chapter. Advocacy for their community was central to each case study site's actions, described by one person as 'enlightened self-interest'.

The role of key individuals is an important theme in our findings. The nature of small rural communities is that individuals often fill several voluntary and paid roles, and there exists a network of intersecting relationships and influences. The person who does shifts in the community shop or volunteers to drive the community bus may also write the local newsletter, teach part-time or serve on a local council. This can include healthcare workers themselves – for instance, in one of our sites, a part-time healthcare practitioner was also self-employed as a tradesperson owing to the need of the area.

The extent to which one or two individuals drove recruitment action, or whether it was a more distributed activity among several community members, varied substantially. In addition, interviews suggested that in some cases the role of particular people was variously interpreted, disputed or resented, as well as praised and given credit as a determining factor. Thus, tensions existed not only between community and NHS authorities but also within communities themselves, with some key powerful individuals occasionally operating in a siloed or exclusionary way. This may have led to a degree of gatekeeping over access to potential interviewees for our study and/or a reluctance to be interviewed in some instances.

Community member: *Everybody has got something to offer, that's the way I look at it. Everybody has got something to offer. . . . But obviously some people are more forefront, aren't they, and more – and I found that quite tricky sometimes because I tend to sit back if that happens and I just do my bit quietly, if I can, if I've got something. Because when you are in a working environment and you are working with the people you know, you can read each other, you know what happens and you know . . . but when you've all come in at different levels kind of thing, it's just really tricky, you've got to be really careful and for it to work well.*
Interviewer: *And did that lead to clashes? I mean I know you said there . . . ?*

Community member: *Yeah, yeah, yeah, yeah, yeah – there were clashes, yeah, yeah.*

Interviewer: *And what would they be over?*

Community member: *Just – the way I felt about it, sometimes if . . . you know, so you try within the group to play within your strengths, 'you do that, you do that', so then you kind of think, 'well I've been told to do that, so I'll do that'. But then 'I didn't know you were going to do that. You didn't ask me!' And if you delegate something, you are just used to doing it, getting on and doing it, you are not going to go and ask them and tell them every five minutes where you are up to and what you are doing. So yes, I think when you've got somebody out-front that is very, very forceful, that's tricky, that's tricky. It's going to sound awful now, but . . . after a while it sometimes grates, it grated a little bit and then that would cause trouble with me because I'd be trying to counter it a little bit. . . . But at the same time, you've got somebody like that who wanted to lead the group and blah-de-blah and she had all the energy. And that's what you need as well. So you need that but it just, you know, it just makes it a bit difficult sometimes. And without that kind of drive and energy, then things might never have happened. So you need it all, it's just hard.*

. . .

It was quite a strange mix of people, it was like not people you'd particularly gravitate towards, usually, and that was challenging sometimes. That was definitely challenging. But you've got to get over that, haven't you, and just do your best.

CAWH-17; community member

The NHS professionals could occasionally find themselves caught between the community and the NHS authorities. In one case, where a GP practice from a neighbouring area was collaborating with the community to take over a practice from a retiring GP, the primary care team in question talked at some length about the bureaucratic hurdles they had faced in trying to negotiate this. To them, it seemed as if there was active resistance to the takeover plan.

Practitioner 1: *So nobody actually had gone any further with an application to take it on, to buy it, and at that point the Local Medical Committee were involved in a local Save our Surgery meeting, with [local NHS organisation]. We weren't involved in that. But after that the executive from the LMC, he was the only person to vote against closing the practice and to see that there could be another way. And at that point, e-mails went out to anybody who wanted to show an expression of interest and we were the only surgery that was. Because we did feel very much that, geographically it was right, but also socially and morally it felt wrong that that area, a lot of poverty, fuel poverty and a lot of inequalities of health and access to health, just no transport plus.*
Practitioner 2: *And no pharmacy.*

Practitioner 1: *And no pharmacy. We just felt maybe we should try. So, because we'd been contacted by the Save our Surgery group, where the LMC were involved as well, on the group, we had a very short time to put our expression of interest in and we were the only ones. And then after that we had to go through the application progress [sic] which nearly killed me because the [local NHS organisation] didn't want it. . . . The application process was outrageous, as far as I was concerned, because they just didn't want it to happen and I presume that was because of money. . . . If I'd not had a background of medical secretarial and PA work there's no way we'd have succeeded with the application because they we remaking us jump through so many hoops and having to do so many things. But at that point then, I said, 'Well no, if we're going to do it, we're going to do it – and do it as well as we could'.*

> **Practitioner 2:** *I think it was the bother of it. The bother of . . . and also, as we found out, when – taking it on, this particular practice seemed to have been run down and I got the feeling that they really, well, they all voted to close it, so they, they didn't – the only reason that I could think of was because that they would save money by dispersing the list and less hassle. And as things progressed, I found out, things that I assumed or was led to believe were happening, weren't happening and it was absolutely hideous. The whole process was awful. And I wouldn't want to go through it again and I would not advise anybody else to do it either. It wasn't worth it in terms of our sanity. But we did it. And we gladly did it.*
>
> *CAWH-21 and 22; HCPs*

This particular pair of interviewees felt the community group did not really appreciate the amount of labour involved for the primary care team, without which the community campaign might have come to nothing.

In some cases, people reported community action that included a financial cost to individuals, whether this was agreeing to set aside rental properties for local workers rather than tourists and keeping the rent low, or putting up capital to purchase premises. While this may have worked for some communities, it is clearly not something that could be generally transferable; not every community can expect a philanthropist or investor to step forward with sufficient funds. At the same time, wealthy individuals in a particular location might be motivated to support health care as a cause even if they have not previously contributed to community initiatives. In one case, we were told that a series of informal conversations had resulted in the idea of a buy-out taking shape.

One common theme among all the case studies was the serendipity of people with professional skills, desire to advocate and take a lead among the community (e.g. be on community councils or committees of social groups) and an opportunity to use those skills and to take a lead to come together. Not all communities will have these forms of social capital or may be unaware of their existence. One of our PPI advisers, for example, commented on the mostly unrealised potential to tap into the skills and networks of local second homeowners.

In several cases, political actors had been involved in marshalling pressure and resources, both Members of Parliament and local councillors, including the example quoted earlier where an MP chaired a community meeting.

> *Fortunately, . . . our councillor, the next day he was doing an interview for [local] radio . . . and he spoke about the problem [community] was having and what a wonderful place it would be to live, you know, so that was the next day or the day after, and then the national press picked that up and ran a feature on it. And I think [another national press paper] picked it up after that, where we had a three-quarter page feature with photographs.*
>
> *CAWH-01; community member*

> *The MP, me, my [council] ward colleagues and [community member] . . . we met every Friday I think it was, at 8am, just for an hour and we thrashed everything out and I would go away and do my bit, [community member] would do his bit and [MP] would shake trees. We did a parliamentary petition which got presented as part of the health and social care. Hundreds of people signed that. The [local NHS organisation] just, it felt to me that they wanted it to disperse, they just wanted an easy life, just to disperse. And we weren't prepared to let that happen.*
>
> *CAWH-14; community member*

Of course, such political involvement was not always met without cynicism by community members:

> **Practitioner 1:** *We had [our MP] on [the group], he came to the first meeting, and the last meeting for the photo opportunity.*
>
> . . .
>
> **Practitioner 2:** *[councillor] included two other councillors . . . but that was more political, for them getting kudos rather than being part of the group and actually doing anything. Again, photograph. [laughter]*
>
> *CAWH-21 and 22; HCPs*

Community members were often pleased with the results of their interventions and felt it was important for the community to have taken back some power and control. Some thought it was just what any community would do in similar circumstances, and did not necessarily conceptualise it as 'work' that they had to do or as an 'intervention'. But there was also a degree of cynicism about having been put into this position in the first place, and concern that constant vigilance was required to maintain the status quo. In one community, where they had two recruitment campaigns several years apart, there was awareness that what had worked the first time might not be appropriate this time around. They described their remote and rural communities as tough and resilient, but also tired of repeatedly fighting for their survival and the labour that involved, and exhausted by shouting to be heard by NHS and government bodies with little understanding of the issues.

> *But keeping people is the big – as [community member] says, keeping not just [healthcare workers] but keeping all these young people on the island without housing, I mean it's such a big battle in all of this. [Community member], herself, did a power of work to find the houses for [them]. I mean [NHS organisation] didn't find any accommodation for them apart from, without [community member] pushing the Housing Association to buy these houses and lease them. It was all really done by [community member] and the community, not by [NHS organisation].*
>
> *CAWH-06: former nurse and community member*

As noted above, recruitment campaigns may not be a one-off activity; the service model of a single-handed practitioner who stays in one place all their working life is no longer common and people will inevitably move on. Healthcare participants and family members described many reasons why this might be the case, including wanting to be closer to older relatives needing care; access to secondary schools for children; a spouse or partner feeling lonely or unhappy, or wanting to move for their own work; wanting a different professional challenge (pre-retirement migration) or personal lifestyle; wanting to move on from the experience of lone or smaller practice working. The implications of this for retention are discussed further in the next chapter. (At the same time, this can present an opportunity for remote and rural communities to attract healthcare staff with no dependents in the latter stages of their career who are looking for a new challenge.)[63,78]

Thus, recruitment may be a repeated work in progress. In one site, two different campaigns were described to us, several years apart and led by different individuals. It was recognised that for the second campaign, novel methods might be needed, and that repeating the same style of campaign from a pre-social media era might not work in a new context.

Discussion

Our analysis of the origins of community-led campaigns has demonstrated that they often emerged through conflict, crisis and a feeling of disempowerment. Communities took action because they felt they had to, or else lose essential services. In some cases, there were existing channels, such as local community councils which could take a lead, while in others, ad hoc coalitions were formed. Tensions existed in the power relations both between the NHS and the community and, in some cases, within the community, as people not used to working together tried to collaborate on a campaign. Strong personalities and individual drive could be both an asset and a challenge.

Asset-based community development provides a helpful lens through which to understand these findings. There is much that communities can do to take the initiative and use the people-and-place-based assets at their disposal to change their fortunes. However, 'fortune' is an apt word, given that both place and people assets are the result of chance. Literature on rural communities has previously discussed this aspect of places that have 'good citizens' able to step up and organise action.[88] The flipside of the 'good citizen community' is that communities without such levels of social capital, or without an attractive environment to present, might be labelled 'bad citizen' communities and face further disadvantage in the competition for scarce healthcare workforce resources.

The asset-based approach also risks overlooking the substantial amount of labour, responsibility and management of risk that is here being passed from the state to individuals – even if those individuals agree or actively seek to take on such labour. Reliance on a small number of key people may prove unsustainable and make it harder to hand back

responsibility. Furthermore, there are many essential assets, such as housing, schooling and employment, which cannot be addressed by communities alone.

Many rural communities have been labelled resilient, or seen as examples of being resilient because of their capacity to adjust to external shocks, whether economic, environmental or social change. This capacity relies on the assets, often, that a community may have. Magis proposes:

> *Community resilience is the existence, development, and engagement of community resources by community members to thrive in an environment characterised by change, uncertainty, unpredictability and surprise. Members of resilient communities intentionally develop personal and collective capacity that they engage to respond to and influence change, to sustain and renew the community and to develop new trajectories for that communities' future. (p. 402)*[89]

Within the context of challenges associated with recruiting and retaining healthcare practitioners, this might present another opportunity for communities to exhibit resilient characteristics. However, we would advocate caution around the language and use of the concept of resilience. MacKinnon and Derickson, citing Peck and Tickell, argue that a focus on resilience can result in giving communities responsibility without power.[90] MacKinnon and Derickson propose an alternative concept of 'resourcefulness', developed in collaboration with community members in the Govan area of Glasgow, as more a more bottom-up approach focused on social justice and challenging power relations.

> *Resourcefulness is meant to problematize both the uneven distribution of material resources and the associated inability of disadvantaged groups and communities to access the levers of social change. In this sense, a politics of resourcefulness attempts to engage with injustice . . . [and] to develop contestable alternative agendas and work in ways that meaningfully challenge existing power relations. (p. 263)*

Communities cannot be seen as the sole drivers of change or engines of success for basic service provision, including health care. Their efforts cannot replace the need for structural, political and organisational drive to maintain service provision for people living in remote and rural communities. Our examples have shown what communities can do and how they can help, but for each success or 'good citizen' resilient community, there are examples which have not had the same successes. This reflects a need for higher-level policy support and redistribution of resources, rather than continuing or perpetuating neoliberal rollback of state provision, under the guise of enabling communities to show resilience.

Chapter 6 Social navigation: from moving to staying

In all our case study sites, new staff were recruited – in one case, by encouraging a neighbouring practice to set up a new branch surgery with a new salaried colleague; in other cases, by direct recruitment. However, in some cases, the person or people recruited left after a while. As discussed in the previous chapter, this is, to some extent, inevitable. For personal or professional reasons, people may choose to leave, and retirement must also be factored in. This raises an interesting question of how long someone needs to stay for it to count as 'retention'. Some remote communities have had considerable success with shorter- and longer-term locums on rotation (e.g. see the Rediscover the Joy of General Practice scheme www.srmc.scot.nhs.uk/joy-project-2/),[91] people splitting their time between remote and urban practice (www.orkney.com/news/nhs-orkney)[92] and/or recruiting people in the later stages of their career who are looking for a new challenge.

Thus 'staying' is a flexible concept, and some people may stay for relatively short periods. While the community might prefer long-term stability and continuity of relationships, and both the community and a practice or hospital might prefer to avoid the labour of a new recruitment campaign, fresh recruits may also bring useful experience from other areas, up-to-date training and new enthusiasm to take on the challenge of rural practice. The issue is making sure there is a suitable pipeline of HCPs to fill these gaps.

The following extract illustrates how one GP was encouraged by a friend living in a remote coastal area to consider a late-career move:

> *So what happened was, I was very happy in my old job, bumping along . . . I guess there were many nudges. There were some very personal, some wider professional. . . . So earlier this year there were a number of things that probably came simultaneously, one was that I turned fifty. Always a powerful catalyst and actually, probably genuinely, it does make you suddenly think, 'Wow, I've got fifteen, seventeen years left of my career, what do I want to do with that?' And that was probably quite a powerful thing, actually, if I think back to what turning fifty meant, it probably meant asking myself some professional questions about what I wanted to do. The second catalyst was, I've got some friends in [coastal village], so one really good friend, she's a really good pal and she's stayed with me and husband quite a bit, so we know each other really well and I often try and catch up with her, not as often as I liked.*
> *So she sent me the job ad, via a Facebook message, saying, you know – smiley face, half-laughing, 'How about it?' And I was then over for a night out with her and some of her mates in [coastal village] in the pub, some of her mates said, 'How about it?' And there was just the real sense of friendliness actually, from her little group, circle of friends, lots of people who kind of said with a nudge and a wink, 'Oi, how about it?' I'd also been with my friend, she'd invited me over to do, to [get involved in a sport team], and I'd been out once and we'd just had a hoot, just a great time, an absolute hoot, none of us very expert at all but it was just a great day and we had a picnic, ate a lot of cake and then came back and had a good laugh. And I stayed on that WhatsApp group of that little circle of people and so I guess there was – so there was genuinely a community, just a sense from me of a really positive community feel there, and a lot of people making me feel, actually if I applied, that would be a really nice thing. So that was a driver. So, I guess the idea was popped in my head with my friend. . . . So then I was in a slight quandary, because I really enjoyed my job, but there was also a growing sense that rural communities were really struggling with recruitment . . . And then I met the other GPs there and it was just really friendly, really welcoming. So yes, I jumped.*
>
> *CAWH-13; GP*

The above extract neatly illustrates also how these welcoming foundations were laid through the serendipity of personal connections, before a vacancy arose and before the person had even considered moving, but generating a feeling that this is somewhere one might want to stay.

We identified a number of ways in which communities took steps to encourage new healthcare staff to stay. By being involved in the recruitment process, sometimes formally and sometimes informally, the community could make people feel welcome from the start, but also express their views about suitability.

Interviewer: *As I understand it, I think one of the community members was on the interview panel and I guess was that something that was normal in your experience of other jobs or, how is that, knowing that the community were part of the recruitment side of things?*
Doctor: *I think it was quite an attractive feature, I think we were aware from the media that the community had sort of led . . . but there were a couple of the very active community members were there and they were very impressive . . . whatever points we raised he [community member] was 'well, they'll be sorted', not 'this can happen, this can't be sorted'. It wasn't necessarily the case that it could be sorted but the general upbeat feeling and the vibe of the community being very involved and you know, it was perhaps maybe another protection as well, that the community really bought in to the whole process, that if we did get the job we'd be guaranteed a welcome that, going in the more usual channels, who knows what the community might think of you? But because it was really the community that had had a lot of say in who was chosen as well, I think their voice was heard very much and who they went for. We felt that that was another reason to go for it, comfortably, really expecting that you'd at least get a reasonable welcome, when you'd got – it was the community themselves that had sort of chosen.*

CAWH-09; GP

In one case, GPs from a neighbouring practice were invited to take over a local surgery, and their existing commitment to rural practice was a key factor.

Community member: *It's one thing having a dispensary and a practice with a doc and a nurse, but if they are not very good, and if they are not very good with people, and they don't 'get' a rural community, it's pointless. So not only did we secure a practice and a GP, we've got a bloody good one, who gets rural communities. . . . I think their mantra is something like 'we are a traditional rural GP with modern methods', so they will do home visits. They've got a Land Rover or equivalent to get.*
Interviewer: *Yeah, yeah, to the country roads.*

Community member: *Exactly. When they retire, which bless them, they long since should have done, because they've done their stint and they are of retirement age, but they love their job, they must be mad to take this on, but they have. But when they retire, my worry is their like go with them, with their retirement.*

CAWH-14; community member

Even so, there was still the challenge of finding the right person (or family) for the right community at the right time, including demographic factors which might be beyond the community's control, as two contrasting examples from an island community highlight below. In the first example, the family eventually left after 5 years, though they reflected on the warmth of the community, and the role of external pull factors in their eventual decision they could not stay.

General practitioner and wife recruited in 2000s

Wife: *I think in some ways it wasn't quite as inclusive as I hoped it might be as a community and at times I felt a little bit isolated but I think being the GP's wife and the GP knows everybody, I think people assume – not that he told me anything – but I think people maybe assume you know their medical secrets. So that side – sorry, it's going away a wee bit from your question – but it wasn't maybe as easy to get involved in the whole community as I thought it might be. In that way. But within sections of the community, it was very easy and very welcoming, the music side of it and the group of – the people that we'd have met anywhere, us getting on with, are people, like-minded people that were easy to get on with. The things that were . . . I obviously met other families through the school, the school at that time were very, very small, so there weren't that many other parents to meet up with at the same stage. And was actually . . . that turned out to be a little bit of an issue for us going ahead because [our daughter] was the only girl at that time in that small class that she was in and didn't maybe quite have the capacity for friendships that she might have had in a larger place. Everybody was lovely, the other families were great, but there was a wee bit of feeling like the outsider at times, in that way, but not intentionally, not that they tried to make you feel that. I remember her coming home from school one day, and she was in primary two or primary one and she comes and she says, 'that's not fair, I'm the only person in my class that can't drive a hill machine', that's the kind of background the kids were from, the range of families and what have you, it's that feeling like the townies*

was quite a strange experience for me because I'd spent most of my life feeling that I wasn't a townie and suddenly I was, we were the ones from the big city, that saw things in a little bit of a different way.
GP: *There was a . . . a demographic of young crofters maybe in their twenties, pairing up and thinking about having babies and there was a lot of folk out and out middle aged, fifty, sixty something, couples that had come over maybe in the 70s, 80s, maybe more to do with the church and such. But there in that kind of middle lot, the thirty-somethings with the young kids, just a little bit of a gap in the market at that time, but something that couldn't be helped, the demographics . . . I think had we come a little bit later, [the island] is back in a big bumper population now and when we've been across again in the last few years for socials or for the music festival or whatever, we've sometimes got almost envious that there are so many little girls around and the primary school is full now, and we do think if we'd just got a bit luckier demographically, that [our daughter] might have had an easier time of it.*

But I think the general overall warmth was something great. . . . Had there been a slightly bigger community, a more . . . more professional type teaching couple, pharmacists or physios, whatever that sort of bods, in that sort of group, in our sort of age, it would be a wee bit easier yet. But I think the overall warmth certainly made up for most of that. Folks really seemed . . . you talk about 'they couldn't be nicer', and I don't think they could have been really, it was great.

Wife: *No, I can't think of anything that they could have done. The things that took us away, it wasn't anything to do with what the community was like, it was a pull rather than a push that really took us away and the things that were tricky, like the schooling etc. I think we would have managed them somehow or other, we would have adapted and managed them if it hadn't had been that we were getting a pull [elsewhere] for family reasons, then I think that's fair enough to say. Like there was enough that kept us there, how we were being treated and amongst the community, how we felt welcomed in the community and what the island itself had to offer, I think we would have quite happily stayed there for quite a lot longer. But there was really a pull from Edinburgh, I can't think of anything else the community could have done. That would have made any difference.*

CAWH-09 and 10; GP and partner

In the second example, a combination of community actions and demographic factors resulted in a completely different family experience. As the participant describes, having been on the receiving end of a warm welcome, she then tried herself to do the same for new arrivals. She and her husband have now been there over 10 years.

Wife of doctor recruited early 2010s

So, I think, [my husband] came here for his interview without me, because I'd just had a baby, so he, I mean it started literally from – I mean it's different now but the hotel was at that point run by a couple who had a small baby who was a little bit older than [our daughter], so literally from the second [husband] got in they were obviously, they were wanting to encourage, they were desperate for a doctor. There was a couple of other candidates as well but . . . so the lady who was running the hotel immediately, [my husband] was messaging me saying 'I've found you a friend, she says you can ring her any time if you want to talk about breastfeeding or whatever', all this kind of thing. So that was literally from that interview, he was like, 'I think you'll get on really well with her'.
So it was right from the beginning really. I remember we came to visit for bonfire night and you know, I was just immediately grabbed by this group of women who had small children. We went to have a little look at the house, another friend, was banging on the door, we were looking at the doctor's house for the surgery, she sort of popped over, she was like, 'Hi, I'm [name], this is my baby, please come to toddler group on Friday, come and meet everybody'. so they were very – everybody was very, yeah, welcoming. So it was literally right from the beginning . . . I've tried to do the same when people have moved here, do you know what I mean, I just wandered around with my baby in a buggy and just people just invited me in for coffee!

CAWH-19; family member

These examples demonstrate the importance of life stage, and how life stage interacts with both individual actions and the wider demographic capacity of a place that can have a profound effect on the experience of those living there and ultimately their willingness to stay.

As the second example above shows, the period between appointment and taking up post could be an important window to identify family needs and interests, and make some useful introductions. This could include supporting partners to find employment, contacting schools and looking for housing, but also simple acts of friendship.

> *The place that I'm staying now . . . I think that probably was through the community council but you sort of forget after a while because it's word of mouth and all sorts of ways that messages get around and Facebook and yeah, so I'm not sure, I think it probably was through the community council, and yeah, certainly went and had a look round a couple of different places, and a friend also had connections with another friend. So it's been, yeah, a bit of the community council, a bit of word of mouth, and that's working about absolutely fine.*
>
> *CAWH-20; GP*

These actions could and did continue once the new person and their family arrived. Having recruited a new person, participants described a varying range of community actions to help the individual and family settle in and feel welcome.

> *It's more informal. I think that's the nature of the community I'm a part of, I live in, and it's more informal. People are naturally sometimes quite guarded, but they want to make people feel welcome. And, for example, on an informal basis they will think about taking people out – say someone else has moved here for work, they will take them after work . . . It's about saying 'we're more than just colleagues here' . . . It's not a community that has barriers, it's not a community that says 'you are new to here'; this is a community . . . that is very welcoming and they want to bring you in. So, there's lots of informal stuff. We've got a book festival, we've got guitar festivals . . . we've got summer festivals of all sorts.*
>
> *CAWH-10; family member of healthcare staff*

> *So when we arrived I think Dr [name] said 'we'll introduce you to [community member], we'll take you over and say hello'. So that was done quite early on . . . and very quickly I was enlisted into the [sports] team. So that was the initial thing but I mean, clearly [community member] was very keen to make us feel welcome and comfortable and the invitation to come to the choir, which is a local thing he was involved with, came hot on the heels with that, possibly because he noticed that [my wife] needed, needed a good social network too. So, there was a bit of social engineering . . . before we'd even set foot in the place. It took the form of a couple of evening meals around the dinner table with a few people he introduced us to and then we'd reciprocate and that's how it all started really. . . . I do watch other people arrive and go through quite a similar journey that I did. . . . But that's very much, yes, social engineering by [community member], essentially, is what happened and I think still happens.*
>
> *CAWH-11; community member/family member/HCP*

Of note here is not just the acknowledged intentionality on the part of colleagues and wider community members but also the active recognition of family members' needs and a sense of an inherited tradition of welcoming arrivals that new arrivals themselves soon become part of.

At one extreme, however, some community participants did not seem to have actively considered retention at all; indeed, in some interviews, it was almost as if they did not understand the question. In one instance, the researcher probed repeatedly for information about community action to help encourage staff to stay, but the person's replies focused mainly on what a safe place they were to live and how grateful everyone was to have a new doctor. After all the labour which had gone into recruitment, some simple things which might have aided retention were overlooked, as another participant described.

> **Community member:** *I don't know, we're not involved with it anymore. I know that group of people have kind of got involved in other local issues as well, but we've not got involved. That was the one that had some meaning, some connection to us, that's why we got involved with that . . . A lot of hard work went into it. So I'm not sure if that's still ongoing and I think they support them with things like on covid booster days and things like that, organising it and stuff like that.*
> **Interviewer:** *Did you have contact, were you aware of who the new doctors were, were they part of the community, they might have had children here and things like that?*

Community member: *No. And that did surprise me a little bit, that's what I mean – I thought there was a little bit of a missed opportunity because the children who we did the video with, I thought at the time how nice it would have been if they'd come to school, because to me that was an obvious thing to do.*

Interviewer: *Yeah, it kind of completes the circle, doesn't it?*

Community member: *Yeah, to me it was an obvious thing to do, come and meet the children who had done . . . they are only kids and a doctor is . . . it didn't occur. You know, I'm not, it depends on what sort of person you are but I'm not a pushy sort of person so I wouldn't have approached them and said, 'will you come and . . .' so that didn't happen.*

Interviewer: *It's interesting you said the doctors hadn't stayed. Did you ever hear why?*

Community member: *To be honest, no. . . . But I think they are all, like that core group, are of retiring age. So I think what's happened is they've jumped out, they've got to, haven't they, at some point, they've got to be able to leave the practice. So I don't think they want to be responsible for the practice. I don't know how it works but I think somebody else is taking over that business side of it, I think.*

CAWH-17; community member

Clearly, there were more factors involved in the new doctors' decision not to stay than simply whether or not they were invited to come and meet those involved in the recruitment campaign. Yet the participant identified it as a missed opportunity for integration. The fact that they described themselves as 'not a pushy sort of person' contrasts markedly with the idea of a 'social engineer' going out of their way to forge social connections and community integration.

One staff participant reflected at length on the importance of key individuals as social engineers or navigators in making connections. They also proposed the idea of a 'social passport' and a welcoming committee to ensure all the burden did not fall on just one person and that actions were co-ordinated and sustainable. At the same time, the crucial importance of housing was identified as an essential prerequisite.

So I think, my take on this . . . you have to address the functional things first. If there's nowhere for anyone to live, the rest of it is all by-the-by, there's no point in forging social connections with someone who can't find a house. So, it's going to fall to the NHS and the council and the authoritarian bodies that govern the place, to recognise that if these places are to survive, they will have to provide some kind of statutory accommodation for people to come and live in whilst they are working here. That's got to happen. Unless you suddenly increase everybody's salaries so they can afford the more expensive properties that do come up for sale, which isn't realistically going to happen. So that's the first thing that has to be addressed and once you've found a way to do that, then you look to your community, I think, and say 'we're inviting these people to come and work here'. [Community member] is great, but you can't just rely on one person, as a community, as a whole, we need to form a welcoming committee and make sure that when these people come to work here, they are absorbed into the social network of the village quickly and it's kind of, it probably will become the job of the people that live here that want the community to succeed and thrive, to recognise, that in order for that to happen, they have to put some effort in. And some people are, some people do that, but I think it probably need to be a little bit more formalised to say – almost sort of when you offer someone a job, you say 'here's the accommodation that you'll be able to afford and here is your social passport . . .' [laughing] 'when you arrive, here is your list of options, tick the ones you are interested in and we will facilitate that for you', so when you do arrive you feel completely – 'I've got this menu of options, I'm appreciated, I'm going to be able to have some social time and not feel isolated and I've got this place to live'. Perfect. Everything is looking rosy. If you arrive here and the social connections are great, but your accommodation is shaky and it might not last for long, that's going to put you off putting those roots down. It's a package of the two things: sort out the functional things and then make sure you've got the lifestyle things ready, ready to go. That's what we have to address, as a community.

CAWH-11; community member/family member/HCP

This demonstrates the importance of the navigation role and the network and knowledge assets that specific community members can bring to bear. However, it also points to the potential risk of relying on individuals to spot the

needs of new staff, and individual willingness to step up to try to address them. This links back to the issue of power, labour and responsibility discussed in the previous chapter.

As noted above, there will be other personal or professional factors involved in people's decision whether to stay or leave; however, welcoming the community is as a whole. In small communities, sometimes healthcare staff may fall out with patients/neighbours or with each other, and in such cases, it can be difficult to remain in the area. The close intersection between personal and professional lives in small remote communities is something that healthcare workers who do not themselves come from a rural background may not fully appreciate before taking up post. Indeed, this may be one reason why those who do have a rural background are more likely to take up rural posts and remain there, being better prepared for the social environment. One GP described the difficulties of separating personal and professional life in small communities:

> *I think that's a big challenge, you know? How do you settle into a community, particularly if you're only meeting people in that role? It's really difficult. People then tend to see you as 'the doctor'. That's still a challenge, it's not as prevalent here but even there, in a small community, you know, we used to call it the SPAR [supermarket] ward round because people would come up to you in the aisles when you're there with the two small kids and start talking about something completely inappropriate. You're like, 'I've got two sets of ears here, this is not the time or place, ring me tomorrow when I'm on duty or call my colleague!' Or people driving past you in the car and pulling up ahead of you and going, 'Oh, could you book me in for an appointment on Tuesday?' (laughs) I don't have the appointment screen in front of me, I haven't the first clue, ring the practice!*
> *So it's trying to, I suppose, the community have a role to play in that, but I think as a GP, you have to kind of put the boundaries in place, you have to, in a way, show that you're a human being as well with a life outside of work.*
>
> *CAWH-23/MI-33; GP*

One participant also commented on the potential for a 'bullying mentality' to evolve within a community (not, in this case, one of our case study sites).

> *I know, [the doctor] – who was a lovely guy, I think they almost had, they ended up having to leave, I think, or feeling that they had to because of personal issues from people on the island like politics and stuff, I think they just felt they loved being on the island but they were forced to sort of feel that they had to leave because they couldn't cope with it, which was a terrible, terrible shame and it 100% was nothing to do with their fault, it was just – there can be a petty level of stuff going on, on the island but also could be a bullying mentality. . . . He was a very good and dedicated doctor and a good family on the island and it was almost like they felt that they just had to leave, which was a terrible shame. And I guess, sort of thinking about that holistically, obviously there was an issue between them and someone on the island and I suppose, looking holistically at that, perhaps there wasn't sufficient support for the doctor or sufficient – or any means of remedying conflict, so difficult situations, and it just becomes a head-to-head type issue which, in their case I think meant that they had to leave. Which is a terrible shame but I guess, you know, looking – the bigger picture is probably support for people like that is very important, so they feel they are best supported from over and above the people directly on the island.*
>
> *CAWH-08; community member*

The idea of some form of external mentoring support was also a recommendation arising from our previous study of doctors' decision-making about remote and rural Scotland.[47]

Discussion

Community action alone cannot explain all the reasons why someone may decide to stay or not. As noted in the previous chapter, many professional, life stage or personal factors beyond the control of the community may intervene, as well as infrastructure issues, such as schools and housing. However, the actions of communities to make people feel warmly welcome and to integrate them quickly into a new social environment can play an important role in increasing the likelihood of someone staying. To use a rural agricultural metaphor, this could be seen as a process of 'hefting'.

Sheep which are hefted have become accustomed and attached to a particular landscape. As James Rebanks describes it, 'In theory our sheep could wander right across the Lake District. But they don't because they know their place on the mountains. They are "hefted" – taught their sense of belonging by their mothers as lambs'.[93]

We are grateful to Dr Tim Sanders, Senior Clinical Lecturer in Rural Medicine, University of Central Lancashire, for suggesting this idea, during discussions at the National Centre for Remote and Rural Medicine conference in 2023.

Community actions may be small, informal acts that people barely recognise as 'acts' at all. While some participants recognised them as intentional and planned, those taking such steps often saw them as just normal, everyday, neighbourly actions one would do for anyone moving to the area – moral rather than transactional acts.

Our research reinforces other work that argues retention is in many ways the 'poor cousin' in the recruitment and retention discourse – less recognised, less well understood and less deliberately planned for.[48] Yet all the labour poured into a recruitment campaign may be wasted if retention is not given greater, more explicit attention. This requires surfacing the hidden work involved and paying attention not just to healthcare workers themselves but also to family members, who may struggle to find a role in the community.

At a broader level, the making and shaping of communities as attractive or unattractive places to stay is a complex and evolving process. This process has historical roots of place, entwined with ever-changing political-economic agendas for rural areas, societal change and expectations, as cohorts of people move in, move away, return, have children; as people start local social groups, join local councils, advocate for place. The recruitment and retention of healthcare workers intersects with, and is bound by, 'people, places, and landscapes in rural areas, and of the social and economic processes that shape these geographies'.[94] Understanding this particular geography of why healthcare workers choose to work somewhere is not only about 'the job'. Rather, it is about why a person, or a family, moves to and stays in rural places which are 'gazed on, lived in, performed, and experienced in so many different ways. It combines and narrates the human and the non-human in diverse assemblages'.[95]

Chapter 7 Discussion

Unhistoric acts, hidden lives and diffusive impact

> *But the effect of her being on those around her was incalculably diffusive: for the growing good of the world is partly dependent on unhistoric acts; and that things are not so ill with you and me as they might have been, is half owing to the number who lived faithfully a hidden life, and rest in unvisited tombs.*
>
> *Closing lines, Middlemarch, George Eliot*[96]

> *My grandfather is, quite simply, one of the great forgotten silent majority of people who lived, worked, loved and died without leaving much written trace that they were ever there. He was, and we his descendants remain, essentially nobodies as far as anyone else is concerned. But that's the point. Landscapes like ours were created by, and survive through, the efforts of nobodies.*
>
> *The Shepherd's Life (p. 6)*[93]

We set out to investigate what actions remote and rural communities can take to improve both recruitment and retention of healthcare staff in their area. We were led to this topic by first-hand accounts from public advisers on a previous project of small, informal acts in their communities, particularly around welcoming new healthcare staff and their families, to encourage them to stay.

As it turned out, it was difficult both to identify and to recruit case study sites. Those we did find through extensive searching were in the public domain mostly because of a focus on more obvious recruitment actions – public campaigns with videos and strong social media presence – rather than what might be described as more hidden, socially enacted retention efforts.

These actions may be so hidden that even communities themselves may not recognise that they are 'doing' anything, making it doubly hard to search for examples, because they are simply not described in public. One of our participants, for example, was intrigued by the idea that things he took for granted as normal actions to welcome people to the community might be considered as a form of labour. Yet, on reflection, he recognised that there was considerable 'work' involved, sometimes borne disproportionately by certain individuals, and that understanding and documenting such work was important.

Thus, the sheer difficulty of finding case study sites is in itself a finding. Identifiable cases of genuinely community-led initiatives are few and far between, and retention initiatives are particularly hard to capture. This does not mean there are no such initiatives taking place but, rather, that they are poorly documented and often barely even recognised as such. At the same time, in some of our sites, the initial energy behind recruitment campaigns did not seem to be matched by comparable efforts to encourage people to stay. In some interviews, questions about retention seemed poorly understood, almost as if individuals felt the recruitment campaign was the only thing worth talking about as a one-off 'success'.

This contrasted with other sites where both recruitment and retention seemed to be understood as an ongoing effort, requiring repeated input and creativity. This meant a focus on whole-community sustainability across many different employment sectors, and making the community a generally attractive place to be, as well as welcoming specific individuals.

The diffusive nature of community actions over time, and the multiple decision-making influences on HCPs considering moving to or staying in a remote or rural post, mean causality is hard to demonstrate. Community action, no matter how positive, may be outweighed by circumstances in someone's professional or personal life that take priority – a falling out with a close colleague, for example, or an elderly relative needing care elsewhere in the country.

What we mean by 'staying' also complicates the picture. What appears to have been a successful initiative may look less successful over time if someone leaves later on – but there is no objective measure of how long someone needs to stay in order to qualify as 'staying'. It may be that people coming for shorter periods, giving of their best and then moving on or retiring, may be judged an effective solution in some places, rather than a failure. (The 'Rediscover the Joy' project in Orkney has had good results with a programme of repeated locum appointments of 1–4 weeks, with a cadre of well-supported staff returning every year to cover leave or sickness. This lowers the threshold for coming to work in a remote location, compared to a decision to permanently relocate, but also gives full-time doctors in Orkney the reassurance that they can take up a permanent post knowing they will always be able to take time off. Orkney has also introduced longer-term rotational working in some posts, enabling people to spend part of the year in remote and rural practice, rather than moving permanently.)

What 'works' in one community might be inappropriate or impossible in another context, depending on the kind of assets they are able to draw upon. There is also perhaps a risk that if every community makes a video, for example, the novelty which draws attention and makes it stand out against others competing for the same small pool of professionals may be lost. What this study does offer, however, is a range of ideas for other communities to consider and test, and suggestions for local and national policy-makers to enhance community efforts to attract and retain HCPs.

Assets, place and people

As described in our *Methods* chapter, asset-based approaches aim to strengthen communities by recognising, identifying and harnessing existing assets to find locally led solutions to community problems.[72]

Communities can draw on a range of local assets to help attract and retain healthcare staff and their families, many of them specifically place-related. These include beautiful local landscapes; outdoor activities; a safe and cohesive community for children; high QoL and work-life balance; and social networks of key individuals who create social links for incoming families and integrate them into community life. Successful exploitation of this range of assets for recruitment requires not just conscious presentation but also the ability to get them in front of those whose interest might be piqued. This is where the skills of local people with marketing and design experience, photographers, filmmakers and those with influential social networks may be a particularly useful further asset.

The NHS job advertisers, too, may showcase these assets, as well as more work-related assets such as attractive modern premises; financial incentives to move; social relations within the healthcare team (e.g. regular coffee and cake); professional and personal mentoring and support; and training and research opportunities.

At the same time, communities struggle with the absence of some key assets, including housing (both cost and availability, particularly in tourist areas); schools, notably secondary schools; transport links and digital connectivity; employment opportunities for other family members; and accessible cultural activities. To an extent, they may also struggle with the lack of a wide social circle; while a close-knit community can be an attraction, it can also make social life difficult for health professionals caring for patients who are also their immediate neighbours, parents of their children's friends, members of their social clubs and so on.

The absence of these assets is often particularly important for retention; after persuading someone to move to their area, disillusion and a sense of isolation may set in. Some issues are intractable, such as the size of the local population or the lack of secondary schooling for a small population. Others may require a national policy response. However, we have found examples of communities finding creative ways of addressing problems, such as housing, and scouting for jobs for partners, as well as working actively to overcome social isolation.

As noted in our *Methods* chapter, the asset-based approach is not without its critics. In particular, MacLeod *et al.* (2014) argue that it risks placing the burden back on individuals and communities, diverting attention from the actions or inaction of government and public bodies which have weakened communities or failed to address their needs.[73] Local social movements to attract healthcare staff may be celebrated as empowerment but may act as a sticking plaster on deeper infrastructure problems. Asset-based approaches may serve to further reinforce inequalities in and between

already underserved areas. Assets are partly a matter of luck. While harnessing available assets is to some extent 'making your own luck', a beautiful natural environment or better facilities will give some communities a head start in the attractiveness stakes. There will be some communities less able than others to take this kind of action, and some which lose out to other nearby communities which are more successful in attracting resources. The absence of assets is also significant. Even communities with an apparent abundance of assets may have limited success in harnessing them or may experience setbacks.

In our case studies, community members usually shouldered responsibility because they felt they had to, either as a reaction to a perceived crisis, or as a preventive action in anticipation of known difficulties (such as the need to retain newly recruited staff). They sometimes described a feeling of weariness at having to repeatedly fight for their patch and the viability of their community. Burnett and Danson describe remote and island communities in Scotland as sites 'imbued with narratives of place as "Romance" and of people as "Resilience"'.[97] Yet the discourse of resilience may also be understood as a neoliberal project placing the burden on communities. Shwaikh has recently called for a move from 'expectations of resilience towards a language of care'.[98] While her research draws primarily on research with survivors of war and violence, her emphasis on the limits to resilience resonates with the experience of remote and rural communities. She argues that people 'do not choose resilience', a focus which emphasises exemplary, heroic strength and resourcefulness, and minimises vulnerability, as well as relieving organisations and governments of responsibility.

This is not to say that communities cannot take useful action and take back some control over their destiny but, rather, that they cannot be expected to solve all recruitment and retention problems. Central and regional government and the NHS could work in supportive partnership with communities at an earlier stage, listening to them, and benefiting from their insights and energy.

Individual or distributed leadership

A related issue is who leads community action, how to avoid disproportionate burden on a small number of individuals and how to ensure other people are not excluded. The concept of distributed leadership[99] proposes leadership as a collective social process, involving multiple actors, as defined below:

> *Distributed leadership is not something 'done' by an individual 'to' others, or a set of individual actions through which people contribute to a group or organization . . . [it] is a group activity that works through and within relationships, rather than individual action. (p. 3)*[100]

This resonates with the Australian literature on community-led action plans[69] and the formation of a liaison committee of stakeholders who work together on developing information packages for prospective applicants and forming a welcome process to help doctors and families settle in. This was certainly something that participants in our study felt would help share the burden more effectively and sustainably, and reduce dependence on specific individuals, though it still requires willing people to make this happen. At the same time, experience in one of our case studies suggests that even with the formation of a group to share action, one dominant person can still adopt a more individual leadership model.

A sense of belonging

Our findings resonate also with the rural migration literature around fostering a sense of belonging and the importance of an engaged community and whole-society approach, particularly for retention.[3] Adopting this migration lens, in our previous work, we have recommended changing the discourse from 'recruitment and retention' to 'moving and staying', to reflect a more holistic person-centred approach. It is worth reiterating Mandal and Phillips' analysis of how the creation of a sense of belonging is a product of reciprocity between physician and community:

> *A physician's sense of belonging, arising from that emotional need for social connectedness, is built via bilateral active efforts at community engagement, reciprocity, social integration of family and workplace collegiality. (p. 1)*[61]

Our case studies have shown varying degrees of this kind of mutual interaction, with some communities working hard (even if they did not perceive it as such) to create a welcoming atmosphere to encourage people to stay, while others applied most effort to recruitment and focused far less on retention. None of our case studies showed the kind of active rejection of incomers found in Sirili's work contrasting the approach of different communities in rural Tanzania;[66] it was more a case of simply not thinking about it or treating it as a priority. However, our findings also include accounts of other communities which people had left, where relationships had broken down and become quite hostile.

In the current situation of a shortage of healthcare workforce across the NHS in all four nations of the UK, and staff are choosing to retire early or work abroad, encouraging people to stay in post and become rooted in the community should be a top priority.

In England, the NHS Long Term Workforce Plan aims to address the shortage of professionals in rural areas partly by the creation of new training placements and a new graduate entry medical school in Carlisle.[101] These plans build on the evidence reviewed in *Chapter 1* that people are more likely to take up and stay in rural posts when they have been born or brought up in rural areas or had exposure during training. As the Workforce Plan notes,

> *By the time the students qualify they will have become embedded into the local ICS [Integrated Care System], encouraging them to continue living and working in the local area after graduation. (p. 85)*[101]

Strengths and limitations

To our knowledge, this is the first UK-based study of community-led efforts to support healthcare recruitment and retention. This study provides novel exploratory evidence on an under-researched topic and contributes to the limited international evidence on this topic. In particular, it provides new insights into the neglected topic of community action to encourage new healthcare workers to stay, and the perspectives of the whole family, not just the professional concerned. It also contributes new analysis of the nature of UK job advertising for remote and rural posts.

This was a relatively small study. Recruitment of case studies, and of participants in some sites, was challenging, partly because there are relatively few known examples of community-led approaches. Pragmatically, we had to reduce our planned number of case studies from six to five. We had hoped to do more fieldwork in the communities studied than we were able to as a result of COVID. This meant there was less opportunity for the lead researcher to experience and observe the communities at first hand.

As noted in *Equality, diversity and inclusion*, our reliance on a lead contact to identify potential participants may have limited both the nature and size of our sample. There might have been minority or more critical voices to whom we did not gain access, particularly if there were tensions within the community. Lead contacts may have wished to control the narrative in such cases. Finding additional participants might have been easier if more in-person fieldwork had been possible, enabling the lead researcher more easily to pursue informal or chance contacts.

Our sample was also shaped by the fact that finding examples of community interventions was difficult. 'Successful' cases were more likely to be identifiable through media searches than those where attempts had ultimately failed. One case study site that we had hoped to include, but where in the end we could not find anyone willing to take part on the record, might have given us more data on how apparent initial successes can founder.

An exploratory study of this kind is not designed to demonstrate causality. However, the data we were able to collect offered rich, detailed and wide-ranging perspectives that enabled us to move beyond a narrow job focus to a whole person, whole family and whole society perspective. This has supported the development of our 'library of examples' (see *Appendix 1* and https://learn.nes.nhs.scot/73640) to help other communities seeking to work with the NHS on recruitment and retention. We believe this also lays the foundation for further research.

A particular strength was the fact that the study was inspired by public partners and the close involvement of two members of the public as full research team members (see *Patient and public involvement*).

Recommendations for research

1. There is scope for further research with new campaigns, to test our findings. Although we found it challenging to recruit case studies, a recent article in GP Online has reported a rise in the number of community-led or community-supported campaigns to recruit staff or avoid practice closures.[102] This suggests that there could be new case studies to include, and a focus on positive stories of success as well as negative experiences would be particularly welcome.
2. We would particularly recommend further research into retention, and the reciprocal relationship between community and healthcare staff. Given how hidden this work is, rather than looking purposively for examples, we would suggest taking a different approach: conducting focused longitudinal ethnography within a range of remote and rural communities which have recently recruited new staff, and observing over time how these staff fare and how the relationship with the wider community unfolds. This could include alternative models such as regular short or long-term rotations as well as permanent staff.
3. In terms of NHS job advertising, there is scope for a health economics study of the cost-effectiveness of adverts of different styles and platforms. This was not within the scope of our small qualitative study, but could yield important information for the NHS about how best to use advertising budgets.
4. We also recommend a qualitative evidence synthesis of published articles on community involvement in recruitment and retention, given that the literature on this topic is growing.

Not arising specifically from this study, but nonetheless important, will be continuing wider research on the career trajectories of current HCPs who come from a remote and rural background, and the career intentions of remote and rural recruits to medical school, particularly as new medical schools and graduate entry programmes come online.

Implications for communities and policy-makers

Our findings demonstrate that there is an important role for communities to play in both recruitment and retention. In remote and rural areas where the NHS is struggling to recruit, they could more proactively invite community members to the table to devise jointly a campaign which showcases the things which that community knows to be its main attractions. NHS managers who do not live in the area may not have this detailed local insight. Underlying this is our recommendation that we reconceptualise 'recruitment and retention' as 'moving and staying', shifting the focus from the job itself to a wider view of people's wider lives. This reflects evidence that often what draws people to a post in remote and rural areas is not so much about the money or the role, important thought these are, but results from a complex interplay of personal and family preferences and needs, life stage and lifestyle, and attraction (or not) to place.

Our findings demonstrate that addressing the lack of available and affordable housing for key workers in remote and rural areas is a fundamental issue for the governments of the four nations of the UK. The Scottish Government has recently responded to the issue of rural housing by committing to publish a Remote, Rural and Islands Housing Action Plan by 2026 and establishing an Affordable Housing Initiative for key workers in rural areas. Up to £25M is being made available over 5 years, 2023–8, to help councils identify affordable homes and to enable local authorities and registered social landlords to acquire or lease properties.[103]

Other infrastructure issues which may need co-ordinated governmental support include schools and child care; investment in Wi-Fi for remote and rural areas, so partners of HCPs can work remotely if required by their jobs; more active consideration of moving packages which help partners find employment.

Retention is a neglected issue. Socially, it is supported by an actively welcoming community, with key individuals who go out of their way to help someone forge links and take part in local social activities. The formation of a community stakeholder group could help formalise this and reduce reliance on the goodwill and energy of individuals.

At the same time, people also need to be happy and supported in the workplace. Professionally, there could be benefits in an NHS remote and rural 'buddying' system, perhaps with a practitioner from a different rural community, to whom

they can talk about the challenges of remote and rural practice and life and gain tips for navigating their new context, as well as wider professional networking and professional development opportunities.

Equality, diversity and inclusion

Our participants were recruited purposively to be those who had been involved in, or affected by, community-led recruitment and retention initiatives in remote and rural areas of the UK. This meant we were not looking for a sample that reflected population diversity as such, but rather a small and highly targeted group, defined by geography and their involvement. We made provision in our budget for translation of materials into Scottish Gaelic, so that we would be able to include anyone from Western Scotland and the Western Isles (Na h-Eileanan Siar) who preferred to be interviewed in Gaelic. In the event, no one took up this option.

Remote and rural areas are in many ways marginalised communities, sometimes literally in the case of remote coastal and island communities, and often in terms of policy, infrastructure, service provision and unequal health outcomes. We are grateful to our PPI partners for consistently reminding us of the lived reality of accessing health care and other essential services in remote areas (see below).

While we are pleased to be able to represent often-neglected perspectives from remote and rural areas in this report, we recognise that this is a small sample and that some minority or more critical voices may have been missed. We were reliant on lead contacts to identify potential participants, and it is possible that some may have acted as informal gatekeepers, particularly if their version of events might have been disputed by others. We also recognise that expressing dissenting views in small close-knit communities can be risky for individuals, both community members and healthcare staff, despite our efforts to ensure complete anonymity. Online interviewing for most of the fieldwork may also have deterred some people from taking part.

It is important to note that remote and rural communities have very distinct characteristics and cultures, so what works in one place may not be relevant elsewhere. However, we anticipate that many of our findings are potentially transferable to other communities, for whom we have developed a 'library of examples' to use in thinking what assets they have that could be harnessed to support recruitment and retention of healthcare workers in their area.

Patient and public involvement

The aim of PPI in our study was to ensure that the research team were grounded in the reality of life in remote and rural communities.

As noted earlier, this study was directly inspired by comments from public advisers on a previous study in Scotland. One of those people became a coinvestigator (Topher Dawson), along with another public partner from England (Lorraine Angell), and the other chose to become a member of the steering committee for this study and join in public advisory group discussions. The whole project was, therefore, built around the need to reflect local community perspectives and potentially help other communities with ideas they could try in future.

The two public coinvestigators were full team members, participating in all monthly research team meetings, shaping data collection and taking part as equal partners in ongoing analytical conversations. They also took part in our quarterly public advisory panel meetings, which also included a retired GP from England, a Highlands resident and a voluntary sector worker living on a Scottish island. As noted in *Chapter 2*, this group discussed data extracts and helped shape the framework for analysing the job adverts in particular.

Given the degree of integration of our two public coinvestigators into the full team, it is generally not easy to ascribe decisions or influences to one specific team member – decisions were made jointly, and everyone contributed to debate about methods and interpretation. However, one way in which public partners repeatedly illuminated our work was by talking about the reality of life in a remote area, but also reminding us that 'remoteness' is in the eye of the beholder.

People who live in what is officially defined as a remote place may not experience it as isolated, if they have lively networks of friends, good services and a busy social and leisure life. This led to interesting analytical discussions about the word 'isolation', derived from the Latin word for island ('isola'), and the varying degrees of 'island-ness' in our sites, even if on the mainland. ('Mainland' is also a problematic word in some ways, as they pointed out – who gets to define what is 'main'?).

Our retired GP adviser also helped bring the other side of the coin – doctors' motivations and preferences – to discussions, and our third-sector partner illuminated the workforce and service provision challenges across several sectors in remote and rural areas, not just health care.

It has been a privilege and pleasure to work with all of them, and the study would simply not have happened without public advisers drawing our attention to an underexplored topic.

Conclusion

Successful recruitment and retention needs to focus on the whole person and family, their preferences and needs, and social integration to the community, not just the job. Our findings demonstrate that there is an important role for communities to play in both recruitment and retention. However, communities cannot be expected to solve all recruitment and retention problems. Central and regional government and the NHS could work in supportive partnership with communities at an earlier stage, listening to them, and benefiting from their insights, local contextual knowledge and energy.

Additional information

CRediT contribution statement

Louise Locock (https://orcid.org/0000-0002-8109-1930): Conceptualisation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Writing – original draft, Writing – reviewing and editing.

Andrew S Maclaren (https://orcid.org/0000-0001-6185-9167): Conceptualisation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Writing – original draft, Writing – reviewing and editing.

Zoë Skea (https://orcid.org/0000-0001-7418-2976): Conceptualisation, Formal analysis, Funding acquisition, Investigation, Methodology, Project administration, Writing – original draft, Writing – reviewing and editing.

Lorraine Angell (https://orcid.org/0009-0006-6564-7464): Conceptualisation, Funding acquisition, Writing – reviewing and editing.

Jennifer Cleland (https://orcid.org/0000-0003-1433-9323): Conceptualisation, Funding acquisition, Writing – reviewing and editing.

Topher Dawson: Conceptualisation, Funding acquisition, Writing – reviewing and editing.

Alan Denison (https://orcid.org/0009-0003-1433-4386): Conceptualisation, Funding acquisition, Writing – reviewing and editing.

Christina Dobson (https://orcid.org/0000-0002-3056-9877): Conceptualisation, Funding acquisition, Writing – reviewing and editing.

Rosemary Hollick (https://orcid.org/0000-0001-6558-7189): Conceptualisation, Funding acquisition, Writing – reviewing and editing.

Peter Murchie (https://orcid.org/0000-0001-9968-5991): Conceptualisation, Funding acquisition, Writing – reviewing and editing.

Diane Skåtun (https://orcid.org/0000-0002-6852-587X): Conceptualisation, Funding acquisition, Writing – reviewing and editing.

Verity Watson (https://orcid.org/0000-0002-3824-5076): Conceptualisation, Funding acquisition, Writing – reviewing and editing.

Other contributions

Lorraine Angell: PPI.

Topher Dawson: PPI.

Acknowledgements

We thank all our participants for their contribution, and also members of our public advisory group for contributing their reflections throughout the study and supporting analysis. The group was formed of our two public coinvestigators, Lorraine Angell and Topher Dawson, David Green (public member of the Study Steering Committee), Stewart Manning (retired GP) and Caron Jenkins (Professional Engagement Manager, vs. Arthritis, Scotland).

We thank medical student Benjamin Tse, who joined us an intern and helped contact job advertisers and organise focus groups with medical students nearing the end of training.

We are grateful to Zoe Batham and Seonaidh Cotton from the Centre for Healthcare Randomised Trials (*CHaRT*) team and Paul Manson, Information Specialist in the Aberdeen Centre for Evaluation, for their support in preparing the report for submission.

Our thanks also go to the School Ethical Review Board team (Katie Crosley, Gareth Jones and Helen Galley) at the University of Aberdeen for their advice and support during the study. We are grateful for the assistance we received from Anne Buckle, Helen Strachan and Bev Smith in managing the study budget. We thank Juliette Snow and Rachael West for their help with contracting.

We thank our transcribers, Hunt and Peck.

During the period of the study, the Health Services Research Unit (HSRU) (now the Aberdeen Centre for Evaluation) and the Health Economics Research Unit (HERU) were core funded by the Chief Scientist Office of the Scottish Government Health and Social Care Directorate.

We extend our thanks to all the participants who took part in the study and without whom the study would not be possible.

We also thank the NIHR for funding, and for the helpful comments from external reviewers and HSDR board members in developing the grant, and our programme managers, Ruth Swire and Elena Rayner, for unfailing support.

We thank the members of the Study Steering Committee for their valued contribution and oversight of the study and for their attendance at regular Study Steering Committee meetings. The independent members of the committee were:

Louella Vaughan, Senior Clinical Fellow, Nuffield Trust (Chair).

Tim Allison, Director of Public Health and Health Policy, NHS Highland.

Jen Callander, NHS Workforce Domestic Recruitment Manager, Recruitment Policy Unit, Health Workforce Directorate, the Scottish Government.

Jim Cannon, Director of Regional Planning, NHS Scotland North Regional Team.

David Green, Public Research Partner.

Namita Kumar, Postgraduate Dean Health Education England North East. Consultant Rheumatologist.

Una MacLeod, Dean and Professor of Primary care Hull-York.

Robert Scully, Regional Director, Irish College of General Practice and Honorary Senior Lecturer, University of St Andrews.

Charlie Siderfin, Rural Emergency Physician, Wick, NHS Highland.

Philip Wilson, Emeritus Professor and former Director of the Centre for Rural Health, University of Aberdeen.

Data-sharing statement

Because of the small size of our case study sites and small number of potentially identifiable participants, there are no data available for sharing.

Ethics statement

This study was granted ethics approval by the University of Aberdeen School of Medicine Research Board, SERB/2021/10/2186 on 2 December 2021. All recruitment was community-based, and we did not recruit through the NHS. Adverts collected were all available publicly on recruitment websites.

Information governance statement

University of Aberdeen is committed to handling all personal information in line with the UK Data Protection Act (2018) and the General Data Protection Regulation (EU GDPR) 2016/679. Under the Data Protection legislation, University of Aberdeen is the Data Controller, and you can find out more about how we handle personal data, including how to exercise your individual rights and the contact details for our Data Protection Officer here: www.abdn.ac.uk/about/privacy/

Disclosure of interests

Full disclosure of interests: Completed ICMJE forms for all authors, including all related interests, are available in the toolkit on the NIHR Journals Library report publication page at https://doi.org/10.3310/DJGR6622.

Primary conflicts of interest: All coauthors report National Institute for Health Research (NIHR) funding for the 'Come and work here' study as support for the present manuscript. Louise Locock, Jennifer Cleland, Alan Denison, Rosemary Hollick, Andrew Maclaren, Peter Murchie, Diane Skåtun, Zoë Skea and Verity Watson also report a grant from the Chief Scientist Office, Scotland 'Enhancing recruitment and retention of rural doctors in Scotland: A mixed methods study' as support for the present manuscript. In both cases Jennifer Cleland was funded on a consultancy basis. Alan Denison was included in both grants on a no-cost basis, and reports salary support for the present manuscript from NHS Education Scotland and honorary status with University of Aberdeen. Louise Locock, Diane Skåtun and Verity Watson report additional salary support for the present manuscript through a core funding grant from the Chief Scientist Office, Scotland.

The authors declare the following other grant funding over the last 36 months:

Louise Locock: NIHR128616 Understanding and using people's experiences of social care to guide service improvements; NIHR150979 Planning mode of birth in routine antenatal care; NIHR202450 Understanding experiences of urogynaecological conditions and health services; NIHR PRP P150 Bridging the translation gap between learning disability policy and practice in search of flourishing lives; MRC MR/W014432/1 Multimorbidity and Pregnancy: Determinants, Clusters, Consequences and Trajectories (MuM-PreDiCT); ESRC ES/V006371/1 Choice, voice and change: developing networks for the involvement of people from seldom heard communities in England, Ireland and Scotland; ESRC ES/V017047/1 Developing practical ethics of care for the dead and bereaved: learning from the ways COVID-19 disrupted and reshaped funeral provision; Health Foundation 2238252 Reshaping secondary care consultations after COVID-19 – the role of asynchronous consultation methods; Chief Scientist Office, Scotland COV/LTE/20/04 Long COVID: Amplifying the voices of people with lived experience to improve understanding, support, treatment and education. Share-to-improve: Long COVID experience (COv-VOICES) Study; MND Association Locock/Sept19/941-794 Understanding family experiences of inherited Motor Neurone Disease – a secondary analysis of qualitative research to develop a new resource for patients, families and clinicians on the Healthtalk website; two awards from THIS Institute, University of Cambridge, Developing a Visual Identification Method for People with

Cognitive Impairment in Hospitals (DA VINCI) and 'Soft' intelligence and online patient feedback: Using Care Opinion for improvement. (PhD studentship).

Louise Locock and Zoë Skea: NIHR COV-LT2-0005 Understanding and using family experiences of managing long COVID to support self care and timely access to services.

Louise Locock, Rosemary Hollick, Peter Murchie and Zoë Skea: versus Arthritis, 21840 Patient-centred Care for Fibromyalgia: New pathway Design (PACFIND).

Louise Locock and Rosemary Hollick: versus Arthritis 12159 Effective healthcare delivery in rare rheumatic disease: evaluating models of care for systemic vasculitis (VOICES).

Louise Locock, Andrew Maclaren, Diane Skåtun and Zoë Skea: NHS Grampian Endowment Fund 20/027 Remote and rural healthcare: Pilot study to investigate experiences, differences and changes to medical care for people living in remote and rural areas of Scotland.

Louise Locock and Andrew Maclaren: NHS Grampian Endowment Fund 21/009 Understanding digital appointment inequalities in NHS Grampian: exploring digital exclusion and identifying solutions to address it with our rural and urban communities.

Louise Locock and Andrew Maclaren report travel and accommodation support from the University of Central Lancashire for attending the annual conference of National Centre for Remote and Rural Medicine, and from the University of Lancaster for a workshop on medical education.

Louise Locock reports honoraria from the Point of Care Foundation for training courses on patient experience and quality improvement.

Louise Locock reports past membership of NIHR HSDR funding committee (membership ceased in 2019) and current membership of the MND Association Health Research Advisory Panel and the THIS Institute, University of Cambridge, Engagement and Involvement Committee. She also reports membership of three study steering committees: LOCO-RISE (LOng COvid Rehabilitation In Scotland: an Evaluation), COV/LTE/20/29 Robert Gordon University and University of Stirling (funded by Chief Scientist Office, Scotland), Optimising people-centred access in primary care in the context of COVID-19: facilitating organisational and policy change. NIHR202311 University of Manchester (funded by NIHR Policy Research Programme), and Trials Engagement in Children and Adolescents (TRECA) NIHR14/21/21 University of York (funded by NIHR HSDR).

Jennifer Cleland reports consultancy fees from the Work Psychology Group (UK) to contribute to a Health Education England-funded project to evaluate the impact of England's new medical schools. She also reports an annual payment from Wiley for Deputy Editor duties for the journal Medical Education, and an unpaid role as Trustee of the Association for Medical Education Europe (AMEE).

Topher Dawson reports chairmanship of the Lochbroom Community Council.

Alan Denison reports a leadership role as Postgraduate Dean, NHS Education for Scotland.

Christina Dobson: grants from Newcastle University and Yorkshire Cancer Research for the 'Animating RURALLY' study. Grant from Bowel Cancer UK for 'Barriers to Immunochemical Test (FIT) completion amongst patients with symptoms of possible colorectal cancer'. Grant from British Society of Gastroenterology for 'ERCP Quality Improvement Programme'. Grant from NIHR for 'Exploring the role of health literacy in the diagnosis of head and neck cancer'. Grant from The British Academy for '"The Two Big 'Cs": Colorectal diagnosis during the COVID-19 pandemic'.

Rosemary Hollick: EULAR (European Alliance of Associations for Rheumatology) Implementing Patient Research Partner Engagement in Research (iPRePaRE); Chief Scientist Office (Scotland) Supporting people with musculoskeletal disorders

in Scotland to remain in work; MRC QUantifying the Impact of Chronic pain on engagement in paid worK (QUICK); Grampian Osteoporosis Trust Supporting osteoporosis care: Can an automated classification system effectively case finding people at risk; Nuffield Foundation Geographical mapping of prevalence and outcomes in rheumatic and musculoskeletal conditions across Wales and Scotland: a data linkage study.

Peter Murchie: NIHR 1300310 Deep infiltrating endometriosis: management by medical treatment if early surgery (DIAMOND); NIHR 17/30/02Catheter II study – randomised controlled trial comparing the clinical and cost-effectiveness of various washout policies versus no washout policy in preventing catheter associated complications in adults living with long-terms catheters; NIHR 14/192/71A randomised controlled trial comparing the clinical effectiveness and cost-effectiveness of laparoscopic cholecystectomy compared with observation/conservative management for preventing recurrent symptoms and complications in adults with uncomplicated symptomatic gallstones (C-GALL); Friends of ANCHOR, CORRECT – Cancer PriOrities in Rural and REmote SCoTland; Royal Society of Edinburgh, Work is hard and time is short: decision fatigue in general practitioners; Chief Scientist Office, Scotland, Interactions between cancer and stroke: a national electronic data linkage study; Scottish Government, National cancer diagnosis audit (NCDA) in Scotland: analysing NCDA data to support the adoption of early cancer diagnostic centres; Scottish Government, Does increased distance to services lead to different treatment and follow-up for cancer in Scotland? Scottish Government, Is current GP referral practice for cancer in Scotland optimal? A detailed exploration of cancer referral pathways using primary care record and a cancer care pathway database; Pharmacy Research UK, Improving the patient-pharmacist interaction: a new approach to help patients make informed decisions; four awards from NHS Grampian University Hospitals NHS Trust (Evolving a prototype for pilot testing in northeast Scotland – a joint NHSG/UoA project; Training non-specialist nurses to triage digital skin images and use the ASICA intervention to support melanoma survivors; Optimising remote consulting and home assessment of rural cancer patients during unscheduled and planned primary care – assessing feasibility of the ORCHARD intervention; Investigating the influence of rural residency on the uptake of screening for breast, cervical and colorectal cancers); two awards from NHS Grampian Endowment Fund (Do patients who travel further present with more advanced head and neck cancer? Decision fatigue in General Practitioners: detecting changes in doctors' decision making over the working day).

Diane Skåtun: Health Foundation, Real Centre Research Units: REALsupply – Research and Economics Analysis for Long-term sustainable SUPPLY; Chief Scientist Office, Scotland, COV/LTE/20/32 Lived Experience Of Long Term COVID-19 On Workers In Health Care Settings In Scotland: A Longitudinal Mixed Methods Study.

Verity Watson: NIHR ICANEQUAL study, 'Public values, universal basic income and health' and NIHR GRIP study; Economic and Social Research Council for 'Remote working in patient and public involvement in health and social care'; Economic and Social Research Council and Global Challenges Research Fund for 'Reducing land degradation and carbon loss from Ethiopia's soils to strengthen livelihoods and resilience (RALENTIR) study'; Imperial College London for 'Patient's preferences in the treatment of hormone-sensitive metastatic prostate cancer'; The Urology Foundation for 'Putting men's preferences at the centre of the doctor-patient relationship'.

Publications

Articles

Maclaren A, Locock L, Skea Z, Angell L, Cleland J, Dawson T, *et al*. 'Come and work here!' A qualitative exploration of local community-led initiatives to recruit and retain health care staff in remote and rural areas of the UK. *J Health Serv Res Policy* 2025;**30**:180–8. https://doi.org/10.1177/13558196251318607

Skea Z, Locock L, Tse BYH, Maclaren AS, Angell L, Cleland J *et al*. 'Get away from it all' or 'Too good to be true?': A qualitative exploration of job adverts for remote and rural posts. Forthcoming in *Rural and Remote Health*.

Presentations

'Moving and Staying': a migration and place-based approach to recruitment and retention. Online presentation for the Scottish National Centre for Remote and Rural Health and Care – Recruitment and Retention Workshop, part of the NHS Education Scotland 'Festival of Remote and Rural Learning', Isle of Skye. 20 September 2022.

‘Moving and Staying’: a migration and place-based approach to recruitment and retention. Online workshop for policy-makers and practitioners, organised by the Scottish National Centre for Remote and Rural Health and Care. 20 February 2023.

Moving, staying and leaving: staffing remote and rural healthcare. Contribution to workshop at National Centre for Remote and Rural Medicine Conference, Penrith, with speakers from Universities of Aberdeen, Lancaster and Exeter. 7 June 2023.

‘Come and Work Here!’ Community initiatives to recruit and retain healthcare staff in remote and rural area. Presentation at HSRUK annual conference, University of Birmingham. 5 July 2023.

Valuing Place in Choosing to Move to and Stay in Rural Practice: recent research and exploring interventions. Presentation to Scotland and Norway Remote and Rural Healthcare Symposium, Aberdeen. 29 November 2023.

‘Come and Work Here!’ Community initiatives to recruit and retain healthcare staff in remote and rural areas. Remote and Island Workforce Recruitment Strategy Workshop (online). Stakeholder workshop organised by Scottish Government Health Workforce Directorate. 29 August 2024.

Recruitment and retention of doctors in remote and rural areas: moving, and staying. Invited presentation to GP Retention Symposium, Royal College of Surgeons Ireland and Irish College of GPs, Dublin. 24 September 2024.

Recruitment and retention of doctors in remote and rural areas: moving, and staying. Invited presentation to Irish College of GPs Winter Meeting, Dublin. 7 December 2024.

References

1. Verma P, Ford JA, Stuart A, Howe A, Everington S, Steel N. A systematic review of strategies to recruit and retain primary care doctors. *BMC Health Serv Res* 2016;**16**:126–1.
2. Kumar R. The Delhi declaration 2018: 'Healthcare for All Rural People' – Alma Ata Revisited. *J Family Med Prim Care* 2018;**7**:649–51.
3. World Health Organization. *WHO Guideline on Health Workforce Development, Attraction, Recruitment and Retention in Rural and Remote Areas*. Geneva: World Health Organization; 2021.
4. Wilson NW, Couper ID, De Vries E, Reid S, Fish T, Marais BJ. A critical review of interventions to redress the inequitable distribution of healthcare professionals to rural and remote areas. *Rural Remote Health* 2009;**9**:1060.
5. Strasser R. Rural health around the world: challenges and solutions. *Fam Pract* 2003;**20**:457–63.
6. Murchie P, Adam R, Wood R, Fielding S. Can we understand and improve poorer cancer survival in rural-dwellers? *BJGP Open* 2019;**3**:bjgpopen19X101646.
7. Turner M, Fielding S, Ong Y, Dibben C, Feng Z, Brewster DH, *et al*. A cancer geography paradox? Poorer cancer outcomes with longer travelling times to healthcare facilities despite prompter diagnosis and treatment: a data-linkage study. *Br J Cancer* 2017;**117**:439–49.
8. Hollick RJ, Stelfox K, Dean LE, Shim J, Walker-Bone K, Macfarlane GJ. Outcomes and treatment responses, including work productivity, among people with axial spondyloarthritis living in urban and rural areas: a mixed-methods study within a national register. *Ann Rheum Dis* 2020;**79**:1055–62.
9. Marchand C, Peckham S. Addressing the crisis of GP recruitment and retention: a systematic review. *Br J Gen Pract* 2017;**67**:e227–37.
10. Green A, Bramley G, Annibal I, Sellick J. *Rural Workforce Issues in Health and Care*. Lincoln, England: National Centre for Rural Health and Care; 2018.
11. Strasser R, Cheu H. Needs of the many: Northern Ontario School of Medicine students' experience of generalism and rural practice. *Can Fam Physician* 2018;**64**:449–55.
12. Hogenbirk J, Wang F, Pong R, Tesson G, Strasser R. *Nature of Rural Medical Practice in Canada: An Analysis of the 2001 National Family Physician Survey*. Sudbury, ON: Centre for Rural and Northern Health Research; 2004.
13. Farmer J, Lauder W, Richards H, Sharkey S. Dr John has gone: assessing health professionals' contribution to remote rural community sustainability in the UK. *Soc Sci Med* 2003;**57**:673–86.
14. Palmer B, Appleby J, Spencer J. *Rural Health Care: A Rapid Review of the Impact of Rurality on the Costs of Delivering Health Care*. London: Nuffield Trust; 2019.
15. Chief Medical Officer. *Chief Medical Officer's Annual Report 2021: Health in Coastal Communities*. London: Department of Health and Social Care; 2021.
16. Public Health Scotland. *General Practice Workforce Survey 2019*. 2021. URL: https://publichealthscotland.scot/media/9866/2021-10-26-gpworkforcesurvey2021-report.pdf (accessed 27 November 2024).
17. NHS Education for Scotland. *NHS Scotland Workforce 31 December 2022*. 2023. URL: https://turasdata.nes.nhs.scot/data-and-reports/official-workforce-statistics/all-official-statistics-publications/07-march-2023-workforce/?pageid=8736 (accessed 24 November 2024).
18. Academy of Medical Royal Colleges and Faculties in Scotland. *External Adviser Service: Annual Report 2022*. Edinburgh: Academy of Medical Royal Colleges and Faculties in Scotland; 2022.
19. BMA Scotland. *Secondary Care Matters: Shaping the Future of Safe, Sustainable Hospital-Based Healthcare in Scotland*. Edinburgh: BMA Scotland; 2019.

20. Royal College of Physicians. *Focus on Physicians: Census of Consultant Physicians and Higher Specialty Trainees 2018*. London: Royal College of Physicians; 2019.
21. NHS Health Education England. *General Practice (GP) Recruitment Hub*. URL: https://medical.hee.nhs.uk/medical-training-recruitment/medical-specialty-training/general-practice-gp (accessed 5 May 2021).
22. Royal College of Nursing. *RCN Issue Briefing on Rural Health in the UK*. London: Royal College of Nursing; 2020.
23. Scottish Government. *Shortage Occupations List 2018/9 Call for Evidence: Scottish Government Response for Health and Social Care*. Edinburgh: Scottish Government; 2019.
24. Palmer W, Rolewicz L. *Rural, Remote and at Risk: Why Rural Health Services Face a Steep Climb to Recovery from COVID-19*. London: Nuffield Trust; 2020.
25. Dewar JA, Tullibardine K, Grierson JC, Lindsay A, Mackenzie WL, McVail JC, *et al. Highlands and Islands Medical Service Committee Report*. London: His Majesty's Stationery Office; 1912.
26. World Health Organization. *Increasing Access to Health Workers in Remote and Rural areas Through Improved Retention: Global Policy Recommendations*. Geneva: World Health Organization; 2010.
27. World Health Organization. *Retention of the Health Workforce in Rural and Remote Areas: A Systematic Review*. Geneva: World Health Organization; 2020.
28. Holloway P, Bain-Donohue S, Moore M. Why do doctors work in rural areas in high-income countries? A qualitative systematic review of recruitment and retention. *Aust J Rural Health* 2020;**28**:543–54.
29. Koebisch SH, Rix J, Holmes MM. Recruitment and retention of healthcare professionals in rural Canada: a systematic review. *Can J Rural Med* 2020;**25**:67–78.
30. Russell D, Mathew S, Fitts M, Liddle Z, Murakami-Gold L, Campbell N, *et al*. Interventions for health workforce retention in rural and remote areas: a systematic review. *Hum Resour Health* 2021;**19**:103–7.
31. Terry D, Phan H, Peck B, Hills D, Kirschbaum M, Bishop J, *et al*. Factors contributing to the recruitment and retention of rural pharmacist workforce: a systematic review. *BMC Health Serv Res* 2021;**21**:1052–1.
32. Saito M, Tsuzaki T, Takeda Y. Evaluation of postgraduate rural medical training programs and implications for rural workforce development: a systematic review. *Rural Remote Health* 2022;**22**:7118.
33. Bes JM, Flinterman LE, González AI, Batenburg RS. Recruitment and retention of general practitioners in European medical deserts: a systematic review. *Rural Remote Health* 2023;**23**:7477.
34. Esu EB, Chibuzor M, Aquaisua E, Udoh E, Sam O, Okoroafor S, *et al*. Interventions for improving attraction and retention of health workers in rural and underserved areas: a systematic review of systematic reviews. *J Public Health (Oxf)* 2021;**43**:i54–66.
35. Hays R. Interpreting rural career intention in medical workforce research. *Educ Prim Care* 2017;**28**:7–9.
36. McGrail MR, Nasir BF, Chater AB, Sangelaji B, Kondalsamy-Chennakesavan S. The value of extended short-term medical training placements in smaller rural and remote locations on future work location: a cohort study. *BMJ Open* 2023;**13**:e068704–068704.
37. Quilliam C, Crawford N, McKinstry C, Wong Shee A, Harvey P, Glenister K, Sutton K. Building a rural workforce through identifying supports for rural, mature-aged nursing and allied health students: a systematic scoping review. *Aust J Rural Health* 2021;**29**:643–55.
38. Obamiro KO, Tesfaye WH, Barnett T. Strategies to increase the pharmacist workforce in rural and remote Australia: a scoping review. *Rural Remote Health* 2020;**20**:5741.
39. Moran A, Nancarrow S, Cosgrave C, Griffith A, Memery R. What works, why and how? A scoping review and logic model of rural clinical placements for allied health students. *BMC Health Serv Res* 2020;**20**:866–6.
40. Cosgrave C, Malatzky C, Gillespie J. Social determinants of rural health workforce retention: a scoping review. *Int J Environ Res Public Health* 2019;**16**:314.

41. Gillespie J, Cosgrave C, Malatzky C, Carden C. Sense of place, place attachment, and belonging-in-place in empirical research: a scoping review for rural health workforce research. *Health Place* 2022;**74**:102756.
42. Nuffield Trust, Academy of Medical Royal Colleges. *Acute Care in Remote Settings: Challenges and Potential Solutions*. London: Nuffield Trust; 2016.
43. Richards HM, Farmer J, Selvaraj S. Sustaining the rural primary healthcare workforce: survey of healthcare professionals in the Scottish Highlands. *Rural Remote Health* 2005;**5**:365.
44. Cleland J, Johnston PW, Walker L, Needham G. Attracting healthcare professionals to remote and rural medicine: learning from doctors in training in the north of Scotland. *Med Teach* 2012;**34**:e476–82.
45. Cleland J, Johnston P, Watson V, Krucien N, Skåtun D. What do UK doctors in training value in a post? A discrete choice experiment. *Med Educ* 2016;**50**:189–202.
46. Cleland J, Porteous T, Ejebu O, Skåtun D. 'Should I stay or should I go now?': a qualitative study of why UK doctors retire. *Med Educ* 2020;**54**:821–31.
47. Locock L, Maclaren AS, Skea Z, Murchie P, Hollick R, Wilson P, *et al*. *Enhancing Recruitment and Retention of Doctors in Rural Scotland*. Edinburgh: Chief Scientist Office; 2023.
48. Malatzky C, Cosgrave C, Gillespie J. The utility of conceptualisations of place and belonging in workforce retention: a proposal for future rural health research. *Health Place* 2020;**62**:102279.
49. Paladine HL, Hustedde C, Wendling A, Sola O, Prasad R, Bjorkman S, Phillips J. The role of rural communities in the recruitment and retention of women physicians. *Women Health* 2020;**60**:113–22.
50. Laurence CO, Williamson V, Sumner KE, Fleming J. 'Latte rural': the tangible and intangible factors important in the choice of a rural practice by recent GP graduates. *Rural Remote Health* 2010;**10**:1316.
51. Farmer J, Kilpatrick S. Are rural health professionals also social entrepreneurs? *Soc Sci Med* 2009;**69**:1651–8.
52. Prior M, Farmer J, Godden DJ, Taylor J. More than health: the added value of health services in remote Scotland and Australia. *Health Place* 2010;**16**:1136–44.
53. Kanakis K, McShane CJ, Kilcullen ML, Swinbourne AL. 'It's the people that keep me here': exploring the role of community attachment in increasing length of residency. *J Rural Stud* 2019;**70**:19–25.
54. Curran V, Bornstein S, Jong M, Fleet L. *Strengthening the Medical Workforce in Rural Canada: The Roles of Rural/northern Medical Education. Component 1: Rural Medical Education: A Review of the Literature*. St John's, Newfoundland: Memorial University of Newfoundland; 2004.
55. Cameron PJ, Este DC, Worthington CA. Professional, personal and community: 3 domains of physician retention in rural communities. *Can J Rural Med* 2012;**17**:47–55.
56. Kazanjian A, Pagliccia N. Key factors in physicians' choice of practice location: findings from a survey of practitioners and their spouses. *Health Place* 1996;**2**:27–34.
57. Mayo E. *Spousal Perspectives on Factors Influencing Recruitment and Retention of Rural Family Physicians*. St John's, Newfoundland: Memorial University of Newfoundland; 2004.
58. Myroniuk L, Adamiak P, Bajaj S, Myhre DL. Recruitment and retention of physicians in rural Alberta: the spousal perspective. *Rural Remote Health* 2016;**16**:3620.
59. McGrail MR, Wingrove PM, Petterson SM, Humphreys JS, Russell DJ, Bazemore AW. Measuring the attractiveness of rural communities in accounting for differences of rural primary care workforce supply. *Rural Remote Health* 2017;**17**:3925.
60. Schmitz DF, Baker E, Nukui A, Epperly T. Idaho rural family physician workforce study: the Community Apgar Questionnaire. *Rural Remote Health* 2011;**11**:1769.
61. Mandal A, Phillips S. To stay or not to stay: the role of sense of belonging in the retention of physicians in rural areas. *Int J Circumpolar Health* 2022;**81**:2076977.

62. Cosgrave C. The whole-of-person retention improvement framework: a guide for addressing health workforce challenges in the rural context. *Int J Environ Res Public Health* 2020;**17**:2698.

63. Maclaren AS, Locock L, Skea Z. Valuing place in doctors' decisions to work in remote and rural locations. *Future Healthc J* 2022;**9**:248–51.

64. Cath Cosgrave Consulting. *Attract Connect Stay*. URL: https://attractconnectstay.com.au/ (accessed 30 October 2023).

65. Pierce J. *How We Came to Stay: Narratives of Social Workers in Remote Northern Regions of British Columbia*. Vancouver: University of British Columbia; 2017.

66. Sirili N, Simba D, Zulu JM, Frumence G, Tetui M. Accommodate or reject: the role of local communities in the retention of health workers in rural Tanzania. *Int J Health Policy Manag* 2022;**11**:59–66.

67. Barnett R, Barnett P. 'If you want to sit on your butts you'll get nothing!' Community activism in response to threats of rural hospital closure in southern New Zealand. *Health Place* 2003;**9**:59–71.

68. Veitch C, Grant M. Community involvement in medical practitioner recruitment and retention: reflections on experience. *Rural Remote Health* 2004;**4**:261.

69. Veitch C, Harte J, Hays R, Pashen D, Clark S. Community participation in the recruitment and retention of rural doctors: methodological and logistical considerations. *Aust J Rural Health* 1999;**7**:206–11.

70. Shannon CKA. Community development approach to rural recruitment. *J Rural Health* 2003;**19**:347–53.

71. Urquhart G. *The Role of Community Engagement in Improving Recruitment and Retention of Health Care Workers in Rural and Remote Areas*. Inverness, Scotland: Scottish Making It Work Group; 2018.

72. Kretzman J, McKnight J. *Building Communities from the Inside Out: A Path Toward Finding and Mobilizing a Community's Assets*. Evanston, IL: Institute for Policy Research; 1993.

73. MacLeod MA, Emejulu A. Neoliberalism with a community face? A critical analysis of asset-based community development in Scotland. *J Community Pract* 2014; **22**:430–50.

74. MacQueen KM, McLellan E, Metzger DS, Kegeles S, Strauss RP, Scotti R, *et al*. What is community? An evidence-based definition for participatory public health. *Am J Public Health* 2001;**91**:1929–38.

75. BMJ Publishing Group. *BMJ Careers*. URL: www.bmj.com/careers/ (accessed 30 October 2023).

76. NHS Scotland. *GP Jobs*. URL: www.gpjobs.scot/ (accessed 30 October 2023).

77. NHS Scotland. *NHS Scotland Jobs*. URL: https://jobs.scot.nhs.uk/ (accessed 30 October 2023).

78. Maclaren AS, Cleland J, Locock L, Skea Z, Denison A, Hollick R, *et al*. Understanding recruitment and retention of doctors in rural Scotland: stakeholder perspectives. *Geogr J* 2022;**188**:261–76.

79. Yin RK. *Case Study Research Design and Methods*. 5th edn. Thousand Oaks, CA: Sage; 2014.

80. Crowe S, Cresswell K, Robertson A, Huby G, Avery A, Sheikh A. The case study approach. *BMC Med Res Methodol* 2011;**11**:100.

81. Sheard L. Telling a story or reporting the facts? Interpretation and description in the qualitative analysis of applied health research data: a documentary analysis of peer review reports. *SSM Qual Res Health* 2022;**2**:100166.

82. Broom A. Conceptualizing qualitative data. *Qual Health Res* 2021;**31**:1767–70.

83. Scottish Rural Medicine Collaborative. *GP Recruitment Good Practice Guide: Advertising*. URL: www.recruitment-support.scot.nhs.uk/advertising/ (accessed 1 June 2023).

84. Goddard A. *The Language of Advertising: Written Texts*. 2nd edn. New York: Routledge; 2002.

85. Rath Foley A, Karlsson M. The language of non-commercial advertising: a pragmatic approach. *Int J Lang Stud* 2021;**15**:99–122.

86. General Medical Council. *Good Medical Practice*. London: General Medical Council; 2013.
87. Thomson S, Atterton J, Tiwasing P, McMillan J, Pate L, Vuin A, *et al*. *Rural and Islands Report: 2023 – An Insights Report. An SRUC Output from the NISRIE Project Funded by the Scottish Government*. Edinburgh: Scotland's Rural College; 2023.
88. Woods M, Edwards B, Anderson J, Gardner G. Leadership in Place: Elites, Institutions and Agency in British Rural Community Governance. In Cheshire L, Lawrence G, Higgins V, editors. *Rural Governance: International Perspectives*. London: Routledge; 2007.
89. Magis K. Community resilience: an indicator of social sustainability. *Soc Natur Resour* 2010;**23**:401–16.
90. MacKinnon D, Kate DD. From resilience to resourcefulness. *Prog Hum Geogr* 2013;**37**:253–70.
91. Scottish Rural Medicine Collaborative. *Rediscover the Joy of General Practice*. URL: www.srmc.scot.nhs.uk/joy-project-2/ (accessed 20 October 2023).
92. Orkney.com. *New Horizons with NHS Orkney*. URL: www.orkney.com/news/nhs-orkney (accessed 20 October 2023).
93. Rebanks J. *The Shepherd's Life: A Tale of the Lake District*. London: Penguin Random House; 2015.
94. Woods M. Rural Geography. In Kitchin R, Thrift N, editors. *International Encyclopedia of Human Geography*. Oxford: Elsevier; 2009. pp. 429–42.
95. Cloke P. Rural Landscapes. In Johnson N, Schein R, Winders J, editors. *The Wiley-Blackwell Companion to Cultural Geography*. London: John Wiley & Sons; 2013. p. 225–37.
96. Eliot G. *Middlemarch*. Salt Lake City, UT: Project Gutenberg; 1994.
97. Burnett KA, Danson M. Romance and resilience: the assets and ambition of Scottish 'remote rural' enterprise contexts. *Int J Entrep Innov* 2022;**23**:176–87.
98. Shwaikh M. Beyond expectations of resilience: towards a language of care. *Glob Stud Q* 2023;**3**:ksad030.
99. Bolden R. Distributed leadership in organizations: a review of theory and research. *Int J Manag Rev* 2011;**13**:251–69.
100. Bennett N, Wise C, Woods P, Harvey J. *Distributed Leadership*. Nottingham: National College of School Leadership; 2003.
101. NHS England. *NHS Long Term Workforce Plan*. London: NHS England; 2023.
102. Philpotts E. *Patients Across the UK Are Campaigning to Save Local GP Services*. URL: www.gponline.com/patients-across-uk-campaigning-save-local-gp-services/article/1820318# (accessed 28 July 2023).
103. Scottish Government. *Affordable Housing Initiative for Key Workers*. URL: www.gov.scot/news/affordable-housing-initiative-for-key-workers/ (accessed 20 October 2023).

Appendix 1 A library of examples of community action

We have put together a set of suggestions and ideas for remote and rural communities to help recruit and retain healthcare workers, from our research findings. Our primary focus is on supporting community-led action, but many of the ideas could be equally useful for the NHS and other employers too. The guide is now available online as part of a resource hosted by NHS Education Scotland's National Centre for Remote and Rural Health and Care. URL: https://learn.nes.nhs.scot/73640 (accessed 5 August 2025).

This guide covers the following areas:

Recruitment

- Stakeholder liaison committee and community action plans
- Contributing to job adverts
- Promoting the area as a good place to work
- Making a video
- Social media campaigns
- Working with neighbouring practices
- Help with sourcing housing and practice buildings
- Organising or contributing to pre-application visits
- Job opportunities for partners

Retention

- Pre-arrival questionnaire
- Welcome pack
- Social navigator and buddying
- Informal integration, family members

Recruitment

Stakeholder liaison committee and community action plans

There is some evidence from rural Australia that forming a community action plan can help support both recruitment and retention. A first step is to form a stakeholder liaison committee of key local people – both from the community and local employing organisations – to develop a strategy. Many of the suggestions which we detail below are the kind of actions which might be included in community action plans.

Forming a stakeholder liaison committee needs genuine commitment and openness from all parties. In our case studies, the spur to action was often a failure to recruit by the NHS and frustration from the local community with what they perceived as a lack of action and energy. Sometimes they felt they had to work through a degree of conflict and hostile meetings to get to a point where they could work together, with the NHS accepting help and suggestions and community members agreeing to support the NHS. But once in place, this joint working could unlock ideas, skills and resources.

Contributing to job adverts

Advertising jobs is the responsibility of the NHS or practice as the employer. However, there are various ways the community can support the NHS in collaboration. They can help source attractive photographs, provide useful

information on local schools, the natural environment, leisure activities, social opportunities, transport and housing. One way to do this might be to put together a community-led illustrated information pack online, which can be linked to from the advert. This could be made generally useful for jobs in other shortage sectors too, such as teachers, care workers, skilled trades (see also *Making a video* and *Social media campaigns*).

Promoting the area as a good place to work

Many remote and rural areas are attractive tourist destinations. While this can cause problems (e.g. leading to high property prices and available housing being bought as second homes or holiday rentals), it also presents an opportunity. Some community councils use tourist information as a way to plant the idea in visitors' minds that they could one day come to live and work in this place they find so attractive as a holiday destination. This could include listing local job vacancies in online information and displaying them prominently in visitor information centres. Again, this can apply to jobs across different sectors.

The Welcome Ullapool website is one example: www.ullapool.com/visit/moving-to-ullapool.php (accessed 20 November 2024). This approach reflects what we know from research that people who move to a post in a remote and rural area are not always actively looking; sometimes it is a half-formed idea that only turns into action when they chance upon an advert or a news item, or a friend or relative sees an opportunity they think might be of interest and sends it to them.

Some communities, including Ullapool, also have social media pages with a range of job adverts for anyone already actively looking to move to an area.

Making a video

There are many great examples of videos to support recruitment campaigns. These might be made by the NHS or by the community acting independently, or produced jointly. Some are focused on a specific post; others are generic to the NHS (or any job sector) and may be left online indefinitely for future use by job advertisers, including the NHS. There is a wide range of elements to consider, and many videos include a combination of these:

- Footage of local scenery and outdoor activities
- 'Talking heads' from local NHS staff talking about the work, the team and their wider lives
- Footage of staff themselves involved in activities (dog-walking, wild swimming, playing golf)
- Local restaurants and shops
- Schools and playgrounds
- Places of worship
- Background music, narration or subtitles

Some videos are, in effect, a series of stills, while others include video and drone footage. The costs and skills needed to produce good-quality video are not as much of a barrier as they used to be but are still something to consider. In some cases, videos have been sponsored and/or made for the community by a local business.

Some examples include:

Moray – a general recruitment film about living in the area, featuring interviews with several HCPs as well as other professionals (including a solicitor and a teacher) and footage of scenery. Produced jointly by Moray Council and NHS and with a range of sponsors and contributors. www.youtube.com/watch?v=jHFNBb3EVIQ (accessed 20 November 2024)

Lostwithiel – specific GP recruitment campaign featuring many members of the community singing about their community and why they need a doctor. Local GP practice and community partnership with a local not-for-profit organisation, Really Lovely Projects CIC. https://www.reallylovelyprojects.org.uk/#/lostwithiel-needs-a-doctor/ (accessed 5 August 2025)

Millom – specific GP recruitment campaign featuring an appeal from local primary school children, as well as interviews with HCPs and footage of outdoor leisure and scenery, and a final appeal from members of the community.

Community-led, partnering with NHS. The process is described in https://ijic.org/articles/10.5334/ijic.3789 (accessed 5 August 2025)

Isle of Man – generic recruitment video about consultant careers, with consultant interviews and local scenery and lifestyle. Produced by Isle of Man health service, Manx Care. www.youtube.com/watch?v=ta-hSBgdEXw (accessed 20 November 2024)

Oban – generic video featuring music and scenery, no interviews or narration, inviting people to 'Live, work, play, relax – and fall in love with Oban'. Made by a local walking company which also runs a video marketing business, Imagine Alba, 'proudly supporting our NHS'. https://youtu.be/SjxX2VS-JKQ (accessed 20 November 2024)

When someone has been recruited following a community video campaign, it is worth considering inviting them to come and meet people who took part in or organised the video, so people can see the impact of their involvement. This may also help the incoming staff member meet people and feel welcome.

Social media campaigns

Often used in conjunction with a video, social media campaigns are aimed at spreading news of a vacancy to the widest possible audience beyond NHS recruitment avenues, including to those not actively looking for a career move but who might be tempted, or to the family members of potential applicants.

Such campaigns often feature a press release, a dedicated website and a catchy hashtag. Some have included photos of the hashtag on a poster taken at local beauty spots, or spoof 'WANTED!' posters. The Lostwithiel campaign includes an image of a large cheque made out to 'YOU' for 'a great salary' and signed by 'Lostwithiel'.

One idea to reach people who may not actively be looking for a post is to use social media groups focused on particular leisure or sporting activities, such as hiking, cycling or wild swimming.

Drawing on local residents' skills in marketing, design and communications, where these exist, can help raise the profile of a campaign, particularly getting it into local and national press and broadcast media. Having a stakeholder liaison committee can help with identifying relevant professional skills available locally. In tourist areas, this could include scouting for skills among second homeowners as well as permanent residents.

The island of Colonsay readvertised their GP job in the *BMJ* after an initial failure to recruit, with the local patient representative group working closely with the NHS. The retiring GP couple made a video about the job and the way of life. https://vimeo.com/371821621?1&ref=fb-share&fbclid=IwY2xjawGqslIleHRuA2FlbQIxMQABHSsL4nB8iHFuodkFM6ikjIRRHKiKQeL2px9pPQN-4XO2VvvVHa_enQ0Bog_aem_Sh67-ZKIo8UbRBFhNz0lyA (accessed 20 November 2024)

www.srmc.scot.nhs.uk/video-helps-put-spotlight-on-rural-gp-opportunities/ (accessed 20 November 2024)

The founder of the patient representative group gave an interview to the Oban Times, and the story of the vacancy was then picked up by other newspapers, including the Scotsman and the Guardian. www.scotsman.com/news/people/remote-scottish-community-will-be-left-with-no-gp-when-married-doctors-retire-1555461 (accessed 20 November 2024)

www.theguardian.com/uk-news/2020/feb/08/colonsay-island-inner-hebrides-doctor-needed (accessed 20 November 2024)

Two of the four members of the patient representative group joined the interview panel, and the SRMC reported on the successful recruitment of a new GP. www.srmc.scot.nhs.uk/new-gp-for-jewel-of-the-hebrides-appointed/ (accessed 20 November 2024)

Working with neighbouring practices

In some cases, where a GP is retiring and an individual replacement cannot be found, communities have turned to GP practices in other towns or villages in the area, and invited them to express interest in taking on a new branch surgery. Negotiating this with the NHS may not always be easy, but communities have, in some cases, developed an alliance with nearby GPs who are already committed to living and working rurally and know the local context.

Help with sourcing housing and practice buildings

Access to affordable housing is a key factor for both recruitment and retention and one that communities may find it difficult to support alone without central and/or local government investment. In some remote areas, there may be no housing available at all, affordable or otherwise, particularly when there is a high percentage of second homes. We heard repeated concerns about the selling off of tied housing, whether for healthcare workers or teachers, police officers and others. A few places are lucky enough to still have some tied housing available, and some communities are looking to re-establish tied accommodation and low-rent properties for key workers.

One example is Tomintoul in Moray, where the Tomintoul and Glenlivet Development Trust worked with the Communities Housing Trust to purchase a derelict secondary school which had been empty for two decades, demolish it and build 12 affordable homes. The properties have been allocated to people with a strong connection to the area and are protected from being used as holiday lets or second homes. www.chtrust.co.uk/case-studies1.html#tomintoul (accessed 20 November 2024)

Creative local solutions have involved local residents who own a second property deciding to rent it only to key workers; community buy-outs; conversion/change of use of disused offices or clinic buildings into homes. Indeed, in some cases, a community buy-out of a surgery building might also become an option, thus not requiring a new GP to invest in practice ownership. Alternatively, communities might be able to work with the local NHS to support or contribute to a buy-out of premises.

Despite these instances of community action, however, housing remains a difficult problem for communities to solve. The Scottish Government has announced an Affordable Housing Initiative for key workers in rural areas. Up to £25M is being made available over 5 years to help councils identify affordable homes and to enable local authorities and registered social landlords to acquire or lease properties. www.gov.scot/news/affordable-housing-initiative-for-key-workers/ (accessed 20 November 2024)

Organising or contributing to pre-application visits

Several communities had arranged orientation visits for people interested in applying, or for shortlisted candidates. The NHS may offer visits to meet the practice team and find out more about the job, but community visits are pitched more around showing people the area, finding out about schools and housing, meeting local people and experiencing transport connections. This overlaps with retention – people are more likely to stay if they have some knowledge of the place and realistic expectations, and they are more likely to settle in quickly if they have already met some people socially. In one case, a couple who had already decided to move were invited to a New Year ceilidh, as a way to meet lots of people in one go.

Job opportunities for partners

Another issue which overlaps with retention is job opportunities for partners (and other adult family members). A key factor for many people in deciding to move or not is whether their partner can find employment that they enjoy. Some communities have put together a list of vacancies in the area and/or made introductions for partners of new healthcare staff to meet potential employers. (See also *Promoting the area as a good place to work*).

It may be possible to recruit dual healthcare worker couples at the same time – for example, to a job share or to a GP and an ANP vacancy separately. One English NHS trust made a point of stating in a job advert that they would actively welcome a discussion with partners about employment opportunities within the trust. Communities could work with local NHS employers to encourage this approach more widely.

Retention

An important factor in retention is ensuring new arrivals feel quickly settled and integrated. This is something where communities can play an active part.

Pre-arrival questionnaire

In order to get a sense of the new arrival, their family and their interests, one suggestion is to send them a questionnaire. This could include questions about what kind of activities they enjoy doing, whether they have any pets, who else in the family is coming and what ages they are, whether they are interested in volunteering or joining any clubs, and what they'd like their new neighbours to know about them. It would be important to stress that this is optional, and word it to be welcoming rather than intrusive.

Welcome pack

Communities might consider putting together a welcome pack for new arrivals, which might be generic but could also include tailored suggestions building on a pre-arrival questionnaire (e.g. new parents might want to know about mother and baby groups).

Examples have included information about:

Schools/nurseries	Shopping, banking	Estate agents	Cinema/theatre/mobile cinemas
Transport	Dentists, pharmacies	Sports clubs	Social/hobby/crafting groups
Outdoor activities	Choirs	Local history	Upcoming events or festivals
Places of worship	Nature/wildlife	Volunteering	Local authorities

Social navigator and buddying

Several communities described to us the role of key individuals who went out of their way to help newcomers meet people, make friends and get involved in local social life. Often, this is very informal and highly dependent on individuals who are willing to make the effort, but it was suggested to us that it could become more organised, with a welcoming committee of several people willing to be assigned to support specific new arrivals as 'social navigators' or buddies. One person envisaged a kind of 'social passport', based on information about the new person's interests, giving them a list of activities to try and names of key people to contact.

Professional practice in remote and rural areas can feel quite isolating, so another suggestion was to link people up with a peer buddy or mentor in another remote area. This was not in the sense of a professional, work-related mentor – though that is also important for the NHS to consider – but someone who understands what it is like to be new and trying to manage the tensions of making friends where everyone is also your patient. Communities may know of a GP in a neighbouring community or island who might be willing to share experiences and be a listening ear.

Informal integration, family members

At the same time, there will always be a role for informal efforts by individual community members to make new healthcare workers and their families feel welcome and less lonely, from taking round a cake to inviting people to dinner or children to come round to play. The original inspiration for our research was a story from one community about a family member of a newly arrived GP; when it transpired that this person liked playing Scrabble, the simple but powerful act was for a 'social navigator' in the community to find other people nearby who also liked to play a game of Scrabble and put them in touch. Importantly, this can also help alleviate loneliness for long-term residents, seeing new arrivals as an asset for the social life of the community.

EME
HSDR
HTA
PGfAR
PHR

Part of the NIHR Journals Library
www.journalslibrary.nihr.ac.uk

Published by the NIHR Journals Library