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Extended Research Article

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

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Scientific summary

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

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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.

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