



Summary Paper of PhD Thesis

**An exploration into the recruitment and retention challenges of nurses to rural Mid
Wales**

(Working Title)

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ii. Caveat

The PhD thesis is still in production but is anticipated to be presented for examination later in the year. The final thesis is therefore subject to amendments and corrections based on examiners comments and may contain content which is slightly different to what is presented here.

iii. Preface

Rural Health and Care Wales [RHCW] has provided a part-time stipend for four years to the candidate, which has enabled the continuation of PhD studies at Aberystwyth University. The focus of the study was to explore workforce challenges, specifically recruitment and retention of nurses to work in rural Mid Wales, in an attempt to determine and understand the barriers and concerns of securing a future nursing workforce in the locality.

Whilst promoting and representing Aberystwyth University, the Centre of Excellence for Rural Health Research and Rural Health and Care Wales, this programme of research has contributed to the following national and international conferences, publications and clinical disseminations:

- | | |
|-----------|--|
| Nov 2020 | Rural Health and Care Wales Conference – Poster presentation
<i>'A historical account of rural health and care services: a brief journey through time'</i> |
| Jan 2020 | Learned Society of Wales – Joint winner for poster and oral presentation
<i>'The Excitement of the City: the perspectives of Welsh urban working nurses regarding the rural recruitment challenge'</i> |
| Nov 2019 | Rural Health and Care Wales Conference – Oral presentation
<i>'How urban based nurses can inform the rural recruitment challenge'</i> |
| Nov 2019 | Published academic article (Journal of Rural Studies – Impact Factor 3.3).
For the full article, see:
<i>Jones, A., Rahman, R. J. & O, J. (2019). A crisis in the countryside - Barriers to nurse recruitment and retention in rural areas of high-income countries: A qualitative meta-analysis. Journal of Rural Studies, 72, 153-163.</i> |
| Feb 2019 | Public Health Wales Showcase Conference – Poster presentation
<i>'Time and Travel: the perspectives of Welsh rural nurses regarding the rural recruitment challenge'</i> |
| Nov 2018 | Rural Health and Care Wales Conference – Oral presentation
<i>'Time, Traffic and Travel: the perspectives of Welsh rural nurses regarding the rural recruitment challenge'</i> |
| Aug 2018 | Rural Health and Care Wales Research Series – Booklet
<i>'Health in the HINTERLANDS: the Welsh rural nurse recruitment and retention challenge'</i> |
| Nov 2017 | Rural Health and Care Wales Conference – Poster presentation
<i>'Health in the HINTERLANDS: the Welsh rural nurse recruitment and retention challenge'</i> |
| July 2017 | Inspiring Innovation in Practice Conference - Oral presentation:
<i>'Rural Nurse Recruitment and Retention: a crisis in the countryside'</i> |
| June 2017 | Trans-Atlantic Rural Research Network - Discussion paper:
<i>'Rural Nurse Recruitment and Retention: a crisis in the countryside'</i> |
| May 2017 | Chief Nursing Officer's Conference - Poster presentation:
<i>'Health in the Hinterlands: the Welsh rural nurse recruitment and retention challenge'</i> |

1. Setting the scene

1.1 The global context

Safeguarding the healthcare workforce is an ongoing concern in countries across the globe; but the situation is exacerbated by the fact that the sector as a whole is affected by significant shortfall in numbers (Scheil-Adlung, 2015; World Health Organisation [WHO], 2006). Although this is worrying for all healthcare employers and care providers, ensuring a rural workforce has been a significant concern for some time, and has affected numerous countries, world-wide (Gross et al., 2010; Paliadelis, Parmenter, Parker, Giles & Higgins, 2012; Leipert & Anderson, 2012; Stroth, 2010). For rural areas, the situation is further compounded by the unbalanced distribution of existing healthcare staff (Grobler, Marais & Mabunda, 2015). Indeed, the WHO (2010) earlier identified this disparity, when they confirmed that half of the world's population live in rural areas, yet their healthcare provision is provided by 24% of the world's doctors and 38% of the world's nurses. Similar maldistributions have been identified in rural Canada, Australia and South Africa (Canadian Institute for Health Information [CIHI], 2018; National Rural Health Alliance, 2013; Department of Health Republic of South Africa, 2011).

Although the healthcare workforce comprises of a range of multidisciplinary health professions, all of which are reduced in rural areas (Lori et al., 2012; Daniels, VanLeit, Skipper, Sanders & Rhyme, 2007; Turner & Lane, 2006; Kippenbrock, Stacy & Gilbert-Palmer, 2004), nurses are identified as the largest of the healthcare team working there, providing holistic, hands-on patient care, 24 hours a day, seven days a week. Shortages in the nursing workforce in any geographic area has knock-on impacts on patient care services, such as reduced hospital inpatient capacity, hospital ward closures, post-operative complications, increased infection rates and sadly, mortality (Lintern, 2016; Longhurst, 2016; Hugonnet, Villaveces & Pittet, 2007; Holmas, 2002).

But efforts to ensure a nursing workforce comes at a time when the profession as a whole is in state of flux regarding its overall numbers in both rural and urban areas (Nursing and Midwifery Council, 2017; Royal College of Nursing [RCN], 2015; CIHI, 2018; Brewer, Zayas, Kahn & Sienkiewicz, 2006; Health Workforce Australia, 2012). Whilst this is concerning and the impacts are severe, this situation is likely to be worse in rural areas (Cramer, Ninaber, Helget & Agrawal, 2006) where other than the existing nursing workforce, very few additional nurses reside permanently in these localities to fill ongoing vacancies. Such a situation has led Rohatinsky and Jahner (2016), Nowrouzi et al., (2015) and Leipert and Anderson (2012) to warn of the negative impact this can present to rural areas in their ability to provide quality, healthcare treatments.

Many authors have studied the rural workforces within low- and middle-income countries (LMIC) (Wurie, Samai & Witters, 2016; Abimbola et al. 2015; Darkwa, Newman, Kawkab & Chowdhury, 2015; Ojaka, Olango & Jarvis, 2014). But the WHO (2010) identified that these concerns were now extending to workforces within high income countries, and this phenomenon is difficult to understand, given the rural idyll perceived in such areas (Welsh Government: Rural Health Plan, 2009; Bourke, Waite & Wright, 2014). Nevertheless, the shortages within the rural nursing workforce continues, and as such presents a complex situation for understanding the barriers that impact on recruitment and retention.

Given the importance of identifying and comprehending these barriers, a systematic literature search and comprehensive qualitative meta-analysis was conducted which specifically focused on high income countries (Jones, Rahman & O, 2019). The results

concluded that themes in relation to *Health Service Demands, Challenges of Accessing Continuous Professional Development and Clinical Progression Restrictions, and the Rural Demography* contributed to recruitment and retention difficulties of nurses to rural areas in the high-income countries represented in the meta-analysis. Whilst this meta-analysis provided important insights regarding the barriers rural areas face in ensuring their workforce, it also identified limitations from a global perspective, which were key considerations to reflect within this programme of study. These included:

- Acknowledging that there was a difference between recruitment and retention – *different barriers may be evident as it was questionable whether the barriers identified impacted on one or both of these factors.*
- The body of evidence included predominantly rural residents and lacked wider stakeholder views - *rural nurses, who provided anecdotal evidence regarding rural workforce barriers, could not speak for other non-rural working nurses' perceptions, intentions or decisions about work in rural areas.*
- The papers included in the meta-analysis contained data from three countries only – namely Australia, Canada and the USA – *resulting in an inability to compare the results on a more global basis, where rural geographies of other high-income countries may vary.*

As a result, the following research aimed to build on the existing body of literature by considering the barriers to nurse recruitment and retention from a specific Welsh perspective, where the scale of rurality could result in different contributing factors than those in countries such as Canada, Australia and the USA. This is highly important given that a significant landmass of Wales is considered as rural, and the people living there are considered as rural residents and understanding barriers to ensuring a health workforce in these rural areas is vital. In addition, the research sought to consider perspectives from both rural and urban based nurses so that wider stakeholder views of the barriers to rural recruitment and retention could be considered from both viewpoints.

1.2 The Welsh context

Countries such as Canada, Australia and the USA have been trailblazers with regard to rural health research. But, interestingly, other countries, such as Wales are echoing rural recruitment and retention challenges, highlighting that rural areas from different high-income countries are also experiencing common difficulties. But this is especially interesting, given that Wales' rural geography is vastly different to those observed in Australia, Canada and the USA.

Indeed, Longley, Llewelyn, Beddow and Evans (2014) identified that the definition of rural was 'hotly contested' (p12), and their report, which accepted Mid Wales as being rural, identified that the recruitment and retention challenges of health staff within that geographical area was also problematic. This realisation presents the possibility that a scale of rurality may exist, which is geographically unique to rural areas across the globe. Research within these areas can potentially contribute new perspectives to the body of evidence regarding global, rural health research. However, whilst the challenges may be similar, the scale of rurality is different leading to the possibility that the barriers and subsequent solutions may also differ. Accepting results from other global research which has been conducted within a specific rural definition may result in the findings being

ungeneralizable to rural Mid Wales. Therefore, in order to develop appropriate strategies to implement within this particular geographical area - to address the reduction in their nursing workforce, there is a need to better understand the challenges which are specific to this geographic area.

Understanding the rural healthcare workforce in Wales is somewhat complex, as Health Board configurations mean that some include both rural and urban geographic areas within their catchments. And as such, nursing numbers across the country are not collated specifically on a rural or urban basis. Shortfalls in the workforce were identified by the RCN Wales (2019), who reported that on an all-Wales basis, additional hours worked by existing nurses to cover gaps in the work rota accounted to 976 full time-nurses, and the agency spend of £63.8m in 2018/19 in Wales equated to the salaries of 2,635 new nurses (RCN Wales, 2019). In addition, during 2018/19 the Health Boards that cover the rural Mid Wales region reported vacancies of around 738 whole time equivalent [WTE] nurses (RCN Wales, 2019), although it is acknowledged that not all of these vacancies were located in their rural regions. Further, the RCN Wales (2019) were somewhat concerned about how this data was collated and felt the overall numbers to be much higher, especially as the agency nurse spend for these Health Board alone amounted to around £28.6 million during 2018-19 (Welsh Government, 2019). These numbers display the concerning scale of the problem, on an all-Wales and rural Wales basis.

1.3 The focus of the research

The root cause of the barriers to recruitment and retention of nurses to rural Wales must be identified before any meaningful solutions can be devised. Therefore, the aim of this exploratory research was to:

Identify the barriers and challenges of recruiting and retaining nurses to rural Mid Wales

2. Methodology

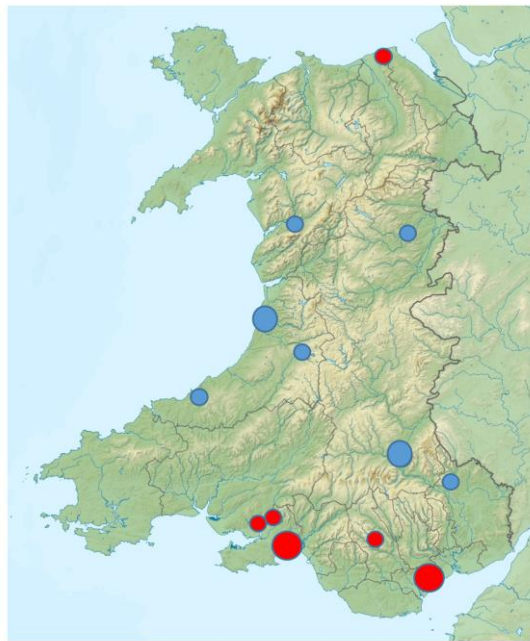
2.1 Research design and focus

This research was conducted utilising a qualitative, exploratory paradigm, which was designed to capture an urban and rural perspective. The definitions of rural and urban were influenced by Bibby and Brindley (2013), Statistics for Wales (2008) and Gartner, Gibbon and Riley's (2007) data maps, who confirmed that a clear divide differentiated rural and urban locations within Wales. These divides were further confirmed with population density information of these localities. Therefore, this research identified Powys, Ceredigion and South Gwynedd, as rural areas of Wales, and Swansea, Neath Port Talbot, Vale of Glamorgan, Cardiff, Denbighshire, Flintshire and Wrexham as urban areas.

In line with the procedure for conducting health related research in Wales, the Integrated Research Application System process was followed (IRAS number 229427), as well as satisfying all permissions and ethical requirements as per NHS Health Research Authority's policy document - UK Policy Framework for Health and Social Care Research (2017), which included consent, anonymity, confidentiality and so forth.

All registered nurses, currently working in Health Boards from the rural/urban definition areas [Hywel Dda University Health Board/Powys Teaching Health Board/Betsi Cadwaladr University Health Board/Abertawe Bro Morgannwg University Health Board (now Swansea Bay University Health Board)/Cardiff and Vale University Health Board] were invited to participate. The invitation was sent by email to key Health Board Senior Nurses

and Research Departments, with a request to share the bilingual information and promote the study widely within their networks. Focus groups of between 2-3 registered nurses were conducted and were complemented by 1:1 interviews when nurses were unable to attend focus group meetings. In total, 30 nurses provided information for the study, which also included demographic data such as age, job roles, number of years working as a nurse, ethnicity and first language preference, with an even number of rural and urban based participants taking part (i.e., rural n=15; urban n=15). The participants provided over 20 hours of data, which resulted in data saturation being reached. Figure 1 shows the locations of the participants on an all-Wales basis. A larger dot denotes multiple participants from the area. Most of the rural participants were identified from the Ceredigion locality, although the Mid Wales region was also represented. The majority of urban participants came from the Cardiff/Swansea localities, with only one participant taking part from North Wales/BCUHB. There was also a mix of participants taking part from these areas, meaning some were nurses who had always lived and worked in either of their rural or urban locations, others who had moved from rural to urban and vice versa, and some who had moved from their rural homes to other areas for training purposes, but had since returned to their rural roots.



*(Figure 2: Locations of participants
Blue dots denote rural participants
Red dots denote urban participants)*

2.2 Data analysis

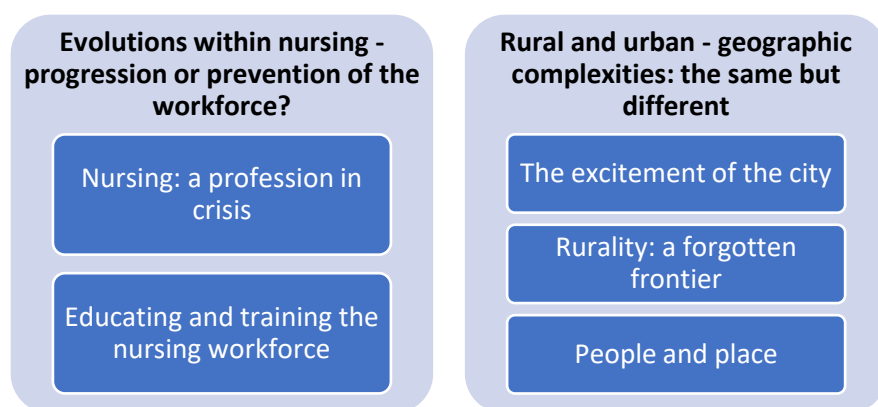
The focus groups and interviews collated information from the participants via a semi-structured written guide, which included demographic variables, and prompts which explored their nursing stories and reasons for becoming a nurse, training location, dates and arrangements. Opinions and perspective regarding rural and urban working, including rural recruitment challenges were also discussed, as well as suggesting possible solutions and future workforce improvements in this field.

Inductive thematic analysis was undertaken on the whole data set to determine key themes and topics which were pertinent to the research question. Braun and Clarke's (2006) data analysis framework was utilised and informed the thematic analysis process. This model also addressed quality concerns (which may be associated with qualitative research), and their six-step approach considered the quality of data analysis at every stage, resulting in valid and reliable results.

The data collection element of the research was conducted during 2017-2018 and had concluded prior to the commencement of the Covid-19 pandemic.

3. Findings

Two overarching themes were identified from the research, with sub-themes pertinent to each topic also being determined. For the purposes of this summary paper, the key findings of the overarching themes are summarised. A full write up of the themes with sub-themes will be available once the final theses has been published. These themes were:



3.1 *Evolutions within nursing - progression or prevention of the workforce?*

3.1.1 *Nursing: a profession in crisis*

As with all professions over time, evolution and changes have occurred; however, in the main participants questioned whether some of the decisions that were made – especially in relation to workforce and educational decisions, were progressive in nature or if they contributed to the challenges currently facing the profession. It was felt that nursing was presently a profession in crisis, with a vacancy rate of over 50,000 nurses being highlighted. But it was identified that changes in society had meant that nursing was having to compete with a myriad of other career choices, which presented as more attractive as a longer-term occupation. The stark realities of shift work, the nature of the work involved, and the lack of financial recompense was a reality that was highlighted as potentially discouraging for future recruits, who favoured different and improved working environments that were perceived to offer better financial rewards.

In view of the first-hand experiences of nurses, they questioned if they would truly advocate the career to others, which in turn did little to support nurse recruitment. However, the nurses' experiences were very real and for some – quite raw, and their discussions highlighted the use of distressing language when describing their nursing careers. Very often their descriptions of their working environments and treatment of them

drew parallels with going into battle, rather than of a healthcare environment, delivering hands-on care.

In view of this, it was felt that nursing as an overall profession had lost its way and had lost its kindness, with many speaking about bullying behaviours which resulted in staff looking to leave the profession. Nursing was felt to be a profession where only the strong and tough survived, and it was felt that it was no longer a career of longevity, as was the case in years past. Nurses described – either from personal or colleagues' experiences, how being worn down and dealing with conflict was a frequent occurrence.

This was concerning in rural areas, where changes to Health Board boundaries meant that some Health Boards subsequently included rural and urban areas within their catchments. Attempts to standardise working practices was believed to impact more greatly on rural areas, where offsite managerial decision-making was felt to rarely consider rural needs. Such an example was mentioned in relation to mandatory training, which had been relocated to an urban locality of a Health Board in order to pool resources, meaning that training that had been routinely available on-site in a rural area now involved rural working staff travelling (up to) two hours each way, to access that training.

In the main, morale was felt to be low, with nurses feeling that they were not listened to. It was felt that their roles had changed from delivering hands on care to having managerial responsibilities and having to juggle several work duties. Some participants also felt that certain high expectations were also evident from their senior management staff regarding meeting those requirements. Participants therefore questioned who was responsible for delivering care to patients on the wards, and a situation arose where the role of the nurse no longer matched the image or expectations which had driven them to become nurses in the first place. Such a view was felt to be associated with retention, as some of the participants highlighted that nurses had left their posts as a result of the mismatch between their expectations and the reality of the role.

Despite being a profession that needed to embrace continual change, the participants felt that on the whole, change within nursing was met with resistance and negativity. Some staff felt that the inability to accept changing practices led to a stagnant service being delivered where no capacity for new and innovative care models could be instigated. However, others felt that the modernisation agenda of clinical change impacted on the holistic ethos of care, where the fundamentals of the professional was again lost. This was especially highlighted in rural areas, where it was felt that nurses went above and beyond their clinical role – mainly as the range of services didn't exist within their localities; however, their contributions to care delivery were felt to be overlooked. Such a lack of understanding led to frustrations within the rural workforce.

Another change that participants critically highlighted was the discontinuation of the State Enrolled Nursing [SEN] role, and as such felt that it contributed to the current staffing difficulties. It was acknowledged that SENs delivered excellent hands-on care and were content in being and remaining as bedside nurses. But ceasing a training route that, in effect provided a significant proportion of the overall nursing workforce, in order to focus on the professionalism agenda was felt to contribute to the current challenges within maintaining workforce numbers. Especially as it was voiced that not everyone had the academic ability to pursue a university route of becoming a nurse. This theme perpetuated the long running debate regarding the need for a degree to provide care, and terms coined in the 1990s as 'too posh to wash' and 'too clever to care' appeared to forever linger.

However, recent workforce developments of introducing a 'nursing associate' role was met with some scepticism, with many believing it was the reintroduction of the aforementioned SEN, but in a new guise. The participants were not altogether resistant to new roles being developed in order to support them in their workplaces, but some felt that repackaging an old role and presenting it as something new highlighted that regulators and service designers had not accepted the mistakes of the past and were insulting nurses with their proposals of 'new' developments.

It was no secret that the centralisation agenda focused on housing services and facilities in larger urban areas, with a 'all in one roof' mantra. The majority of the urban participants felt this to be a positive development; although some did recognise the additional hardship this would impose on people living in more rural areas, who were a distance away from the central core, and the challenges this would pose for accessing healthcare treatments. The economy of scale that centralisation provided proved to be attractive, with urban participants highlighting that better scope of care provision could be ensured. The suite of services on offer, was also believed to be able to drive and improve healthcare treatments through collaboration and research, and crucially nurse recruitment was boosted by the opportunities on offer, which was seen as a draw to work in such specific areas.

These elements were felt to be missing in rural areas, although it was understood that such regions had little choice in the matter, as the centralisation agenda and its resulting implications were felt to have been imposed on them, rather than the model of care being a mutually agreed move. Rural areas were left with the perception that they were looked down upon by their urban counterparts, delivering a type of healthcare that was slow and boring. Urban healthcare in contrast was described as being fast paced, dynamic and being able to provide cutting edge treatments. Numerous participants spoke of the cut and thrust of their urban working environments, which attracted them and kept them in post. An apathy for rural working was identified from those working in such urban environments, and rural working therefore had no appeal. Urban participants, despite the rural idyll, remarked that they would not be attracted to such posts, which questioned the focus and success rates of attraction campaigns concentrating on urban recruits for rural recruitment.

Despite the attraction of urban working vocalised, an element that was also interestingly determined in the analysis was the realisations of what urban practice ultimately meant. The specialised nature of such working meant that once nurses had specialised in their working career, they felt unable to move locations due to limited opportunities to continue their specialism elsewhere. This was identified in several of the discussions, and in order to show commitment to their specialised urban roles they were required to sacrifice other aspects of their lives.

Rural healthcare was identified as being a type of healthcare practice that was all things to all people. Meaning that due to the lack of larger health teams working in such areas, rural practitioners needed to be well versed and confident in a range of generalist skills and having vast clinical knowledge in being able to deal with any healthcare situation presented to them. This introduced the identification of the characteristics of rural working, which included autonomy and responsibility against a backdrop of professional isolation. Due to the realities of rural working, concepts such as lone working, clinical confidence, competence and advanced clinical skills abilities needed to be accepted and practiced when working in such geographic environments. It was acknowledged that not all nurses could

work under such circumstances, and the rural nurses highlighted this within their working areas and felt that it contributed to their recruitment and retention problems.

The advanced scope of practice that the rural nurses spoke of was in contrast to what the urban participants had expressed earlier, regarding rural working being considered slow and not dynamic. However, urban participants' concerns regarding the erosion of clinical skills contributed to an interesting debate. The lower population density of rural areas highlighted that the throughput of patients was very different to that in urban areas. Therefore, a situation arose where rural nurses who must possess advanced and varied clinical skills appeared to be at odds with a working environment that presented reduced opportunities to use such skills regularly in order to maintain their competence. Such a situation added to the complexity of rural nursing practice. The rural geography dictated much of rural practice. This was seen in the number of visits rural community practitioners were able to make during their working day or the type of input families needed during a home visit, as geographic distances meant that it was not always possible for nurses to pop back and forth. Rural nurses also spoke of the holistic nature of their input, which resulted in them participating in activities that at times, fell outside of their healthcare remit but would impact the health of their patients and the wider family.

3.1.2 *Educating and training the nursing workforce*

The data highlighted that there was debate regarding the academic requirements for university entry being too high for prospective recruits, with many failing to gain places. Although some participants explained that different entry pathways were now available, others felt that more support and pathway programmes could be devised to help those interested in nursing careers realise their goals. In addition, centralisation was favoured within educational models, and this was felt to be important to a number of the urban based participants who championed its existence. They highlighted that a lack of consistent practices on an all-Wales basis was concerning and suggestions aimed at devolving educational responsibilities and academic learning from centralised cores in order to improve rural access, could result in further inconsistent nursing approaches. In addition, the teaching profession was felt to be spread too thinly, and policing quality nursing standards would be made more difficult. It was felt that areas outside of urban localities would not be able to provide enough exposure and the grounding needed for students to learn their profession. However, other urban based nurses could see the benefit of rural education delivery, especially for those rural dwelling individuals who were unable relocate their lives, but the viability, sustainability and potential success of such programmes were questioned and the need for careful thought and planning was emphasised were this to be pursued.

However, this viewpoint was contested by the rural working nurses, which was felt to contribute towards the negative perceptions which rural professionals felt that their urban counterparts held towards them. They felt that nursing at its core was about delivering hands on care to patients, and that the fundamental principles of care could be taught anywhere. Therefore, nurse training was felt to be about enabling students to become general nurses, who all possessed the foundational knowledge that met with their registration requirements. It was felt that nurse training was not about urban based centres producing future nurses capable of urban working only, moulded in the model of urban centralisation. The rural participants felt that the upskill to nurse specialism should come later on in nursing careers.

The financial and practical arrangements of nurse training featured very strongly in the participants' narratives. The nurses within the study all experienced different training routes via Schools of Nursing or University provision. Relocating nurse training into universities saw nurse education being moved from regional localities to specified urbanised areas within the country. Such a move made geographic access very difficult for those living away from those centralised university areas, and again participants felt this contributed to the current staffing difficulty. Especially as those interested to become nurses who lived considerable distances away from university campuses may not always be able to relocate or commute because of financial constraints and/or family commitments.

This move was also viewed as a barrier for more mature people to enter nursing, as they may be unable to leave paid employment to live on student loans, where the financial input from those systems would not meet rental/mortgage payments, bills, childcare and living costs. It was felt that such mature people could also have caring responsibilities. Therefore, completing a degree programme that required students to work full time in the clinical area, having to complete associated assignment work as well as having to secure additional employment and ensure personal family time could prove to be untenable for some and therefore resulted in a missed opportunity for a pipeline into the profession.

The centralisation of nurse education also posed problems for current registered nurses to access continuous professional development [CPD] activities, as again both groups identified that provision in the main were delivered from large urban education centres. The urban group spoke about the ease of access to ensure their CPD requirements, whilst the rural nurses highlighted the lengthy commute they faced to access additional training opportunities. This element featured heavily in the consideration about whether to undertake CPD training. The lack of use of technological advancements were criticised, with many believing that despite technology being available, universities still favoured attendances in class and were not open or sympathetic to rural practitioners' needs by changing their education delivery focus to support their CPD endeavours.

In view of the issues highlighted by the participants, it was apparent that the profession was no longer in control of its own destiny. Power struggles were evident between policy makers, regulators, managers, and universities, which resulted in the nursing profession being the casualty of such battles.

3.2 Rural and urban - geographic complexities: the same but different

3.2.1 The excitement of the city

The movement of people globally is a natural phenomenon; however, it was suggested that urban areas benefit disproportionately from this occurrence compared to rural areas. The bright lights of the city were felt to be a strong magnet, especially for the younger generation, who after leaving college or school were wanting to leave home and explore the world. This was supported by discussions from all of the participants, who also felt that rural youngsters were leaving home with the belief that the city had more to offer them in terms of working and social opportunities. Whilst it was accepted by both groups that the city held a certain attraction, participants from rural areas also felt that a negative perception of living and working in their geographic areas existed.

3.2.2 Rurality: a forgotten frontier

It was felt that rural was a loaded term meaning different things to different people. This proved to be the case in the manner with which different participants discussed their

view of rurality. Although in the main, descriptions referred to where it was, who was there and what was there. Therefore, participants regarded rural as in the middle of nowhere, far from anywhere, with low population density - which was sparse and contained very little industry and infrastructure, other than agricultural communities. However, participants talked about other aspects of rurality in different ways and understanding the differences in how rural was perceived provided valuable insights to how individuals considered working and living in these environments.

Urban participants believed that rural existed within their urban environments, linking their urban green spaces to their descriptions. Some urban participants spoke about urban development destroying their rural areas, meaning that historically some communities within the urban counties were - to them, considered rural, because they weren't located in the actual city boundary. But the progression of urbanised infrastructures over the years meant that it was now impossible to determine where one community started, and another ended. These participants acknowledged that whilst these areas were considered as rural to them due to their historic memories, to others they would be very much seen as urban.

The rural workforce lived within their rural communities within a description that ultimately accepted it being located a great distance away from urbanised areas. Again, very different descriptions of lifestyles emerged, when compared to earlier viewpoints regarding the buzz of city living. Whilst negatives such as limited childcare facilities, reduced access to services, amenities and resources, and reduced socialisation opportunities were identified by both groups, and did cause hardships for some, overall, these arrangements appeared to be accepted by the rural working participants but were looked at unfavourably by the urban nurses.

However, the reduced infrastructure in rural areas did underline the lack of industry that was housed in these regions, which in turn highlighted the lack of employment opportunities available. This was especially so if people had careers outside of healthcare services. Some rural nurses disclosed a situation where their children had moved away after leaving home, but now wanted to come back to embrace their rural upbringing. However, the employment opportunities with comparable salaries were not available, which was made doubly challenging when those grown-up children returned with spouses, and both needed to secure work.

Travelling was also highlighted by both rural and urban participants as an important consideration, for rural working and living. The lack of public transport made owning a car a necessity, and long commutes to access work, home or services had to be regularly observed. Again, this was not viewed negatively by the rural participants, who instead preferred this to the idea of significant traffic congestion experienced in urban areas. Although the urban participants discussed their dislike of the daily congestion they experienced in their urban commutes, they equally viewed the amount of travelling and the distances involved in navigating around rural areas also as quite negative. This was an interesting distinction considering that the amount of time they spent sitting in traffic was comparable to the time taken by rural residents to cover more distances.

3.2.3 People and place

The geographic locations where nurse training was delivered was felt to be a significant factor with participants believing that it contributed as a barrier to rural nurse recruitment. Even urban participants acknowledged that the urban location of nurse

training favoured those living in such areas, recognising the hardships involved for rural residents who lived large distances away from them.

It was identified that two-thirds of all participants chose nurse training locations that were close to their homes or were the closest to their homes – despite this being a significant distance away for some. For some rural nurses, attending the closest university still involved needing to relocate or commit to significant daily commutes. On exploring the reasons for their choices, participants spoke of wanting to be close to family support whilst at the same time having the opportunity to spread their wings. Therefore, the correct proximity to home was of paramount importance. Several of the participants spoke of being very homesick and the emotional upheaval of having to move away from home had had a significant impact on them. Interestingly, this was also evident in discussions from urban participants who had moved into nurses' accommodation that were located only a few miles away from their home areas. For some of these urban nurses, living away was too much of a hardship and they decided to move back home, and commuted for the remainder of their training.

Moving back home permanently though wasn't an option for all participants – especially for homesick rural nurses, and many spoke of going home on days off, weekends or as often as possible. The enjoyment and experiences during nurse training were evaluated under the context of the proximity of their training establishment and clinical placements to their home locality. This resulted in those living close to their training bases, describing how they loved their nurse training days. Whilst for those living further away, the element of learning the art of nursing was enjoyable; but when viewed in totality, and within the context of the hardships they endured, it was described as a '*nightmare*' and '*hell*', especially if they faced significant daily travelling or were homesick. No additional costs for travelling reimbursement were noted for these nurses.

The training schools' location also had an association with future employment decisions, as it was identified that 25 of the 30 nurses interviewed worked in the hospitals at which they trained. Of the remaining five nurses, three decided to return to their home localities and two chose completely different hospitals. For the latter two though, it was interesting to note that securing work at different hospitals didn't require a move from their homes. Due to their urban locations, it was identified that more employment opportunities were on offer, giving urban nurses additional choices in their working careers; this was clearly something that was not replicated in rural areas. Familiarity and routine with their training hospital were identified as being a significant factor in the decision-making process of deciding where to work post qualifying; although, after a period of time, a draw to home was compelling.

Out of the 30 participants included in this study, 23 were currently living and working in the same place, or close to their childhood homes. This was clarified in relation to the older rural participants within this study being able to access training establishments from their home localities as educational provisions were based there at that time; for others, they remained in their rural homes and commuted to their training locations; and for those who were unable to commute and had to relocate, after a period of time working in their training hospitals, they had since returned to their rural home roots.

Whilst the other seven nurses had decided on different locations, it was found for the majority of these that their new homes and lives had echoes of their childhood homes and lifestyles. For example, an urban participant who had been raised on an island saw her current home having good access to the sea or urban participants who had rural

backgrounds were living in quieter parts of the city or had close proximity to green spaces or were properties set aside from any close neighbours.

A rootedness in place was strongly identified in both rural and urban participants. And whilst they discussed very different arrangements in relation to the realities of living in their home locations, similar elements were identified within their discussions, resulting in participants from across Wales being the same, but different. Such a discovery highlighted that for all participants, irrelevant of their urban or rural locations, their geographic past and rootedness in place are significant contributory factors on their present day lives, be this consciously or subconsciously.

4. Discussion

The themes identified that recruitment and retention of nurses is problematic regardless of geographic location; however, participants felt the situation was exacerbated in rural areas, where the opportunity to fill vacancies were an ongoing problem. Further, the situation of rural recruitment appeared multidimensional, with the main themes identifying professional concerns as well as geographic complexities arising from personal and individual factors.

How individuals from different areas viewed the concept of rural living and working was a key outcome of this research, highlighting clear disparities in the appeal. Concerns regarding population numbers in rural areas were focused on the outmigration patterns of the rural young to more urbanised areas, leaving an older demographic and quiet pace of life, whereas urban living was full of promise and hope. For urban based participants, the perceived slowness of rural life and lack of career pathways for spouses influenced an unattractive view about rural living and this was an important influential factor in their lack of desire to relocate. Rural based nurses recognised the urban participants' perspectives of the attractiveness of urban living, and concerns were voiced regarding the ability of rural areas to attract their rural youths back to their childhood roots. The rural-urban distinction that was discussed by participants was explained in part by Li, Westlund and Liu (2019) who asserted that urbanised policies had created a situation that viewed urban as having more opportunities and this was particularly evident in narratives that discussed employment. Despite this, the majority of nurses within this study who had moved away from their rural homes to undertake their nurse training had since returned to their rural roots, echoing suggestions by Gustafson (2001; 2009) and Pollini (2005) that mobile rural youths displayed strong attachments to their homes, providing some hope at least that their rural fledglings may return. However, unlike their urban counterparts, rural nurses spoke passionately of living within the beauty of their rural landscapes. This was similarly identified by DeValpine (2014) who identified that despite the hardships associated with rural remoteness, rural nurses flourished within their communities, contributing to their vibrant and thriving natures.

The polarisation of viewpoints determined that in the main, like for like posts in either of these geographic areas would not attract nurses from the opposite area. For example, an urban nurse appeared not to be enticed to a similar job in a rural location and vice versa for rural nurses in urban locations. This was also a concept identified by Cooper, Heald and Samuals (1977) and Rabinowitz (1990) in rural general practice. Therefore, it appeared that individuals may be attracted to their geographical roots, be that rural or urban areas and that facilitating comparable nursing roles and specialties may not be sufficient to attract urban nurses to relocate to rural areas. As such, future strategies aimed

at rural recruitment may need to focus on how to attract rural residents into a nursing career. Some professions have exploited this rural connection by creating practices which specifically target people with rural backgrounds for university entry. For example, rural pipelines have been developed for medical school applicants in the USA, who are specifically chosen because of their rural backgrounds, having identified that future doctors with this background were more likely to return to work in rural areas upon qualifying (Dunbabin & Levitt, 2003). One such programme that embraced the rural pipeline practice is the WWAMI programme, covering the states of Washington, Wyoming, Alaska, Montana and Idaho. The first seven years of the programme highlighted that 23% of their graduates worked in rural areas on qualifying, compared with 13% of all USA physicians. In addition, 61% of the WWAMI graduates worked in primary care, compared with only 35% of all USA physicians (Adkins et al., 1987). More recent studies continue to confirm the success of such pipeline approaches (Kwan, Kondalsamy-Chennakesaven, Ranmuthugala, Toombs & Nicholson, 2017).

Over the years, many advancements and evolutions had occurred within the nursing profession and these changes may not have been conducive to the profession. Examples provided related to the discontinuation of the SEN role, the pursuit of the professionalism agenda, the closure of locally based schools of nursing, establishing urban based training centres and moving the nursing profession to a degree only workforce. Additionally, following the discontinuation of the personal bursary to support living costs, centralising nurse education had resulted in financial inequity for rural residents, who incur higher travelling costs to access their nurse training locations. Where to train as a nurse was frequently influenced by closeness of the training centre to home, and the lack of local nurse education opportunities resulted in the potential to exclude excellent individuals from rural areas applying to enter the profession. This was echoed by Stephenson (2019) who found that 33% of people aged between 18-24 felt living away from home prevented them from embarking on their nurse training, which resulted in one in 20 places not being filled in 2019.

However, physical access to nurse training was not the only concern and participants voiced perceptions that universities were asserting control over which professional courses individual nurses could undertake, suggesting that the organisations that should support the workforce had become adrift from each other (these organisations being policy makers, professional bodies and regulators, and universities). This resulted in superiority struggles and tensions being evident. This tension was particularly apparent in discussions relating to old and new, rural and urban, management and front-line, degree and no degree, university-led and actual service need, clinical prudence and holistic care. However, the situation that the participants described raises important questions regarding the overall management of both healthcare and rural healthcare, especially as an era of societal change had resulted in politics and policy development directing the profession from within different organisations as opposed to the profession navigating and controlling its own destiny. Consequently, these tensions impact on workforce retention, and were very real to the participants.

Onnis (2016) determined the importance of people, practice and place elements, and their effects within the rural workforce. The interconnecting relationship between these three elements resulted in understanding that a rural nurse needed to be able to confidently work within rural practice whilst also thriving within rural living arrangements. However, this study identified that once within the nursing profession, advance practice and

expectations of working at senior levels has resulted in a dichotomy for rural nurses where their clinical readiness was required to compensate for the lack of specialist team support. However, maintaining this clinical readiness was problematic, as centralisation and specialisation of healthcare services had resulted in complex patient cases being transferred out of area, reducing the opportunities to practice certain skills-based care and de-skilling the rural workforce. This is in stark contrast to urban healthcare environment and contributes to the less favourable perceptions of the type of care delivered in rural areas and the attractiveness of working there. Similarly, this was in line with Paliadelis et al., (2012) who identified that working in rural areas presented challenges regarding the lack of professional supervision and support on offer and the lack of multidisciplinary working which led to professional isolation. This resulted in newer graduates being attracted to work in urban locations, who prefer well-resourced health facilities which nurtures specialist practice, rather than a 'jack of all trades' generalist approach (Paliadelis et al., 2012).

Recent times have seen the reconfiguration of Health Board structures, and rural areas are often managed by Health Boards who also have urban regions within their catchment. The mismatch of urban-based senior decision-making and rural practice has seemingly led to low morale and frustrations for rural nurses, which have influenced retention decisions. Burn-out has also led to older nurses not to be making use of the 'retire and return' element. In cases of discontent, job hopping was described as easier in urban areas due to more posts being available, which were less so in rural localities. Although, certain narratives suggested that even in rural areas, when/if pushed to breaking points, nurses would leave their posts; although it was unclear if they would fully leave the profession or concentrate on other aspects of their lives, and farming was suggested as one job alternative example.

Advancing practice and working at senior levels also led to perceptions that nurses had become mini-doctors, and this had contributed to a loss of clarity about their role identity. Concerns regarding the ability to define the role of the nurse led many to believe that the profession had lost its way. However, nursing's identity crisis appears to have occurred at a time when the 21st century sees the profession sitting alongside a vast range of competing career opportunities. The increased availability to pursue different careers, especially for women, has resulted in decreased numbers entering the profession. Although such changes impacted the workforce in both rural and urban areas, it was felt that rural areas were hardest hit. Ironically, the lack of career opportunities in rural areas which detract urban nurse relocation, may offer potential recruitment opportunity for the profession in rural areas.

As such the main considerations identified in this research has determined the following important factors which are believed to impact recruitment and retention:

- Rural residents are potentially more inclined to stay working in the locality and urban based nurses appear to be reluctant to consider relocating to rural areas.
- Current urban-based training provisions present as challenging, if not impossible for certain rural residents to enter nurse training.
- The financial challenges associated with training in rural areas are significant due to increased travelling costs and reduced opportunities to seek additional employment.
- Nurses in rural areas report to feeling deskilled by the lack of opportunity to contribute to specialist care but are required to work at an advanced level because of the lack of team specialist support available.

- Power struggles have resulted in rural nurses, as well as their off-site managerial structures and their training providers becoming adrift from each other and have lost focus of their caring ethos.

The identification of these key findings gives rise to consideration about how best to shape rural healthcare services so that they can train, attract and keep its nursing workforce.

5. Recommendations

The problems facing rural recruitment are complex; therefore, solutions for addressing these will require multiple ways of thinking to address the many facets affecting the Welsh rural nursing workforce. For a number of urban nurses, rural working will never be attractive and as such strategies may need to focus on how to improve the appeal of nursing and the access to nurse training provisions for rural residents who might be willing to consider rural nursing as a long-term career. The findings from this research suggest that consideration should be given to the following recommendations.

1. Policy makers/commissioners/nurse educators need to consider rurality and how they are truly reflected within educational provisions, especially in relation to how rural residents who wish to become nurses can access nurse training from their rural homes, without them having to commute long distances or relocate – if remaining living in their rural homes is a persons' choice.
2. Creating locality based rural career pathways, to include unqualified to qualified roles can potentially provide different routes into rural nursing which will help boost numbers at different levels of the workforce.
3. Local/rural CPD opportunities need to acknowledge the level of specific rural skills needed to perform professional nursing duties and should make better use of technology to make this accessible and more economically effective for rural nurses and Health Boards to access.
4. Education and training provisions must be driven by identified service need to enable the progression of the rural nursing profession so that rural nurses can deliver healthcare services which reflects the requirements of their specific localities, as urban-based blanket decisions will continue to cause discontent.
5. Policy makers/commissioners need to consider the funding mechanisms for supporting nurse training, giving particular regard to additional costs incurred by rurally based student nurses. Similar systems can be seen in London via their London weighting scheme. Such considerations could include investigating the possibility of introducing a living bursary scheme for student nurses during training, which incorporates payback schemes, post qualifying.

6. The profession appears to feel that the image of the nursing role has become unattractive and high expectations have impacted on the numbers entering and leaving the workforce; therefore, there is a need to re-brand the career and to develop a compassionate, values-based work ethos and caring clinical environments.

iv. Conclusions

To conclude, this programme of research explored barriers to recruitment and retention of qualified nurses to rural Mid Wales and is the first study to focus on the rural nursing workforce within this specific geographic area. By utilising a qualitative approach, and by conducting focus groups and semi-structured interviews, thematic analysis has been able to unpick key themes from the narratives of nurses from across Wales. The challenges discussed were broad and varied, which led to appreciating why the concept of rural recruitment and retention had become complex over the years; however, issues relating to geography, educational provisions, power struggles and control have been identified as particularly problematic which impacts on the recruitment and retention decisions of nurses.

Attempting to attract urban based nurses with no rural background to rural areas could prove fruitless given the evident attachment to geographical roots. Recruitment efforts should therefore focus on bringing about significant changes that would enable rural residents to undertake nurse training in a more accessible manner, whilst retention could focus on CPD being more congruent to the needs of the rural workforce. Further solutions lie in re-branding the career and to develop a compassionate, values-based work ethos and caring clinical environments which appeared to have first attracted nurses into their chosen careers.

By truly embracing rurality and creating new and innovative healthcare and educational structures that focuses on enabling equity of access, care and compassion, rural areas do not have to look far for their future nurses, as their upcoming workforce already resides in the area.

v. References

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