

Considering community engagement for remote and rural healthcare design in Scotland

exploring the journey from rhetoric to reality

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Considering community engagement for remote and rural healthcare design in Scotland: exploring the journey from rhetoric to reality

A thesis presented for the degree of Doctor of Philosophy at the University of Aberdeen

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2012

Declaration of originality

I confirm that this doctoral thesis has been written entirely by myself and has not been submitted for any other degree. I confirm that the work reported in the thesis was conducted by myself and not collaboratively, except where stated. All quotations have been distinguished by quotation marks and sources of information acknowledged.

Amy Nimegeer

30th November, 2012

Thesis Abstract: Considering community engagement for remote and rural healthcare design in Scotland: exploring the journey from rhetoric to reality

Amy Nimegeer

The way health care services are delivered in remote and rural Scottish communities is in a state of reconfiguration. At the same time the NHS faces pressure to plan these new services *in partnership* with communities themselves. Evidence, however, suggests that this is not necessarily being done well.

This study considered the contextual aspects of remote and rural Scottish communities that may impact on health care-related engagement, and examined current understanding of what constitutes a ‘good’ engagement process. It then went on to consider a two-year action research project (RSF) that took place in four remote and rural Scottish communities to engage local residents in an anticipatory process co-designing their own future health care services. Finally, this study examined ways in which individuals were able to wield power within the engagement described in the RSF project, by using a combination of participant observation and Foucauldian Discourse Analysis.

As well as making a number of practical recommendations for future engagement practice in a remote and rural context, this study makes three key contributions. Firstly, it contributes further contextual knowledge about the challenges of engaging with remote and rural Scottish communities for local health care service design; a topic about which little has been written. Secondly, it contributes a novel method for anticipatory health care budgeting aimed at a remote and rural Scottish context, namely the RSF Game. Thirdly, it draws the conclusion that individual (non-elite) community members have the ability to use French and Raven’s bases of social power to impact the engagement process at all stages, and also posits that discourse can be used within rural engagement as a new ‘base of power’, which contributes to the debate around individual power and agency within remote and rural community engagement for healthcare, which few studies have examined.

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Table of Contents

Declaration of originality	ii
Thesis Abstract.....	iii
Acknowledgements	iv
Table of Contents.....	v
List of Tables	ix
List of Figures	ix
List of Abbreviations.....	x
Chapter 1: Introduction	11
1.1 Introduction	12
1.2 Context: Remote and Rural Scotland.....	15
1.3 Remote and Rural	17
1.4 Community	19
1.5 Community Engagement.....	20
1.6 Context: Community Engagement and Power	22
1.7 Intended contribution.....	23
1.8 The Remote Service Futures Project	24
1.9 The theoretical approach – from the practical to the postmodern	25
1.10 Outline of Study.....	27
1.11 Structure of the Thesis	30
Chapter 2: Scottish remote and rural healthcare engagement: understanding the context.....	33
2.1 Introduction	34
2.2 The Literature Review Methodology.....	34
2.3 History of Community Engagement: Community Development, Consumerism, Democracy and Co-Production	37
2.4 Scottish Policy Background.....	44

2.5 Engaging in Health Care Decision Making.....	46
2.6 Engagement in a remote and rural context	51
2.7 ‘Good’ community engagement.....	58
2.8 Engagement in practice	66
Engagement Methods.....	66
Typologies	67
2.9 Conclusion	72
Chapter 3: Engagement Methodology.....	74
3.1 Introduction.....	75
3.2 Ethnographic Action Research	76
3.3 Selection of Sites.....	81
3.4 Selection of Participants.....	84
3.5 The Action Research project – timeline and actions	88
3.6 Engagement Strategy.....	92
3.7 Engagement steps and methods	95
3.8 Interviews.....	96
3.9 Stage One: Community Meetings	98
3.10 Stage Two: Community Workshop: Assets, Challenges and Needs	99
3.11 Stage Three: Community Conference.....	101
Meet the Service Providers, Think about the Future: Community Conference	101
Information Road-show	102
3.12 Stage Four: Remote Service Futures Card Game: design and implementation..	103
Trialling the New Method.....	106
The Remote Service Futures Game	107
3.13 Evaluating the methods	109
3.14 Participant Observation.....	111
Participant Observation Methodology	112
3.15 Formative Feedback.....	113
Questionnaires	113

Chapter 4: Engagement Findings	114
4.1 Introduction	115
4.2 Participants	115
4.3 Mapping outcomes	116
4.4 Stage One: The Community Meeting	121
4.5 Stage Two: Assets and challenges: a SWOT-based community workshop.....	123
4.6 Stage Three: Community Conference: meet your service providers, think about the future, and the Information Road-Show	127
The Information Road-show	128
Community Conference	129
4.7 Stage Four: Playing the card game	131
Overall findings for the Remote Service Futures Game.....	136
Service design outcomes from the Remote Service Futures Game	138
4.8 Evaluating the Action Research: considering validity in light of the findings.....	140
Increased trust between stakeholders.....	140
Combining experiential and technical knowledge in one process	141
Early involvement	141
Clear timely feedback.....	141
Fosters ideological debate	142
Increased understanding and awareness of context and issues.....	142
Improved communication between stakeholders.....	143
Involving 'hard to reach' participants	144
Meaningful contribution and participation.....	145
The creation of useable plans	147
Cost Effectiveness.....	147
Validity of the Action Research process	148
Outcome Validity	148
Process Validity	149
Dialogic Validity	149
Catalytic Validity	150
Democratic Validity	150
4.9 Community engagement for co-design: a way forward.....	151

4.10 Discussion and Conclusions	156
Chapter 5: Power, discourse and the rural community	164
5.1 Introduction: addressing research question 3	165
5.2 Postmodernism and Poststructuralism	166
5.3 Community Engagement and Theories of Power	168
Theories of Power.....	170
Power and rural community engagement	173
5.4 Planning, Power and Discourse.....	176
5.5 Foucauldian Discourse Analysis.....	179
5.6 Methodology	183
Selection of Texts	183
Analysis.....	187
5.7 Reflexivity	188
5.8 Findings	192
Overt References to Power	193
Local ‘Legitimate’ Bodies	193
Individuals in Positions of Power.....	194
Discourse of nature and organic growth/decay	207
Othering Discourses.....	209
Local Health Care Practitioner and the Other.....	210
5.9 Participant Observation	218
5.10 Findings.....	218
Legitimate Power Positions	218
Locals versus incomers:	220
The Position of Local Doctors and Nurses	221
Observed behaviours relating to power	222
Gatekeeping Activities	222
Peripheral Gatekeeping Activities.....	225
Withholding Activities	226
5.11 Discussion and Conclusion	229
Chapter 6. Conclusion.....	235

6.1 Return to the original problem.....	236
6.2 Addressing the original research questions.....	237
6.4 Remote and rural healthcare in Scotland: a context for anticipatory engagement	241
6.5 A new method for engaging remote and rural communities for health care service design.....	245
6.6 Power, Discourse, and Rural Community Engagement for Healthcare	246
6.7 Recommendations for further research.....	255
Bibliography.....	257
Appendix 1: Feedback Questionnaire	275
Appendix 2: Individual Community Design Outcomes (results of the RSF Game in full)	277
Appendix 3: Health and Place Article	285

List of Tables

Table 1 Aspects of health care that may affect engagement for service design.....	50
Table 2: Aspects of remote and rural that may affect engagement.....	58
Table 3: 'Best practice' principles of engagement (process and outcome)	66
Table 4: White's Typology of Community Engagement (1996)	70
Table 5: Herr and Anderson's validity criteria for Action Research	80
Table 6: Key characteristics of the four Highland case study communities (based on data available 2008/2009).....	84
Table 7: Data gathered on behalf of communities	120
Table 8: Common community-related assets and challenges emerging from Stage 2	124
Table 9: Results of the Remote Service Futures Game.....	139
Table 10: French and Raven's Bases of Social Power (1959, 1965)	172
Table 11: Summary of potential effects of individual power on community engagement (individual level effects).....	233
Table 12: Summary of potential effects of individual power on community engagement (community level effects)	233
Table 13: French and Raven's (1959) Bases of Social Power	249

List of Figures

Figure 1 Overall thesis: combining the RSF Project with doctoral research	29
Figure 2: A selection of headlines from Scottish newspapers	50
Figure 3: The Ladder of Citizen Participation (Arnstein 1969)	68
Figure 4: NHS Highland Health Board region (source: NHS Scotland). The four case study communities all fall within the region highlighted by the oval.....	83
Figure 5: Stakeholder map for remote and rural healthcare engagement (based on WHO (2000) Partnership Pentagram).....	87
Figure 6: Stakeholder influence on decision making in the RSF project.....	88
Figure 7: Action Research diagram illustrating how feedback from each stage was used to inform others	91
Figure 8: Action Research engagement methodology process diagram	96
Figure 9: Displaying information at the road-show in Community C.....	103
Figure 10: A sample of 'practitioner' cards from the Remote Service Futures Game	108
Figure 11: Summary of success indicators used, based on Boutillier et al (2001).....	110
Figure 12: Quantitative feedback from Stage 2	127
Figure 13: Quantitative feedback from Stage 3	131
Figure 14: Quantitative feedback from Stage 4	138
Figure 15: Conceptual diagram illustrating the influence of discursive power within the engagement process	251

List of Abbreviations

CHP = Community Health Partnership

GP = General Practitioner

KTP = Knowledge Transfer Partnership

NHS = National Health Service

QOF = Quality Outcomes Framework

RSF = Remote Service Futures

VOiCE = Visioning Outcomes in Community Engagement

Chapter 1: Introduction

1.1 Introduction

This study examines remote and rural community engagement for anticipatory health care service design in Scotland, considering the policy and guidance rhetoric that surrounds such engagement as well as the reality of its implementation. This chapter will describe the context and rationale for the study, outlining key concepts such as 'remote and rural', 'community' and 'engagement'. It will then describe an Action Research project which forms the basis of this thesis, and will go on to describe the aims, research questions, and theoretical approach that this thesis has taken. It will conclude by outlining the contents of the remaining five chapters.

Within Scotland, the way in which health care is delivered in remote and rural communities is in a state of reconfiguration. Changing roles for health care workers (NHS Staff Council, 2004) and budget deficits for healthcare in an age of austerity (OECD, 2006; The Scottish Government, 2008; MacRae, 2009), not to mention an ageing rural workforce (NHS Staff Council, 2004), mean that the traditional service models that have existed in rural areas for the last century are being forced to change (Farmer et al, 2007). These local changes are further complicated, and some may argue exacerbated, by the wider social and economic effects associated with globalisation (Shucksmith, 2000) and new rural governance structures (Little, 2001; Shucksmith, 2009) and it is argued that rural areas find themselves particularly vulnerable to these changes with the decline of their traditional industries such as farming and mining (Prior, 2009; Shucksmith, 2000; Rennie, 2003) leading to less economic stability.

Evidence suggests that, due to the net in-migration of older adults to rural Scotland, the median population age in these regions is increasing more rapidly than in other parts of the country (Jeannet 2010). According to Rural Scotland in Focus (Skerrett, 2012: 12), a summary of rural statistics published by SRUC:

"An ageing population impacts on many areas of Scottish society including rural affairs, health, housing, infrastructure, social welfare, culture, economy, employment, politics, justice, etc. These demographic changes pressurise available services, particularly healthcare but will also put pressure on Scotland's system of universal benefits (free personal and nursing care, free prescriptions and bus passes, etc.) as well as having a greatly increased budgetary cost through public pension provision."

Many of these changes manifest suddenly in remote and rural communities with the retirement or leaving of a key local health care professional, for example the General Practitioner (GP) or district nurse (Farmer et al, 2003) whom the Scottish National Health Service (NHS) is unable to replace. The realization of these new plans can often lead to confrontations between rural communities and the NHS (Farmer et al, 2010). In some cases, 'standoff situations' have arisen in which trust between stakeholders has been dissolved and communication has broken down (Kearns, 1998). Evidence suggests that health care service change in remote and rural Scotland may be a particularly loaded issue due to the high value of social capital that is placed on individual practitioners within these communities (Prior et al, 2010).

At the same time, the symbolic boundaries between the NHS and its service users are also being redrawn. Community engagement and service co-planning have become priorities for public service providers such as the NHS (Scottish Executive, 2001). In light of recent Scottish government policy including Patient Focus and Public Involvement (Scottish Executive, 2001) Better Health Better Care (Scottish Government, 2007), Delivering for Remote and Rural Health Care (Scottish Government, 2008), and a broader UK shift towards civil involvement (Cabinet Office, 2010) and community empowerment through joint decision making, health care service providers are encouraged to move towards *mutual service planning*, that is, planning services in conjunction with potential service users. Mutual service planning is not a new concept but has gained prominence within policy and practice in Scotland. Indeed, within both the health and wider public planning sectors, engaging stakeholders in decision making has now become a statutory requirement (with the NHS Reform Scotland Act 2004, Planning etc. (Scotland) Act 2006). According to proponents of deliberative community engagement, it has the potential to lead to more egalitarian, contextually appropriate decisions and to shift the balance of power towards service users (Arnstein, 1969; WHO, 1979; OECD, 2001, Beierle and Konisky, 2000). Although community engagement is far from a new concept, others claim that in its present guise the rhetoric around community engagement may be used to mask a "*lack of local control over local state agencies*" (MacKinnon, 2002).

In the UK, engagement with service users originally became popular as a part of the consumerist neo-liberal agenda of the Conservative government (1979-1997) and was then championed by a New Labour government (with subtle ideological changes) in 1997

under the new guise of active democratic citizenship (Needham, 2007). In other words, under the Conservative government, community engagement was encouraged through consumer choice, via the utilization (or not) of particular services as an example of market forces in action. Under the New Labour government, rhetoric turned more to the right of individuals as tax paying citizens to make decisions about those public services that they receive (Needham, 2007; Clarke, 2005). Recently community engagement has formed the basis of the popular co-production movement (Alford, 2009) which *“emphasises the role that service users play in both the consumption and production of public services”* (my emphasis) (Needham, 2007: 221). All of these approaches ostensibly are underpinned by an empowerment agenda (Patterson, 2010) – the potential for people to have more agency in decision making and therefore more control over issues that affect their lives, although the degree to which that potential is realised remains to be seen (Carlisle, 2010; Crawford et al, 2002; Hodge, 2005).

According to Rifkin (2009: 33), this discourse of empowerment with regards to participation has emphasised the need to develop the decision making capabilities of citizens, primarily the underprivileged, so that they *“may exercise their power to gain specific demands, and to give people confidence to act for their own improvement.”* In recent decades, however, critics of community engagement have begun to suggest that studies dealing with power and empowerment within engagement processes focus too much on a simplistic power transfer between homogenous binary groups (Doherty and Rispell, 1995; Porter and Shortall, 2009; Barnes, 2009) and not enough on the agency and power of individuals within the engagement process (Van der Arend and Behagel, 2011).

Furthermore, despite rhetorical support at policy level, in reality public engagement with health services in Scotland as elsewhere, has, for a number of reasons, often inclined more towards the perfunctory and less towards genuine mutuality (Carlisle, 2010; Renedo and Marston, 2011; Scutchfield et al, 2005). As a result, Scottish rural community members may have mistrust of NHS managers and of further efforts at engagement (Farmer et al, 2010) which can exacerbate tensions within the required mutual planning process. There is a need, therefore, to better understand the mechanisms behind rural community engagement for healthcare planning in Scotland, and to consider how and why it may or may not be successful.

1.2 Context: Remote and Rural Scotland

Health care, context, history and governance

In Scotland, remote and rural areas have historically enjoyed accessible GP and community nursing services and enjoy better overall health status, when compared with their urban counterparts (Skerrett et al, 2010; Scottish Government, 2012). These members of peripheral Scottish communities are often apprehensive about service change as, in direct and indirect ways, it threatens their vision of how they will be sustained into the future. (Prior et al, 2010; Farmer et al, 2003). Consequently, many Scottish rural residents are often actively resistant to proposed service reconfiguration (Farmer et al, 2007) and examples of failed attempts to engage rural communities around health service change can be often found in the Scottish media (Pollock, 2008; Cramb, 2007). Healthcare managers may report exhaustion with the perceived unrealistic demands of rural residents for local services; demands which do not always take into account the needs of the wider region (Farmer et al, 2010). Metaphorically, Healey (2009) characterises the problem as stakeholders' failure to speak the same 'language'. Service providers tend to use summarised area quantitative data and utilitarian evaluative frameworks to make planning decisions (Healey, 2009), whereas community members may prioritise local, narrative, and experiential dimensions of health care. This creates a gulf of understanding that is not necessarily addressed by current engagement practice. Another way of framing the 'translation' problem, this thesis will consider, is that community based engagement as it is advocated through policy is a postmodern practice (in that, at least theoretically acknowledges a multiplicity of viewpoints and rhetorically frames these viewpoints as equal or mutual) and, as such, it is difficult to incorporate the results of such a process into a modern planning framework, such as exists within the NHS. This concept will be explored more thoroughly in Chapter 5, as well as the section of this chapter dealing with theoretical approaches.

Contextual factors

While the wider causes of change (such as declining budgets, changing employment structures, requirement to engage with stakeholders) may not be exclusive to the remote and rural, as previously stated, these changes can affect these communities in complex

ways due to a challenging rural infrastructure, small (and therefore fragile) service delivery teams, dispersed populations, and the fact that rural health care professionals are often inextricably linked with other community assets, such as social capital, beyond their role in health care delivery (Prior et al, 2010). As Skerrett et al (2012: 5) assert:

“The evidence unequivocally supports the claim that specific characteristics make rural Scotland different from urban Scotland. This does not argue for “privileging” rural over urban. Rather, to enhance growth or development, inclusion and life-chances, the design and deployment of policies must be “tailored” to rural Scotland.”

Additionally, while issues such as aging populations, scarcity of resources and rural-specific methods of working are issues that many developed countries face in their rural areas (OECD, 2006), Scottish rural populations are atypical of global rural trends in several aspects. Firstly, they tend to be marginally wealthier and better educated than their urban counterparts, which is atypical amongst European countries (Scottish Government, 2012). Secondly, as previously stated, Scottish rural populations tend to report better overall health than their urban counterparts in many respects (with a few notable exceptions) more so than in other European nations (Scottish Government, 2012; OECD, 2006). The effect of these differences is largely unexplored within engagement literature and goes unaddressed, at least explicitly, in the majority of engagement guidance documents. This may have implications for the efficacy of rural-centric engagement methodologies which are often aimed at developing areas.

Since the Dewar report was issued in 1912, there has been an acknowledgement within the NHS that remote and rural Scotland requires different and creative solutions to overcome the particular challenges of the region (MacRae, 2003). Dewar’s suggestions included: *“better training for rural doctors, better use of transport and technology, and guaranteed minimal levels of service provision for rural populations, despite geography”* (Douglas, 2005: 1). These issues, identified a century ago, remain pertinent today. Localised, rural-specific solutions to these challenges were put into place in 1923 with the establishment of the Highlands and Islands Medical Service (NHS Scotland, 2012) that featured a series of community hospitals and GP surgeries in the majority of rural communities. Many of these historical service configurations have been maintained to the present day and the current necessity to redesign services in remote and rural Scotland, Douglas asserts, is complicated due to an attachment to these historical models

of service provision, coupled with a high level of service expectation on the part of rural residents (2005), however these historical services may have been uniquely suited to their context and may have contributed to the better levels of health experienced in remote and rural regions today.

The way in which remote and rural Scotland is governed has also changed in recent years. In response to the effects of globalisation, neoliberal reforms have resulted in a phenomenon referred to as new rural governance, or sometimes, the new rural paradigm (OECD, 2006). The new rural governance is an occurrence *“in which the ‘rolled back’ (laid back?) state is attempting to involve a broader range of institutions and individuals in the allocative/decision making process”* (Little, 2001: 99) New rural governance, then, implies a shift from central government control, to governance undertaken by a range of non-government organisations (NGOs), and even individuals themselves. This shift is often couched in terms of community empowerment or rural *“self help”* (Day, 1998: 99). New rural governance has manifested itself in the Scottish Highlands with the rolling back of local authority power, and the establishment of a complex array of new institutions, initiatives and agencies responsible for local governance, many of whom are unelected (MacKinnon, 2002). In this complex new paradigm, remote and rural Scottish communities and individual community members are increasingly being asked to participate in decision-making that relates to their own governance and service provision.

1.3 Remote and Rural

It is fundamental in the introductory chapter to explain more fully some of the basic concepts that underpin the research. The first of these concepts is the remote and rural. As already described, remote and rural communities have a number of characteristics that can differentiate them from urban communities. But what is meant at a basic level by the terms ‘rural’ and ‘remote’? According to Farmer et al (2010) *“[t]axonomies of rurality differ internationally, but most are based on population density, demographic structure and land use”* (Ryan-Nicolls, 2004; Australian Institute of Health and Welfare 2004, Scottish Government, 2008). Remoteness, on the other hand, is separate from rurality as it implies distance from services or population centres (Woods, 2006; Prior, 2010). For the purposes of this thesis the Scottish Government’s Six Fold Urban-Rural

Classification was used. This classification defines remote and rural as having a population of 3000 people or less and a drive time of more than 30 minutes from a settlement of 10,000 people or more (Scottish Government, 2010). According to Douglas (2005: 1)

“islands, mountains and historical National Health Service provision complicate definitions [of remoteness and rurality] for NHS Scotland, and pragmatic definitions for analysis of health service provision are best analysed on the basis of “drive time” to a core facility such as a Consultant-led A&E unit or a general practitioner.”

Therefore, all of these factors were also considered for the four remote and rural Highland communities that took part in this study.

Two of the chosen communities are situated within the mainland Highland region of Scotland and the other two are islands situated off of the west coast of the Highlands. Although all four communities are classified as remote and rural within the Scottish Government’s Six Fold Urban-Rural Classification, their unique geographies, demographics, and economies allowed the study to explore different dimensions of rurality whilst simultaneously allowing an understanding of remote and rural commonalities to emerge.

Although around 18% of Scotland’s population live in rural areas, approximately 1 million people in total, (Scottish Government, 2012, Skerrett et al, 2012) Scotland’s rural areas cover 98% of its total land mass, with remote and rural regions accounting for 64% of the total area (Scottish Government, 2012). Scotland’s rural population has been increasing in recent years due to low birth rates, longer life expectancy, and in-migration (Scottish Government, 2012). Scotland’s remote and rural residents experience higher life expectancy than their urban counterparts, higher educational attainment, and less income or employer deprivation (Scottish Government, 2012). However, at the same time remote and rural Scotland may face challenges with hidden deprivation (Farmer et al, 2001), in other words those living in deprivation in these regions may find they have less access to support because they are not as visible. Remote and rural Scotland also faces a number of challenges for service delivery: populations are often small and geographically scattered, making it expensive to deliver services due to a lack of economies of scale. These regions are also characterised by a lack of or poor quality infrastructure in terms of public transport, roads or internet provision (Hannaford et al, 1999; Farmer et al, 2003;

Birnie et al, 2005). Within Chapters 2 and 3, a more thorough investigation of the remote and rural aspects of these communities, as well as the criteria used to select them, can be found.

1.4 Community

While there are numerous of definitions of 'community' that vary according to academic discipline, context and subject matter, most definitions tend to fall into one of George Hillery's (1955) three categories: these being geographical communities, communities based on social systems, and communities of shared identity and values.

To attempt to disentangle these definitions or types of community from each other, especially within an isolated remote and rural area, would be challenging at best (Prior, 2009). According to Rifkin et al (2000) concerning the definition of community in the health literature, there is a tendency to define community, firstly, in terms of geography. She posits that this may reflect a primarily epidemiological history of conceptualising target communities of need. This thesis proceeds on the assumption that, although the four 'communities' within the study were selected based on geographical boundaries defined primarily by health care service delivery, it would be overly simplistic to assume that both communities of social systems and shared identities and values do not also exist within this shared space. Nor is it assumed that the geographical communities described here are the only communities that residents can and do belong to. Some residents may have moved to the area from another geographical region and have conflicted feelings about which geographical community they identify with, or indeed they may only live in the community part time. The possibilities are both fluid and varied.

The four communities in the study were selected based on NHS Highland recommendation due to of their remote and rural geography, and because they were considered by the NHS to have a particularly 'fragile' health care service, that is, a primary health care service delivered by a very small team, in which one team member was nearing retirement age (with one community as a notable exception). In terms of a health care service delivery context, the geographical aspect of communities was defined primarily by the boundaries of service provision, but this was more widely accepted by

participants in some areas than others. The two islands in the study, for example, formed discretely bounded geographical regions and there was little disagreement, either from service providers or residents, about what constituted part of the *geographical* community. The two mainland areas, on the other hand, were more complex, for example, one of the mainland ‘communities’ was comprised of a number of smaller townships. Although respondents from this area did not object to being defined as part of a geographical community, they did request that the community was referred to a different community name that was more reflective of the region.

Within a health context, uncertainty around what constitutes a community can have a negative effect when it comes to engagement. According to MacQueen et al (2001: 1929)

“[t]he lack of an accepted definition of community can result in different collaborators forming contradictory or incompatible assumptions about community and can undermine our ability to evaluate the contribution of community collaborations to achievement of public health objectives.”

Additionally, MacKinnon (2002) points out that *“contemporary discourses of community development rely upon an implicit naturalism where communities are presented as essentially autonomous, harmonious and self-regulating sets of social relations and networks”* (311). For this reason, one of the intended outcomes of this study was a greater understanding of the dynamics of remote and rural communities and the impact of such symbolic boundaries on the engagement process (see section 1.10).

1.5 Community Engagement

Community engagement, community involvement, empowerment, consultation, participation, co-production, and participative democracy: all of these terms can refer to the involvement of citizens or service users in making or contributing to decisions about the services that they access. The terms themselves have been used generally to refer to any level of involvement with service providers (from simple information gathering all the way through to partnership working), or they can be loaded with individual value and meaning (Shortall, 2008). The challenge is that there is no consensus within the academic community around acceptable terminology, with the result that *“that there is limited consistency and clarity in the application of concepts and definitions”* (Staniszewska 1999, 296). As Rifkin (2009, 32-33), points out *“the lack of a standard definition for community*

participation continues to plague and provoke both academics and planners.” Often, Rifkin continues, in the area of health promotion, “*the term empowerment replaces community participation*”, reflecting, perhaps, the goals of the process. In Chapter 2 the definitions and values of community engagement are explored more fully, however, for the purposes of this thesis a pragmatic approach to terminology was taken, and the terms ‘engage’ and ‘involve’ are used generically to refer to the wider action of involving stakeholders in decision making. This decision was made in order to retain some consistency with the terminology used within current Scottish Government policy surrounding the practice.

Engagement, however, can occur at many levels of decision making. Kilpatrick (2009) refers to community engagement as “*a multi-level concept, ranging from engagement in policy development through partnerships with agencies and consumers to plan and deliver local services, to individual engagement with programs.*” (37) Also, although the term ‘community engagement’ is frequently used as shorthand throughout the thesis, the aim of which is to explore a *multi-stakeholder engagement process*: one that involves as many people as possible that contribute to or benefit from the design, delivery and use of rural health and associated services. Although there are formalized permanent programmes for engagement within NHS Scotland, namely the Better Together (NHS Scotland) patient experience programme (a programme of patient experience reporting), a complaint reporting procedure (NHS Scotland), and Public Partnership Forums (PPFs) (Scottish Health Council, 2010), a process which brings together patient/community representatives with health care professionals and NHS managers, these programmes are not the focus of this thesis. Several studies already deal with the efficacy of such formalised institutional processes of engagement (including Baggot, 2005 and Rowe and Shepherd, 2002). Rather, this thesis will focus on the less regulated and formalized practice of engaging *directly* with remote and rural communities in order to plan service change, and will do so with the assumption that engagement for service design can also be considered a form of co-production (or producing services *with* service users). Despite more formalised mechanisms for engagement present within NHS Scotland’s governance structure, managers are still required to engage directly with communities around major service change (Scottish Executive, 2004). It is with this more fluid and ill-defined form of healthcare engagement that this thesis concerns itself with.

Key stakeholders for each area were identified, first by ascertaining which *groups* of stakeholders were likely to have some interest in the outcome of health discussions using the classification of community health care stakeholders as identified by Boelen (2001) for the World Health Organisation in their 'partnership pentagram'. Boelen identifies these groups as being community members, health professionals, health managers, policy makers/government, and academics. To Boelen's list, it was contextually appropriate to add professionals and managers from the two Local Authorities involved and the Scottish Ambulance Service, as well as members of several voluntary organisations (such as local community care forums) and groups that may have specialist knowledge in particular areas of health care of interest to the community, such as the Scottish Centre for Telehealth and the Scottish Health Council.

According to a 2008 review of community engagement evidence and literature by NICE (Popay), community engagement literature has the following gaps: There is little publicly available evidence on the effectiveness of a variety of community engagement approaches, including the collaborative; there are few existing studies that evaluate the factors that hinder or encourage community engagement (including the impact of individual power); there are few studies that assess the effectiveness of using community engagement approaches to aid priority setting and resource planning; and there is often a lack of detail on how the community was engaged. This study attempts to address these gaps.

1.6 Context: Community Engagement and Power

Traditional conceptualisations of community engagement postulate a basic dichotomic power struggle between the engager and engagee (White, 1996; Rifkin, 2000; Popay, 2006). In fact, the Ladder of Citizen Participation, a typology created by Arnstein (1956) that operates on this basic assumption, remains the basis of most practical engagement guidance today. There is little attention paid, however, to the power struggles that exist *within* these stakeholder groups, for example, within the community itself. In addition, academic studies that do deal with power relations within rural areas tend to focus on 'static' power structures such as local government and economic loci of power, or else on the 'power elite' within communities (Walton, 1966; Stone, 1980). There is little

information, however, on how power is created, reinforced or undermined by *all* individuals within a rural engagement process with few notable exceptions (Doherty and Rispeil, 1995; Porter and Shortall, 2009; Barnes 2009). It is the contention of this thesis that within a small, remote and rural community, there is potential for individuals to exert even more influence over an engagement process than in a larger, more metropolitan setting with more potential 'players' and with fewer 'connections', and therefore a closer look at the complexity of power relations within such a process could be illuminating for future engagement practice. This thesis will review existing theories of power, and will employ Foucault's theories of power and discourse to examine how individual community members continuously use language to broker power and how this affects this community engagement process in practice. In order to consider use of discourse and its effects on individual power in social interactions, French and Raven's (1959) bases of social power theory is also employed with the purpose of further illuminating the types of individual power affected.

1.7 Intended contribution

To summarise, there is a need for a better understanding, within engagement practice, of the circumstances of remote and rural Scotland and how to appropriately tailor engagement practice to this context. This study will address this need by reviewing the relevant literature on the topic and by considering the example of an Action Research project that engaged with four remote and rural Highland communities and in doing so will consider any issues or challenges specific to remote and rural Scotland for these purposes.

In addition, there is a need to address the 'language barrier' that Healey speaks of (2009), with specific emphasis on creating a method that may bridge this gap for remote and rural healthcare planning purposes. This thesis will meet this need by describing a novel health care planning card game that was created by the author during the aforementioned project for use in remote and rural areas.

Finally, there is a need to address the complex nature of individual power and agency within the remote and rural Scottish healthcare context, and the effects that it may have on process outcomes. This study will address this need by providing an analysis of

individual power in the previously mentioned Action Research project, using a combination of participant observation and Foucauldian discourse analysis on qualitative interview data.

1.8 The Remote Service Futures Project

To put forth an example of the reality of engaging in this particular context, this thesis will reflexively examine a knowledge exchange project on the topic of community engagement for which I was the project manager.

To address the challenge of co-designing Scottish rural health care services, the Remote Service Futures (RSF) Project, funded by the Scottish Government's Knowledge Transfer Partnership scheme (in conjunction with Highlands and Islands Enterprise and NHS Highland), investigated effective ways to engage with remote and rural community members by reviewing tools and techniques used in community engagement and community planning contexts. It then aimed to create a suitable basic deliberative methodology for use in remote and rural areas which was then tested and refined using an iterative Action Research framework in four case study communities in the Scottish Highlands and Islands.

This thesis is based on my work as the project manager and KTP Associate for the RSF Project. In my role as project manager it was my remit to review the current literature on community engagement and to attempt to create a context-appropriate methodology for engaging with remote and rural Scottish communities for health care service design, including the design of a new, fit-for-purpose planning method (The RSF Game). Although it was my role to lead this project, some data collection and facilitation of engagement events was assisted by a series of other researchers from the Centre for Rural Health and the project was guided not only by myself but also by a supervisory team (Professor Jane Farmer and Christina West) and a Project Steering Group consisting of members from the Centre for Rural Health as well as NHS Highland. Therefore, several of the initial methodological and practical decisions within the Action Research project were collaborative, rather than simply my own. I have attempted to highlight where collaborative decision making has influenced the research within this thesis where possible by making reference to the RSF Project Steering Group and other influencing

factors. Also, due to the collaborative nature of Action Research in general, methodology and data collection were also shaped by members of the four Highland communities.

In order to differentiate between the knowledge exchange project with a distinctly practical set of outcomes (and a pragmatic approach to decision making), and this thesis, it should be noted the following additions have been made to the project work for doctoral level study. While Chapter 3 and 4 for the most part describe work that took place as part of the KTP-funded Action Research project (RSF), and therefore by its nature describes work that was the result of a collaborative effort, Chapter 2 (the literature review) contains significant additional material, including the historical and theoretical background to engagement practice, and Chapter 4, in which power relations are examined, is based on additional analysis of the Action Research data that I undertook following the completion of the KTP project, specifically for this thesis. My intention is that this thesis will provide a framework to examine the work done within the RSF in a more theoretically robust and analytical way, and to be able to provide some insight into the results that were achieved. In short, the RSF project will act as a case study with which to highlight wider issues about the realities of engagement in this context. The final report of the RSF Project is available within Appendix 4 of this thesis for comparative purposes.

1.9 The theoretical approach – from the practical to the postmodern

This thesis endeavours to marry a practical outcomes-based Action Research project with a robust analytical framework, specifically a postmodern/poststructural framework. Postmodernism and Poststructuralism are (generally overlapping) theories that stand together in opposition to a modernist, and indeed a positivist tradition. Postmodernism and poststructuralism both broadly reject claims of universal truth (Agger, 1991) and emphasise instead plurality, flexibility and individual creation of meaning (Simonsen 1990). Postmodernism is most frequently associated with theorists such Baudrillard, Lyotard, and Barthes, and poststructuralism is often associated with the work of Foucault as well as Derrida and his concept of deconstruction (Agger 1991). Postmodernism and poststructuralism are widely acknowledged to be very narrowly differentiated, but this thesis will broadly support the view put forward by Agger (1991) that “poststructuralism

(Derrida, the French feminists) is a theory of knowledge and language, whereas postmodernism (Barthes, Lyotard, Baudrillard) is a theory of society, culture, and history” (112). For the purposes of this study, it is considered that postmodernism is the theoretical umbrella under which the analysis sits, whereas poststructuralism is the tool that is wielded to undertake the analysis properly.

While it may intuitively seem like an uncomfortable fit between the practical and the more abstract, this thesis considers that community engagement itself can be conceptualised as an inherently postmodern concept. Community engagement constitutes a shift in health care planning away from an algorithmic form of problem solving, towards a style of decision-making that, theoretically at least, simultaneously acknowledges the validity of a multiplicity of viewpoints. The postmodern concept of engagement is, however, struggling to find its place in the midst of a bureaucratic, thoroughly modern NHS planning system. The majority of engagement advice offered within or to the NHS, including guidance notes and the standardising online tool VOiCE (Scottish Community Development Centre, 2008), approach community engagement as a solvable problem, a process with a start, a middle, and most importantly, an end. This is by no means exclusively a healthcare problem. Considering urban architectural planning, Hedgcock, Hillier and Wood (1991: 220) state that *“[p]lanning thus finds itself thinking and acting modernistically in an increasingly postmodern world, where the idea of a general public interest is displaced by an appreciation and affirmation of difference.”* It is not illogical, then, to consider a poststructural frame of analysis for examining the intricacies of such a problem. Poststructuralism, and specifically its analytical techniques of deconstruction, can defamiliarise a familiar problem; it can help to view a contextual problem from a different light and can help researchers to *“disrupt habitual and mechanistic ways of being...to break away from inappropriate and inadequate category systems.”* (Brown and Jones, 2001: 117)

Methodologically, this thesis describes an iterative Action Research framework (Chapter 3) to assess the contextual efficacy of remote and rural engagement practices. Action Research, according to Herr and Anderson (2005) is research that is undertaken *within* the context being studied, often in partnership with the study ‘subjects’. There is also a strong emphasis on cycles of planning, acting and reflecting in order to create context appropriate solutions. Brown and Jones (2001) suggest that viewing Action Research from

a postmodern perspective can provide insight into the complexities present in what can be considered a highly subjective methodology due to its qualitative and contextual nature. In order to critically assess such a complex, contextual situation, a postmodern analysis can even assist with one of the core values of Action Research and ethnography, making explicit the reflective viewpoint of the researcher:

“Hitherto, Action Research has assumed a reality which can be uncovered and then altered in some way or improved upon for emancipatory purposes. This however begs key questions about where our ideas of what counts as ‘improvement’ come from. How can the researcher both ‘observe’ reality as well as being part of it and thus be implicated in its continual creation and recreation? These issues are much more complex than Action Research has acknowledged so far. We need to move beyond the notion of the ‘reflective practitioner’ to encompass poststructuralism which attends more to the way in which we construct reality.” (5)

In other words, a postmodern/poststructural framework can help to achieve the very aims that Action Research strives for, to see a problem in all of its contextual complexity without the disconcerting potential for oversimplification.

1.10 Outline of Study

The aims of this study are:

- to consider remote and rural community engagement for healthcare design in a Scottish context, understanding the roots of current practice, the policy environment, and key contextual issues,
- to review an iterative process for engaging remote and rural areas of Scotland for the purpose of designing their future health care services that was undertaken from 2008-2010 in the Scottish Highlands, considering the realities of engagement within this context, and finally
- to investigate how power could be constructed, deconstructed and brokered by the community-based stakeholders during this process, using participant observation and a poststructuralist discourse analysis, and consider whether individual power/agency could affect the engagement process.

In order to meet these aims, three corresponding core research questions were addressed:

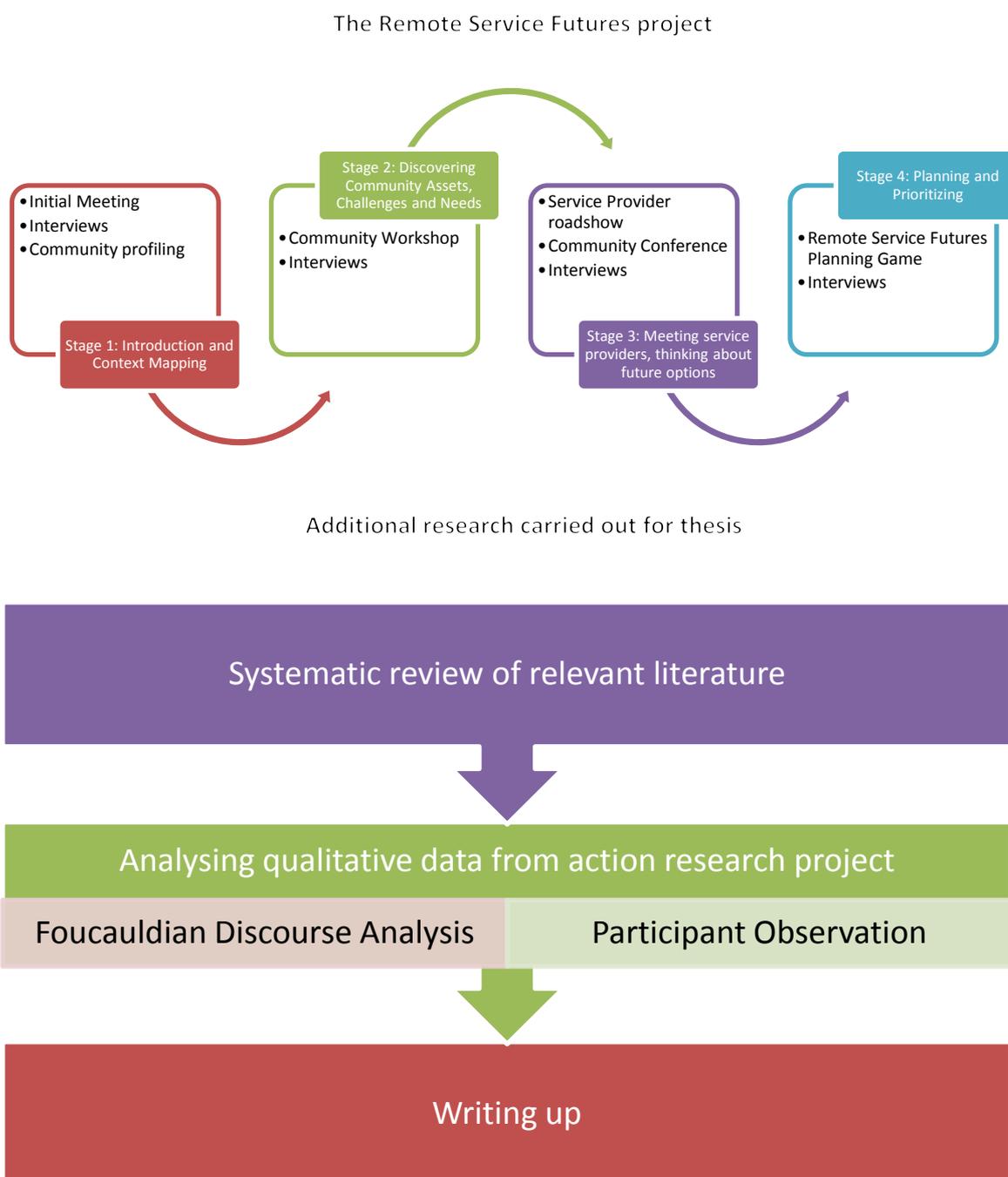
Research Question 1: What is the context and evidence base for engaging remote and rural Scottish communities for health care service design?

Research Question 2: How successful was the Action Research process described in the thesis at achieving its aims and what wider learning can be extrapolated from these results about the reality of engaging with remote and rural Scottish communities for health care design?

Research Question 3: To what extent was individual agency and power observed within the Action Research process and could this have affected the process?

The process by which this thesis was undertaken is outlined below:

Figure 1 Overall thesis: combining the RSF Project with doctoral research



The RSF project (which was described in detail in section 1.8) was a pragmatic study on the topic of engaging Scottish remote and rural communities for health care design, which aimed to find an appropriate methodology to do so effectively. Work done on this project will form the basis of this thesis as a core case study for examining the reality of remote and rural engagement.

Following completion of this project, a systematic review of the literature on remote and rural community engagement was undertaken in order to better understand the

theoretical and contextual background to the work and its results. Qualitative data from the study, in the form of project participant interviews and field notes, were then analysed using a poststructural discourse analysis and French and Raven's (1959) theory of social power bases to better understand the role that individual power and agency may have played in the study results.

1.11 Structure of the Thesis

This thesis is structured in the form of six chapters, including the introduction. The remaining chapters are as follows:

Chapter 2: Scottish remote and rural healthcare engagement: understanding the context

This chapter addresses the first research question by interrogating the current evidence base around community engagement; its context and history as well as its aims and commonly held principles of what constitutes a 'good' engagement process. Within this chapter there is an exploration of who is driving community engagement, what it is being used for, what the results are, and what the policy background is. Chapter Two also examines the contextual factors that have the potential to influence engagement in a remote and rural health care context.

Chapter 3: Remote Service Futures: engagement methodology

This chapter describes the methodology employed within the RSF Project, an Action Research project in which a prototype engagement methodology for remote and rural areas was iteratively applied within four remote and rural Highland communities. Engagement methods featured in this methodology include community meetings, workshops, conferences, individual interviews, ethnographic observation, and a new fit-for-purpose budgetary decision making game that was created and iteratively refined during the Action Research project.

Chapter 4: Remote Service Futures: Engagement Findings

Chapter Four will address the second research question, namely: how successful was the Action Research process described in the thesis at achieving its aims and what wider learning can be extrapolated from these results about the reality of engaging with remote and rural Scottish communities for health care design? Using a combination of formative feedback questionnaires along with participant observation, this chapter examines the success of each method individually, and then the methodology as a whole to consider whether it was effective according to the agreed parameters of success. Special attention is paid to the efficacy of the novel RSF Game, a new method for health care decision making designed specifically for the RSF project, as well as any context-specific challenges uncovered. The chapter concludes with recommendations for future engagement work in this region.

5. Discourse, Power and Community Engagement

This chapter examines the qualitative data gathered throughout the Action Research project described in Chapters 3 and 4, and seeks to address whether more complex power relations exist within the context of remote and rural engagement than the reviewed literature would suggest. This research question focuses on qualitative data gathered throughout the Action Research project in the form of both participant observation and recorded unstructured interviews with community members in three of the four research sites. This chapter aims to investigate any patterns or themes present in the data already gathered that could go some way to offering suggestions as to how power relations may have impacted on community engagement. Using Foucauldian Discourse Analysis (Parker 1998), and with reference to French and Raven's bases of social power theory (1959), this chapter adds a further layer of analysis to the existing qualitative data, as well as providing an interpretation of the results from the previous chapter using a postmodern framework. It also offers a further understanding of how the complexities of remote and rural power relations can affect community engagement in general, an area that has been largely overlooked within the literature.

Chapter 5: Conclusion

This chapter draws together the strands of the three research questions to examine learning from the thesis as a whole. Chapter Five briefly summarises the results of the four core chapters (2-5) in the light of the original research questions. This chapter then considers the main contributions to knowledge made by this thesis before making recommendations for further research.

Chapter 2: Scottish remote and rural healthcare engagement: understanding the context

2.1 Introduction

This chapter interrogates the current evidence base around community engagement for service redesign; its context and history as well as the theoretical traditions that it has emerged from. It also examines the contextual factors that could influence engagement in a Scottish remote and rural health care context. In doing so, this chapter aims to consider where the concept of community engagement has emerged from, who is using it and to what purpose, as well as which methods people are using. The chapter also seeks to address current understandings about measures of success within an engagement process, as well as considering the challenges that surround engagement in general and any issues going forward that are important to reflect upon when considering the Action Research study that will be described in the following chapter.

In order to achieve these aims, a thorough review of the literature around community engagement was undertaken. This review will serve as a background to the research presented in Chapters 3 and 4.

In summary, the aims of the literature review were:

1. to understand the background, principles and aims associated with community engagement, and to identify its roots as a movement,
2. to discover what, if anything, makes remote and rural Scottish communities different as a context for engagement in health service design,
3. to consider which elements constitute a 'good' engagement process, according to the evidence base, and
4. to establish key challenges and operational issues within community engagement that will be expanded on with practical examples in the following chapters.

2.2 The Literature Review Methodology

A literature review was chosen as the most appropriate method for this purpose as it is the most widely accepted means of gaining a detailed critical understanding of a chosen topic area (Hart, 2003: 1) and is considered vital to research for five primary reasons. Firstly the literature review helps one to gain an understanding of the theoretical

background to the topic. It was also relevant for this study to understand the principles or framework criteria that previous studies have used to create their engagement methodologies. A literature review also provides the researcher with secondary sources of data, and stimulates questions to inform data gathering and data analysis. In addition, the review can direct subsequent theoretical sampling and, finally, it can be used as an additional source of validation to explain where one's research findings fit within the overall topic landscape (Strauss and Corbin, 1990; Hart, 2003; Silverman, 2005). According to Tranfield et al (2003), the literature review is *the "key tool...used to manage the diversity of knowledge for a specific academic inquiry"* and allows a researcher to *"map and to assess the existing intellectual territory, and to specify a research question to develop the existing body of knowledge further"* (208). This particular review included published and unpublished studies, narrative articles, academic books, project reports, how-to guides and toolkits, websites, newspaper articles, demographic reports, and policy documents. In other words it contained a mixture of academic literature, grey literature, and policy. The focus of the review was on literature that dealt with the topic of community engagement within health care in rural areas, and this was done in an international context. The review focused not just on evidence and methods from Scotland or even the United Kingdom, but from any nations with comparable challenges of rurality or civic engagement, the majority of which emerged from Australia, Canada, the United States of America, and the Scandinavian countries.

Reference lists of key papers were used as a starting point for the review, as were key word searches using academic literature databases from the University of Aberdeen and The University of the Highlands and Islands (Metalib and Shibboleth). Keywords used for searches included 'community', 'engagement', 'citizen', 'involvement', 'participation', 'civic', 'citizen', 'public services', 'public', 'health care', 'NHS', 'priorities', 'empowerment', 'rural', 'remote', 'primary care', 'Scotland', 'Scottish', 'Highlands' and others. Following the key word search a snowball sampling method was used and the literature found as a result of these initial searches was mined for references, which was then examined and mined for references itself. This iterative cycle continued until searches began bringing up familiar references. In addition, other databases were accessed including the Scottish Government documents and website policy repository (<http://www.scotland.gov.uk/Publications>), and other websites featuring community

engagement including the Joseph Rowntree Foundation website (<http://www.jrf.org.uk/publications>), Scottish Community Development Centre (<http://www.scdc.org.uk/>) and a number of sources of demographic and descriptive data including the ISD Scotland (Information Services Division) website and Scottish Neighbourhood Statistics (<http://www.sns.gov.uk/>). This inductive strategy yielded vast array of literature that touched on the topic of community engagement in health care either directly or peripherally, and from an extremely wide sample of discipline areas which was important because the topic of community engagement, by its nature, has been covered by both academic and more pragmatic sources. The table below shows a sample of the different discipline areas that emerged as having an interest in the theory and practice of community engagement:

- Community Development
- Semiotics
- Sociology
- Political Science
- Social Psychology
- Environmental Studies
- Geography/Social Geography
- Architecture/Studies of the Built Environment
- Public Planning
- Health and Medicine
- Management
- Philosophy
- Public Policy
- Rural Studies/Urban Studies
- Art/Photography/Drama
- Education
- Economics

This diversity provided a challenge as each discipline has its own epistemological and theoretical conventions, language and set of standards for what constitutes robust research. The majority of academic literature around engagement came from the fields of community development and environmental planning, however there was also a large amount of material on public involvement in healthcare. It was helpful, therefore, to focus specifically on the similarities and differences of findings, and to examine critically when literature from any one discipline made claims that either contradicted or deviated from what was emerging from the wider body of literature. What follows is a summary of

the literature uncovered that was helpful in illuminating the context of remote and rural healthcare engagement in Scotland.

2.3 History of Community Engagement: Community Development, Consumerism, Democracy and Co-Production

In the previous chapter, community engagement was defined as

“a multi-level concept, ranging from engagement in policy development through partnerships with agencies and consumers to plan and deliver local services, to individual engagement with programs” (Kilpatrick 2009, 37)

Following the World Health Organisation’s Alma Ata Declaration in 1978, there has been an impetus on community engagement in public service decision making. Forms of governance emphasising citizen involvement in decision making have been gaining prominence amongst policy makers, academics and practitioners in the United Kingdom since the 1970s (Croft and Beresford, 1992). Although it would be overstating the case to imply that there was agreement in the literature around the theoretical origins of current community engagement practice, a Health Development Agency (HDA) review of participation in health promotion and health planning states that engagement practice can fit broadly into one of four core theoretical constructs: community empowerment, community development, civic participation, or Action Research. It is significant, they point out, to consider the theoretical construct being used because it can *“have important implications for how community participation is put into practice and the choice of methods used to do this”*(Rifkin et al, 2000). The community development perspective finds its roots in post-World War Two America, and is concerned primarily with using participation for the alleviation of poverty (Rifkin et al, 2000), however, it is a fundamentally top down approach in that the central feature of community development is that communities are being developed *from outside*, and in this way very little transfer of decision making power could be realised. (Rifkin et al, 2000) Following on from the empowerment agenda in the 1960s and 70s was the concept of the peoples’ participation which focused on citizen’s civic right to participate in their democratic society (Pelletier et al, 1999); and alongside civic participation was the notion of community empowerment. Empowerment, as opposed to people’s participation, focused on engagement as a way to

empower communities and individuals through the acquisition of knowledge and new skills as well as new decision making powers (Butterfoss, 2006). Both of these theories of participation, as opposed to the community development approach, feature grassroots involvement, engagement occurring from the bottom-up. The final step in the Rifkin et al's summary of the evaluation of community engagement is Action Research. A participatory Action Research approach to community engagement features a combination of bottom up and top down involvement in decision making. Due to the contextual and participant-led nature of Action Research, it provides a partnership approach to engagement that *"can be seen as the application of the more theoretical notions of people's participation and empowerment"* (Rifkin et al:5). It has been argued that, in current day United Kingdom, these theoretical categorisations have also become subsumed within a neo-liberal framework for service withdrawal (Barnes, 2009).

It is worthwhile considering how the actual practice of community engagement became so engrained within Scottish public services. In developing nations including countries within the Africa and Indian subcontinents, engagement practices have been used in impoverished rural areas in a community development context since the 1950s (Rifkin et al 2000, Mezirow, 1963). Taking a longer view, however, current community engagement practice can also be seen as part of a wider effort *"to move from representative to participatory democracy"* (Croft and Beresford, 1992: 27) that has been taking place for almost 3,000 years since the inception of ancient Athenian democracy. In other words, community engagement is far from a new concept. Indeed, much of the engagement literature refers to the act of engaging citizens as being intrinsic to the democratic political system (Elster, 1998; Beierle, 1999; Martin, 2008b, Bayley and French, 2008), the most widely subscribed to system of governance in the world today (Elster, 1998). While the idea of collective decision making, or at least public representation in decision making, may be central to the ideological foundation of democracy (Elster 1998), the concept of community or citizen engagement has not necessarily been a natural part of the political or governmental agenda within mature industrialised democracies (Marinetto, 2003). Active citizenship was a cornerstone of the original Athenian democratic concept (Elster, 2009), however, the political mechanisms of modern western democracies have been tempered by a history of Medieval feudal systems. With increased trade, revolutions and the Protestant Reformation, feudal society began to

disintegrate and a "*liberal constitutional tradition*" (Marinetto, 2003: 105) gained authority in Europe. This led to a model of 'protective democracy' (Marinetto, 2003), a form of democratic governance that emphasised the need to protect citizens from themselves as well as outside forces. In practice, what this meant for citizen involvement was that it happened in an indirect way, through representatives (Elster, 2009) rather than directly through the individual citizens themselves. Within liberal western democratic thought there became a preoccupation with the freedom of the individual and their freedom from oppression, which manifested itself in a separation of "*the state from civil society*" (Marinetto, 2003: 106). How, then, did a western democratic nation, such as that of the UK, arrive at a place where direct community engagement has become not only the norm (Carlisle, 2010), but a legal requirement for public service providers? Croft and Beresford (1992) argue that there are four developments in western history that have impacted on involvement. These include the emergence of new social movements concerned with 'participatory politics' such as feminism and special interest advocacy, a rekindling of interest in human need, a new emphasis on the concept of 'citizenship', and the emergence of postmodern thought and its preoccupation with fragmentation, difference and diversity.

Western democratic market economies, although outwardly affluent, continue to deal with a number of significant problems including "*gross inequalities, the concentration of political and economic power, and the failure to reconcile profit and the accumulation of capital with the meeting of need and guaranteeing of people's rights*" (Croft and Beresford, 1992: 21). The United Kingdom is an interesting case in that a number of services (including health care, welfare and housing) came under direct state control following the Second World War (Needham, 2007). The 'welfare state' came into being with the establishment of a welfare system for those unable to work, and, most notably for this study, with the creation of the National Health Service (NHS) in 1948, a health service that, to this day, offers its citizens service that is free at the point of delivery. Although the 'welfare state' embodied a number of social values, it was also criticised for its tendency towards power inequalities (particularly between powerful 'professionals' and less powerful 'clients', such as doctors and their patients who were seen as having few opportunities to influence their own treatment), a focus on economies of scale, and a centralisation of planning and production that led to a 'uniform product', not always

appropriate for variances of context (Stoker, 1989; Needham, 2007) Criticisms came to a head during the Conservative government from 1979-1997 when the gap between rich and poor began widening (and has continued since) and funding to the social institutions of the 'welfare state' (a central pillar of which is the NHS) was incrementally rolled back or made subject cost savings, while at the same time privatisation and a market-based approach to public management was encouraged by Thatcher's administration (Needham 2007, Alford 2009). The Conservative government came to foster the relatively new ideology of neoliberalism, a concept that Farmer et al (2010) define succinctly as "*a political agenda prescribing withdrawal of the state and encouragement of individual and community responsibility*" (276). According to Orbach (2011):

"with the growth of a neoliberal emphasis on small government and the free market as the best regulator of human affairs, participation was considered the new road to decentralisation, a means to achieve local control while minimizing the reach of the state" (197).

Nikolas Rose (1996) refers to this as "*governing through community*". In the case of the UK Conservative government at the time, the neoliberal agenda included an emphasis on privatisation (which for the NHS may mean the purchasing of services from non-government suppliers) and the idea that *individual* service users (or 'clients') had the right to *choose* the services and providers that they wanted. This is also referred to by Campbell and Marshall (2000) as "*the politics of the consumer*". Citizens were encouraged to express their preferences for services individually by 'voting with their feet' and their collective decisions would be made through the exercising of market forces (that is, services that delivered what the individual 'clients' wanted would flourish, and those that did not would flounder). The free market, however, did not prove to be an equitable marketplace for all citizens. People from minority backgrounds or who lacked formal education found that they were not equitably represented by these types of involvement, but also found that there was now an increased expectation, that "*what were once seen as problems for the state are now reconstituted as individual problems*" (Cheshire and Lawrence, 2005: 438). Although many critics of the Conservative government bristled at the idea of the commodification of public services, of health care being 'consumed' in the same way that one chooses a new shirt or a restaurant to frequent, there was a significant ideological and rhetorical shift during this period towards an emphasis on services that were, at least theoretically high quality and responsive, and the beginnings

of a power shift away from professionals and towards citizens had begun (Needham, 2007; Alford, 2009). The extent to which this promise was actually fulfilled however, is debated (Scutchfield et al, 2005). Needham (2007) summarises the situation below:

“Supporters of the consumer-oriented approach express bewilderment that anyone, other than unapologetic paternalists or producerists, could resist its penetration into public services. Critics of consumerism see its common sense pretensions as a hegemonic project to erode the distinctive civic space of public services” (1).

In other words, a neoliberal consumerist approach uses the rhetoric of engagement and empowerment to mask the withdrawal of support from public services, including some of those that may be significant sources of social capital (Prior et al, 2009).

With the advent of a New Labour government in 1997, the push for citizen involvement grew, and Neoliberal ideals took further hold, however it was still being described in consumerist terms. As Croft and Beresford pointed out, around this time in the United Kingdom, a new interest arose in the concept of citizenship and what it meant to be a ‘good citizen.’ (1992) This led to a renewed interest in the democratic aspect of community engagement; in other words, the focus shifted from the right to be engaged as a consumer, to the right to be engaged as a citizen and a tax payer (Alford, 2009). The distinction between the ‘consumerist’ and ‘democratic’ approaches may not be significant in terms of engagement methodologies, but it is significant in terms of how the engagement is conceptualised and the goals used to measure success. Within the consumerist perspective, the idea is one of *“converting...needs into markets to be met by the creation of goods and services”* (Croft and Beresford, 1992), whereas the democratic perspective focuses on empowerment and encouraging people to speak for themselves by fostering involvement in democratic processes. The first perspective, as we have seen, was primarily led by the government and service organisations, whereas, the second was developed by ‘grassroots’ support; a bottom-up approach focused on empowering those in society that were marginalised. These two approaches, although often both grouped together under the general heading of neoliberalism, are not necessarily complementary. As Croft and Beresford put it, *“[t]he politics of liberation don’t necessarily sit comfortably with the politics of the supermarket.”* (1992: 32)

In recent years, however, there has been an interesting shift in the conceptualisation of public services that, it can be argued, has offered a third alternative to the aforementioned dichotomous ideologies of engagement. This alternative is co-production.

“Co-production is the involvement of citizens, clients, consumers, volunteers and/or community organisations in producing public services as well as consuming or otherwise benefiting from them” (Alford, 1998: 128).

Or, alternatively, co-production can be viewed as:

“the provision of services through regular, long-term relationships between professionalized service providers (in any sector) and service users or other members of the community, where all parties make substantial resource contributions” (Boviard, 2007: 847).

In either definition, the concept of co-production challenges the idea of the relationship between state and citizen as being either that of a producer and consumer, or that of adversaries locked in a struggle for power and liberation (Needham, 2007a) Instead, co-production *“emphasises the role that service users play in both the consumption and production of public services”* (Needham, 2007a: 221, also espoused by Parks et al, 1981 and Ostrom, 1996). In other words, citizens are partners in the creation of services; they have responsibilities as well as rights.

According to Boviard (2007), the concept of co-production goes further than community engagement, in that it substantially changes the relationship and indeed the power balance between service producer and service user (Boviard, 2007). Co-production, according to Boviard, finds its roots in the theory of Richard Normann (1984) who posited that clients within (private sector) service systems were not always merely passive recipients. Instead, on an increasing basis, clients were becoming more and more a part of delivery systems, in that they are often called upon to complete service transactions. In this scenario, service providers are merely “enablers” of service provision. Boviard gives the example of an automated supermarket checkout. When at Tesco (for example), more and more the acts of shopping, ringing up goods, and paying are all completed by the customer. In this instance, the supermarket chain merely enables this service to be delivered, rather than directly delivering it themselves. In fact, Boviard (2007) and Hood (1998) argue that co-production is in fact far from a recent phenomenon, citing the

examples of citizen juries and citizen militias as examples dating back for decades within the UK.

While co-production as a concept has wider implications for involving citizens in the actual *delivery* of services (through mechanisms such as social enterprises or volunteering schemes), involving citizens in making decisions about service configurations in a mutual way, in partnership with service providers is a very important aspect of a co-producing society (Needham, 2007). Indeed, co-production not only emphasises the ‘rights’ of service users to be involved, but also their responsibility to do so. Advocates claim that the collaborative nature of co-production allows for a number of potential advantages, several of which include: potential to add to community empowerment and resilience; and the potential to aid in overcoming resource scarcity by not only improving allocative efficiency but also by providing community-led services at less cost to central government (for example in the form of volunteer schemes or social enterprises).

There are, however, also a number of potential pitfalls associated with the concept. It can be seen as the state abdicating responsibility for service provision, and putting unrealistic demands on its citizenry (Evans and Shields, 2000). Certainly, it can be seen to obscure the boundaries between service users and producers, however, co-production is something that, for the moment, has worked its way in to policy rhetoric. Health policy in the UK, and Scotland in particular, heavily emphasises co-production, with terms such as “mutuality”, “sustainability” and “resilience” featuring strongly in recent health policy publications such as Patient Focus and Public Involvement (Scottish Executive, 2003) and Better Health, Better Care (Scottish Government, 2007). McCabe (2010) also points out that the concept of co-production is central to one of the current UK coalition government’s key policies: the Big Society. To a large extent, the Big Society is the apex of a new wave of Conservative neoliberalism within the UK. As Barnes (2009) argues, engagement and the co-production of services is “*one way in which citizens learn to be self-governing subjects*” (33) within neoliberal governance structures.

2.4 Scottish Policy Background

“Mutual organisations are designed to serve their members. They are designed to gather people around a common sense of purpose. They are designed to bring the organisation together in what people often call “co-production”. The concept of the mutual organisation sits extremely comfortably with the Scottish Government’s commitments to stronger public involvement, improving the patient experience, clearer patient rights, enhanced local democracy - for example through direct elections to NHS Boards – and independent scrutiny of proposals for major service change. It also underpins the Government’s commitment to partnership working, better staff governance and improving the NHS as a place to work” (Better Health, Better Care, Scottish Government 2007).

As previously mentioned, Scottish Government policy that affects remote and rural health care in Scotland, such as the Our National Health: A Plan for Action, A Plan for Change (Scottish Government, 2000), the NHS Reform (Scotland) Act (2004), Patient Focus and Public Involvement (or PFPI, 2003), Better Health Better Care (2007), the Patient Rights (Scotland) Act (2011) and the Healthcare Quality Strategy for NHSScotland, (2010) the last of which promises to *“develop a mutual NHS – offering the people of Scotland new rights and a stronger voice”*(15). These policies - as can be seen in the above quotation from Better Health, Better Care - place strong emphasis on mutuality and the need to involve service users as partners in decision making about their current and future health care services. As Forbat et al (2009) point out, PFPI, as a central tenet of the Scottish Government’s engagement agenda, *“invoked the three parallel ideas of participation, empowerment and partnership as routes to improving services.”* (2547) and, in doing so, put forward a vision of patients as *“full and equal partners in their healthcare”* (2547). Although there is a lack of clarity around the terminology used to advocate engagement, the support for engagement is unequivocal. In the forward to Better Health Better Care (Scottish Government, 2007), Minister for Health Nicola Sturgeon said *“I want us to move to a more mutual NHS where partners have real involvement, representation and a voice that is heard.”*(v). Within the policy document itself the emphasis on involvement continues:

“Our Action Plan brings together our commitments to public participation, improving patient experience, patient rights and enhanced local democracy and expresses them in terms of a more mutual approach to healthcare. The Scottish people are more than consumers of NHS services. They share ownership of the NHS

and that gives them rights and responsibilities.” (Better Health, Better Care, Scottish Government 2007))

The language of partnership and mutuality is particularly striking because there is an implication of *equal* partnership that is unlikely to be realised (Renado and Marston, 2011). Porter and Shortall (2008) warn that an equal partnership may not always be productive, but the illusion of equality in which the system is weighted towards the judgement of the professional partner can be damaging.

In addition to policy encouraging the use of engagement in health care decision making, the NHS Reform (Scotland) Act (2004) actually places a legal duty on health boards to engage with service users in the following excerpt:

Duty to encourage public involvement

(1)It is the duty of every body to which this section applies to take action with a view to securing, as respects health services for which it is responsible, that persons to whom those services are being or may be provided are involved in, and consulted on—

(a) the planning and development, and

(b) decisions to be made by the body significantly affecting the operation, of those services.

However, this ideological stance is somewhat complicated by other national, European, and professional policies that could be described as one size fits all and not always rural-appropriate, (for example, policies that discourage generalist skill attainment may preclude community members’ desire for particular professional skill sets). According to Anton et al (2007: 470) there are “*tensions and ambiguities relating to [public involvement in] policy*” in Scotland that have not been adequately explored. In other words, while policy rhetoric implies that service users should have some degree of latitude in determining a contextually appropriate health care service model for their area, they are constrained by other policies and structures that restrict actual staffing practices such as the European Working Time Directive, which essentially limits the health care professionals able to provide twenty four hour care to those who are ‘self-employed’ such as General Practitioners, and Agenda for Change (which strictly delineates scope of practice for registered health care professionals employed by the NHS and allows for little flexibility of roles). These, in addition to other recent developments such as the change in General Medical Services contracts to allow general practitioners to opt out of providing

out of hours care (2004), and the restriction of nurses from providing triple or double duty services have had a significant impact on the way services can be provided in remote and rural areas (Farmer et al, 2003).

There is, then, an interesting juxtaposition between a policy emphasis on community engagement and joint decision making, and a wider policy landscape that does not necessarily support the outcomes of that decision making process. While there have been a glut of policy documents in the last decade that emphasise the need for increased public involvement in decision making, there is still a lack of statutory requirement for health boards to actually implement any outcomes of the engagement process (Milewa, 1997). In other words, service providers may be obliged by policy to engage with citizens in decision making, but whether the results of the engagement are implemented is left to the discretion of the service providers themselves. It should also be noted that a policy emphasis on community engagement for decision making is by not only limited to Scotland or the UK. It is indicative of a wider policy trend within other western countries including Canada (Health Canada, 2000), Australia (Kilpatrick, 2009) and the United States (Morone and Marmor, 1981). Indeed, it has become central to current good practice recommendations for governance from such organisations as the OECD and the World Bank.

2.5 Engaging in Health Care Decision Making

In order to determine which methods would be most appropriate for decision making/service design in a health care context, it is necessary to first understand how that context differs from other service delivery and engagement contexts. In a health care decision making context, surveyed literature on how citizens can become engaged in health care decision making fell broadly into three main categories.

Firstly, citizens can be involved on an individual level with making decisions about their own treatments and care plans. This is referred to as clinical decision making (Mitton et al, 2009) and this type of engagement is often carried out via an individual consultation with a health care practitioner, such as a doctor or nurse.

Secondly, citizens can be involved in helping to shape or improve current services by evaluating their quality. This often takes the form of survey questionnaires (such as NHS Scotland's Better Together patient experience programme) or, occasionally, the form of patient-representative positions on existing groups such as Patient Public Forums (Scottish Executive, 2004).

The third and final type of engagement identified in health care, and the type that is of interest in this study, is engagement in service design and planning. This is simultaneously the type of engagement with the greatest potential for true co-production, and the most complex and value-laden type of engagement (Scottish Executive, 2001a). There are myriad ways that the NHS can engage with citizens for planning and design, indeed there are guidelines and toolkits and recommendations aplenty for NHS employees in how to engage with communities for decision making purposes however, the evidence still points to it not being done well (Milewa, 1997; Scutchfield et al, 2005; Barnes and Coelho, 2009). In fact, health care service decisions, in reality may still *"take place in situations that are largely uninfluenced by the opinions of ordinary people"* (Scutchfield et al, 2005, 77). In practice, community engagement within the NHS often relies

"on indirect mechanisms and passive forms of representation which reinforce existing hierarchies and social inequality limiting opportunities for service design...[and]...tend to remain at the consultation level with professionals' decisions taking priority" (Renedo and Marston, 2011: 269).

In other words, although community engagement exists within the NHS in a nominal sense, it may not be having a significant impact on actual service design decisions. Milewa et al (1999) point out that, historically, the power of the expert within the NHS has been an overriding factor in decision making and that citizens in the NHS have previously been *"merely recipients of technocratic and medical expertise delivered in accordance with central planning and critical judgement"* (508). Alford, in 1978, identified three categories of actor within the NHS health care delivery and policy context: 'corporate rationalisers' (NHS managers and corporate administrators), 'professional monopolists' (the *"powerful medical profession and its representative bodies"* (as described in Milewa et al, 1999)), and the community population who were categorised as *"diffuse"*, *"marginalised"* and *"repressed"* by Milewa (1999). This view has been challenged by the co-production agenda evident within Scottish health policy that promises to reconfigure these categories into equal partnerships, however, evidence suggests that this shift is proving

challenging within the NHS due to its hierarchical, bureaucratic nature (Renato and Marsten, 2011) and the dominance of evidence-based practice as a model for best practice decision making.

Engagement processes (other than via established patient forums) undertaken by NHS Scotland were found to be episodic rather than process based (Ellison, 2000) and a review of current engagement guidance available to NHS staff including illustrates this type of problem solving, project management-style approach to engagement. Outside of Public Partnership Forums, where there may be continuity of participation, NHS staff are encouraged to view engagement as a process with a beginning, middle and end that is to be planned, acted on and ultimately reviewed. The recommended support mechanism for use within NHS Scotland is an online planning tool called VOiCE, or Visioning Outcomes in Community Engagement (<http://www.scdc.org.uk/what/voice/>) that strongly advocates for episodic engagement practice within the Scottish National Standards for Community Engagement. It could be argued that this type of episodic engagement has the potential to *disempower* community members by relying on defensive (or problem based) engagement and effectively removing the option to retain the status quo (Ellison, 2000), and by disallowing the accumulation of knowledge, skill and trust within participants (Scottish Health Council, 2012).

One challenge with current engagement practice, according to the literature, is that planners and community members tend to conceptualise and value services in different ways. For example, service providers base their service design plans on aggregated, comparative data using a somewhat “utilitarian” philosophy of resource allocation (Healey, 2009), whereas community members tend to place emphasis on contextual knowledge of what it is like to actually access the service. This knowledge is often anecdotal in nature (Farmer et al, 2007) and, as decision making power still lies in functional terms with the service providers, there is the danger that service providers and community members are not really speaking the same ‘language’ (Healey, 2009) when it comes to resource allocation and decision making, and that the utilitarian discourse will be prioritised over the contextual discourse of community members, essentially negating any impact of the engagement exercise. This echoes the sentiment expressed by Barnes et al (1999) that, in interviews with health care professionals, professionals often did not trust service users to make ‘responsible’ decisions. Anton et al (2007) also point out that

the egalitarian philosophy of community engagement may at times clash with one of the key pillars of the health care delivery context: that of evidence based practice. While it may be argued that community input is a type of front line evidence in itself, the tradition of evidence based-decision making is heavily weighted towards a privileging of quantitative controlled studies (Anton et al, 2007). Additionally, if community members are to be more than providing additional data, if they are to be making decisions about resource allocation in cooperation with health care managers, there is the potential for these 'ways of knowing' to clash.

An unresolved question for joint decision making between communities and service managers in a health care context what to do when there is a disconnect between professional assessments of service safety and community opinion. Anton et al (2007) summarise thusly: "*what people want may not be what the research says is effective,*" (480) and in this case, how much weight is to be given to the voice of the expert and to the service user respectively? These are questions that are not answered within the literature at present. Harrison and Moran (2000) also point out that NHS Scotland is a system of third party payment, in which budgets and budget restrictions are set by central government and therefore there are constraints, as well as those posed by professional and safety legislation, on the results of engagement for planning.

There is evidence that health is a highly sensitised topic for service users (Scottish Executive, 2001a) and discussions around health services can be highly emotive and polarised. Examples of situations in which communities do not feel adequately involved in the decision making process for health care service planning, and as a result form 'stand-off' situations with their service providers, (Kearns, 1998) can be found in the Scottish media. A few examples of such cases can be found below, a common theme of which is the perceived failure of the NHS to adequately engage local rural communities in the decision making process.



Figure 2: A selection of headlines from Scottish newspapers

Considering these issues, along with the previously discussed policy context for community engagement in a health care context, there are a number of unique features that should be considered when planning a health care engagement initiative. These features are now summarised:

Table 1 Aspects of health care that may affect engagement for service design

Aspects of health care engagement
Health care is a complex and value-laden topic that often has emotional connotations for service users
Service providers and users may not value the same types of knowledge and this can lead to poor communication (i.e. not speaking the same 'language')
Service providers are obliged to engage but there are no formal guidelines for <i>implementing</i> the outcomes of engagement
Service configuration is constrained by some policy and legislation (EWTD, Agenda for Change)
Health care is a highly sensitive topic and without due attention can lead to 'stand-off' situations between service users and providers

2.6 Engagement in a remote and rural context

In Scotland as elsewhere in the UK, health care in the community is delivered by a primary health care team traditionally consisting of:

Staff employed directly by a general practice, including general medical practitioners, practice nurses and administrative staff; and staff employed directly by a health board through a primary care trust...including district (community) nurses, health visitors and midwives (summarised in Farmer et al, 2005).

Farmer et al (2005) also point out that, although these small teams are located in remote and rural areas, largely adhering to the same guidelines and employment regulations as their urban counterparts. In some parts of remote and rural Scotland, alternative health care service delivery models have evolved outside of these frameworks, and are allowed to do so due to 'historical precedent' (Douglas, 2005) however, these historical arrangements – which may be uniquely contextually appropriate, are phased out with the retirement of the local health care practitioners who carry out these patterns of service delivery (Scottish Government, 2008a). While rural practitioners by their very nature tend to be generalists (Douglas, 2005), there is an increasing trend towards specialisation within the NHS and internationally (Farmer et al, 2003; Douglas, 2005). Health care practitioners who specialise have a clearer job progression and better salary prospects, and in addition, there is little prestige in becoming a rural health care provider (Farmer et al, 2003). An example of this trend in practice is the recent reorganisation of Scottish community nursing services in which double or even triple duty nurses, who were historically found in rural areas (West et al, 2004) were forced to reduce their function to single duty in order to focus on one specialisation, often being compelled to choose from one of the two or three disciplines they previously practiced. While the impetus for this change was the difficulty of maintaining the skills of three separate professions in an area of small population, it has made a significant impact on the perception of services in rural communities where some services, for example community midwifery, are now delivered peripatetically rather than by a health professional in situ. Ironically, there have been moves in recent years to introduce a 'new' nursing model (the Community Nursing model) that follows the old integrated care model and, unsurprisingly, was found to be popular in more rural areas (Kennedy et al, 2008) which may suggest that there is value in considering whether historical service delivery models may in fact be contextually

appropriate even if they do not fit with current (predominantly urban-conceived) service models. There are, in fact, a number additional professional difficulties for rural practitioners including skill retention (especially for lone workers) (Richards et al 2005), being able to find relief workers to backfill time off (Elliott et al, 2012), lack of professional peer support (Remote and Rural Areas Resources Initiative (RARARI) Solutions Group, 2002).) and a need to balance the professional demands of the role (including professional detachment) with simultaneously being part of a small community where the worker is known to everyone (Farmer et al, 2003). By logical extension, this could imply that there are additional sensitivities in engaging with people in small rural areas to discuss service design. When discussing the benefits and drawbacks of the way a service is delivered, this often translates directly to discussing one or two individual health care practitioners (Farmer et al, 2003).

A 2005 study by Farmer et al showed the adaptive nature of primary care teams in remote and rural areas of Scotland, highlighting the fact that prescribed NHS models have 'evolved' to suit local circumstances and the workloads of these teams no longer reflect the 'traditional' job descriptions of the workers. In the year prior to this paper, a comparative article by West et al (2004) examined the workload of remote and rural primary care staff as compared to that of urban primary care teams, and found that the health care workers (including district nurses and general practitioners) often had blurred professional boundaries. Nurses in rural areas, for example, carried out a list of activities that were not performed by their urban counterparts (although it should be noted that these activities were not always within their formal scope of practice). This included being on-call (and potentially called out at any time of day or night), transporting elderly patients, making social visits to elderly patients, delivering medicines to patients' homes, taking specimens to the ferry, and reviewing casualty patients. West et al also noted that much of this activity is not captured by traditional, one-size-fits-all data recording procedures and therefore is often not included as an 'official' part of their job descriptions (West et al, 2004). This flexible approach to primary care delivery is clearly of value to patients in rural areas as rural patients often report higher satisfaction from their primary care services (Scottish Government, 2012). Although the holistic care that patients appear to receive in rural areas fits in well with aspects of the current policy climate (the new emphasis on pre-emptive care, for example) it is also a double edged

sword for practitioners. Although patients often receive a flexible, often twenty four hour on call service, this can lead to feelings of pressure on local practitioners who may feel that they are always 'on duty'. For example, in a paper by Farmer et al (2005) also considering the rural health care workload, one rural district nurse commented, "*It is trying to please all of the people, if you can, all of the time*" (160) and another rural practitioner noted feeling pressure to do more (than an urban practitioner would have to) simply because they had a familiarity and community relationship with their patients. Also, this rural 'flexibility' is an ill-fit for NHS staffing regulations brought in with Agenda for Change (The NHS Staff Council, 2004) which, as mentioned earlier, rigidly delineates exactly what staff are and are not allowed to do within the confines of their roles.

These two papers (West et al, 2004 and Farmer et al, 2005) are illustrative of a potential danger in service planning; if traditional workload data are not capturing the scope of the services provided in rural areas then there is the danger that any planning process that does not delve deeper into the service delivery context (in this case, the individual rural communities) could ignore important parts of the rural primary care services. Indeed, as Farmer et al (2005) point out, this disconnect between the services the community experiences and the services the NHS acknowledges to providing is part of what has led to 'stand-off' situations between the NHS and rural communities when it comes to service reconfiguration. In addition to providing services that may fall outside their job descriptions, rural health care practitioners also become "*embedded*" (Farmer et al, 2009) within the community by virtue of the practitioner contributing to the community both professionally and socially.

According to Prior (2009), health care practitioners in rural areas provide the community with social capital, as well as other 'added value' elements that may be only indirectly connected with their professional remit. This can have implications for engagement in remote and rural areas as discussions that focus on the official 'services' provided by the local practitioner may be insufficient to reflect the scope of what the community perceives as that practitioner's role and consequent value. In other words, when a practitioner retires or leaves a community and they have been performing additional (but unofficial) duties, the full loss of services to the community may well not be acknowledged by NHS managers.

Internationally, there is a crisis in attracting and retaining skilled general practitioners (GPs) to work in rural areas (OECD, 2006). In Scotland, however, since the advent of the new GMS contract (GP contract) in 2004 which offered GPs the potential to opt out of providing out-of-hours services (except in the most remote areas) and increased their pay, this crisis appears to have eased somewhat, although it has far from disappeared. There is a growing body of literature recognising the potential for alternative models for service provision in rural areas, including the use of new roles such as Nurse Practitioners (Chang et al, 2001, Burgess et al, 2003) and Physician's Assistants (Farmer et al, 2009, O'Connor and Hooker, 2007) and the University of Aberdeen has recently become the first institution in Scotland to offer training for the Physician's Assistant role. It has been argued (Farmer et al, 2011) that there may be a need for remote and rural communities, along with the NHS, to think creatively about how their services are to be delivered in order for them to be not only safe but sustainable into the future. Remote and rural areas, with their unique requirements, therefore, may instead face a difficulty attracting the *right* practitioner.

Remote and rural areas of the Scottish Highlands, since the time of the Dewar report, have tended to have different service configurations than are available in urban areas. Within remote and rural Scotland, primary care services are likely to be delivered by a very small team comprised of a GP and district nurse or nurses, sometimes supported by health visitors or health care assistants (Scottish Government, 2008). In very remote regions it is likely that the primary health care practitioner (be they GP or district nurse) will also be on call 24 hours a day as the first response in case of medical emergency, supported later by (air) ambulance if necessary (Scottish Government, 2008). Additionally, as has already been touched upon, practitioners in these areas tend to perform a number of health and social care related duties out with their job description. These models of service delivery, however, are in the process of changing (Farmer et al, 2005). The Scottish NHS is facing a crisis of funding (Dean, 2010) and government policy (as was discussed in a previous section) is calling for services to be delivered in a more collaborative way. Simply put, the high levels of service expectation that rural areas of Scotland have experienced for years (Douglas, 2005) may no longer be met (RARARI, 2002), and as professionals retire from rural areas, NHS managers are taking the opportunity to reconfigure services in a more cost effective way. In order attempt to do

this sensitively, various NHS boards have been undertaking community engagement to help plan and design new service configurations, with varying degrees of success (see Figure 2, as well as Anton et al, 2007). As has already been discussed there exists a wealth of literature about community engagement, however, much of this literature does not focus on remote and rural circumstances, nor does it explore engaging for health care planning on the small, contextually driven community-based scale in which remote and rural health care services are delivered (Farmer and Nimegeer, 2008). One exception to this is the Scottish Government's Advice Note on Remote and Rural Practice (Scottish Community Development Centre -undated) that was added as a support material to accompany their National Standards for Community Engagement, following its publication. The document draws attention to a number of issues specific to remote and rural engagement practice in Scotland that may need to be addressed including issues of anonymity and confidentiality, the potential for personalising of conflicts due to the small scale of the community, and the potential for parochialism, deference to local power figures, and pre-existing relationships to influence engagement outcomes, amongst other things (Scottish Community Development Centre - undated). The advice note was formulated from discussions with practitioners who had identified gaps in the current guidance and, perhaps significantly, this note was the only item identified within the literature review to directly acknowledge that engaging remote and rural Scottish communities may require a different approach and one of the few documents found that highlighted the potential for rural intra-community conflict and power struggles.

Remote and rural Scotland, as was mentioned in the previous chapter, has a number of characteristics including dispersed populations, lack of infrastructure (including physical infrastructure and, increasingly, technological infrastructure such as high speed broadband), challenging physical geography, and lack of economies of scale (Scottish Government, 2012; Skerrett et al, 2012; Farmer et al 2005) that differentiates it from urban areas as a service delivery context. Each of these characteristics has an impact on the way services are delivered and, often, translates to a higher cost of service delivery than in urban areas (King and Farmer, 2009). Rural areas in the UK have higher percentages of older people than do urban areas (Scottish Government, 2012; Wenger, 2001) and this percentage is on the increase with the out-migration of younger residents and the in-migration of older retirees (Scottish Government, 2012; Skerrett et al, 2012).

While immigration of older people to *accessible* rural areas is common to other countries including Australia (Davis and Bartlett, 2008), Canada (Everitt and Gfellner, 2008) and the United States (Johnson and Beale, 1978), within Scotland immigration of older people also occurs in remote areas (Scottish Government, 2008) placing strain on an even smaller, more fragile health delivery system. With rising numbers of older people also comes an increase in the number of complex and chronic conditions (NHS Scotland, 2010), and an increased need for health and social care provision (Skerrett et al, 2010), leading to increased strain on the local primary care system. In fact, by 2033, estimates suggest that primary care expenditure on over 65 year olds could increase by 70% (Jeannet, 2010).

If remote and rural primary care services are being delivered by just one or two key workers, a small increase in patient load can translate to a large proportionate change in actual workload. For example, on a small island with one district nurse carrying out home visits, if two people requiring care move to the area it could require two visits per person per day. Factoring in travelling time, which is a significant factor in delivering health care in remote and rural areas, it is easy to see how such a fragile system could quickly become strained.

In addition, like many other nations with significant issues of rurality, there are difficulties in Scotland's remote regions with recruitment and retention of skilled health care staff (Scottish Executive, 2005a). Additionally, staff in remote and rural Scotland face challenges of skill retention and lack of support through their isolated working conditions. Recent Scottish policy document *Delivering for Remote and Rural Healthcare (2008)* clearly states that lone working practices are to be actively discouraged and, where possible, geographically disparate service providers should form professional networks, an arrangement which may lead to some health care services being delivered peripatetically, constituting (arguably) a significant change for remote and rural residents accessing primary care services.

While issues including aging populations, scarcity of resources, difficulties with recruitment and retention, and rural-specific methods of working are issues that many developed countries face in their rural areas, Scottish rural populations are also atypical of global rural trends in several aspects. Firstly, they tend to be wealthier, and better

educated than their urban counterparts. (Scottish Government, 2012). Secondly, Scottish rural populations tend to experience better health than their urban counterparts, to a higher degree than in other European nations (Scottish Government, 2012; OECD, 2008). The effect of these differences is largely unexplored within engagement literature and goes unaddressed, at least explicitly, in much engagement practice. This has implications for community engagement for several reasons. Firstly, most of the specifically rural community engagement literature has come out of developing nations and the field of community development (Rifkin et al, 2000). These engagement techniques are often geared towards overcoming *deficits* of education and training, for example many participatory rural appraisal techniques are aimed at using non-verbal communication, or at least non-written, to overcome challenges of literacy. As spatial entities, Scottish rural communities, on the other hand, have the highest percentage of degree holders (Scottish Government, 2012) in the country. Therefore, it is clear that a considered approach is needed. Because of this, remote and rural Scotland has a number of vocal and educated retirees who are often politically savvy and connected, and able are to use media leverage to air service-related grievances. In other words, many Scottish rural residents have what Putnam (1995) would refer to as bridging social capital. An additional trend in Scottish remote and rural areas is the in-migration of older retirees who have 'bought into' (in some cases literally) the rural lifestyle. (Stockdale et al, 2000; Farmer et al, 2010) These incomers may in fact be *more* protective of traditional service arrangements because they perceive them to be part of the lifestyle that they have bought into. It is clear, therefore, that rural communities form complex social 'ecosystems' that must be appropriately addressed by community engagement initiatives. These characteristics are summarised in the table below:

Aspects of remote and rural engagement	
Dispersed populations	Distance from hospitals/secondary care
Poor infrastructure (physical and technical)	Larger percentages of older people
'Informal' health care services provided but not necessarily accounted for by data	Small, fragile health services
Pre-existing power relationships /parochialism	Intertwined services
Educated, well-off populations	More complex/chronic conditions
Challenging physical geography	Higher cost of service delivery
Lack of economies of scale	Health care practitioners linked with social capital in the community
Sensitive to discuss services as practitioners highly visible in community	Ageing population

Table 2: Aspects of remote and rural that may affect engagement

2.7 'Good' community engagement

Community engagement as a normative process

Literature in the field of community engagement has, up until the last ten years or so, tended to discuss engagement in normative terms, in other words, the literature has taken for granted that community engagement and, by extension, increased citizen involvement in decision making, is an inherently positive thing and therefore the *"potential for negative or iatrogenic impacts has received much less attention"* (Staniszewska, 1999). There has been an underlying assumption within the literature that *"if citizens become actively involved as participants in their democracy, the governance that emerges from this process will be more democratic and effective"* (Irvin and Stansbury, 2004). Other studies have found that community engagement in decision making has the potential to: generate improved support for decisions (Health Canada, 2000); create decisions that are more grounded in patient preference (McBride and

Korczak, 2007); to promote confidence in services, to create confidence in participants (Beetham et al, 2008); to encourage skill acquisition (Popay, 2006); and to improve cross-agency working and to create more accountability for service providers (Health Canada, 2000).

There are, however, a few voices of dissent within the literature that point out the potential dangers of community engagement. Indeed, there are a number of positive potential outcomes postulated within the literature although a review by Staniszewska (1999) found there to be limited evidence to this effect. As Shortall (2008: 452) points out:

“[w]hile participation is seen as an indication of social inclusion and social engagement, it is not the case that non-participation equates with social exclusion (Hayward et al, 2004). Nonparticipation can represent a valid and legitimate choice, and often one made from a position of power”

A recent review by Attree et al (2011) synthesised the data from existing studies that highlighted the effects of engagement on individuals. Their analysis found that overall the majority of participants in the surveyed studies *had* received some benefit in the form of better health and wellbeing, increased confidence, social relationships or personal empowerment. They also found evidence of negative consequences including disapproval, criticism, or bullying from fellow community members for taking part in decision making. In their 2009 paper, Porter and Shortall, put forward a case study of challenging engagement in order to *“counterbalance the almost universally sanguine literature concerning public involvement”* (271). Rowe and Frewer (2000) admit that there is potential for poorer decision making through deliberative engagement, and that through engagement, people can actually be persuaded to make incorrect choices. Irvin and Stansbury (2004) argue out that, however effective community engagement techniques may be in theory, in practice they are not always successful or positive. Health care managers may control meetings to their own advantage, selectively implement the outcomes of the process, or may even *“manipulate public participation to ensure that it advances their own interests”* (Martin, 2008; Milewa et al, 1999; Tritter et al, 2003). Engagement can also be costly in terms of time and resources, it can be uncomfortable and messy, and participants on all sides may be unwilling to take part for fear of upsetting the status quo (Scottish Community Development Centre - undated). In addition, a (2011)

review of engagement process impact by Attree et al found that, while community engagement was often found to have a positive effect on participants in terms of empowerment and learning, it could also be deleterious in terms of causing participants stress and causing community conflict.

The goals of community engagement

Within the reviewed literature there are examples of a number of different conceptual frameworks for assessing the success of an engagement method or process. There is some overlap between these frameworks in the form of a number of indicators that are emphasised by more than one author, but it was noted by Draper et al (2010) that there is no one definitive set of standards for judging success in engagement. Each individual engagement initiative is likely to have a combination of indicators of success based on both the process and its outcomes.

According to Rifkin et al (2000) there are four interconnected perspectives on what constitutes a successful engagement process. The first is based on the belief that engagement has the potential to strengthen the perceived validity of democratic institutions (Creasy et al, 2007). Indicators related to this participative goal might include increased trust in institutions or increased participation and attendance at democratic events such as voter turnout or engagement events. The second perspective is focused on the belief that engagement has the potential to empower communities and positively affect social cohesion (Blake et al, 2008). This view of participation draws heavily on the concept of social capital, which, according to Shortall (2008)

“argues that dense networks of civic engagement produce a capacity for trust, reciprocity and co-operation (‘social capital’) which in turn leads to a healthy economy and a healthy democracy” (451).

Within Scotland, the Scottish Government commissioned the Scottish Community Development Centre, their national lead body for community development, to develop a set of national standards that highlight aspects of a successful community engagement exercise. These ten national guidelines, as illustrated in the box below, are a helpful place to start, but by no means constitute an exhaustive list of features that they define as characterising a ‘good’ community engagement process. These are summarised below:

1. The Involvement Standard: Identify and involve the people and organisations with an interest in the focus of the engagement.
2. The Support Standard: Identify and overcome any barriers to involvement.
3. The Planning Standard: Gather evidence of the needs and available resources and use this to agree the purpose, scope and timescale of the engagement and the actions to be taken.
4. The Methods Standard: Agree the use methods of engagement that are fit for purpose.
5. The Working Together Standard: Agree and use clear procedures to enable the participants to work with one another efficiently and effectively.
6. The Sharing Information Standard: Ensure necessary information is communicated between the participants.
7. The Working With Others Standard: Work effectively with others with an interest in the engagement.
8. The Improvement Standard: Develop actively the skills, knowledge and confidence of all the participants.
9. The Feedback Standard: Feedback the results of the engagement to the wider community and agencies affected.
10. The Monitoring and Evaluation Standard: Monitor and evaluate whether the engagement meets its purposes and the national standards for community engagement.

Although participation standards do encompass many of the characteristics raised within the literature, it is interesting to note that all ten standards refer to process related goals rather than outcome related goals. On the one hand this may be due to the fact that different engagement projects are likely to have different substantive outputs, however, it may also reflect the ambiguity present in most policy and guidance documents reviewed about the extent to which participant input should actually affect planning outputs.

Webler et al (2001), suggest five chief elements of a successful engagement process. Firstly, a successful engagement process both acquires and maintains “*popular legitimacy*” (435) that is, by using a democratic process, the participants consider the process and its outcomes to be legitimate. Secondly, the process should facilitate a discussion that makes explicit the ideological perspectives of all parties, that is, a healthy

debate is fostered. Thirdly the process should promote equality between the different stakeholders, in other words, the process should facilitate a shifting of power towards those who have less of it (traditionally this would be seen as a shift away from agencies and towards the community, although this will be discussed in more detail later). Finally, the process should have strong leadership to keep the process on track (Webler et al, 2001) Specific principles, therefore, that come out of Webler et al's analysis include empowerment, open deliberation, legitimacy and representation, and strong leadership.

Rowe and Frewer (2000) differentiate between two types of success criteria; acceptance criteria and process criteria. Acceptance criteria relate to the degree to which the process and its outcomes are acceptable to stakeholders. Process criteria relate to the specific features that lead to the success of a process (Rowe and Frewer, 2000) Acceptance criteria include the representativeness of participants, independence of the process (which is related to lack of bias), early involvement (before crisis arises), and transparency of process so stakeholders can all see how decisions are being made. Process criteria include resource accessibility (access to information, time, and materials needed to take part), clear task definition, a structured process for decision making, and cost effectiveness of the process. (Rowe and Frewer, 2000).

Rather than differentiating between acceptance or process criteria, Beierle (2000) prefers to consider engagement as a whole and identifies five social goals or principles that successful community engagement should incorporate. He believes that engagement should educate and inform the public, include public values into the decision making process, improve decision making quality, increase trust between participants, increase cost efficiency, and reduce conflict (Beierle, 2000:81). It could be argued that increasing cost efficiency is not a social goal in and of itself, however, it is possible that increased cost efficiency could contribute to the other social principles.

A pattern emerges from the discussion of 'best practice' that highlights several central principles including communication, equity, empowerment, quality decision making, and representativeness. It is this last concept, however, which requires further consideration as it appears to coalesce all four of the other concepts within itself. A key theme emerging from the literature is that legitimacy of process, or the degree to which stakeholders 'buy into' the decisions which are made as a result of community

engagement, is dependent on how 'representative' engagement participants are considered to be. In other words, a process is considered 'legitimate' if those who are 'engaged with' are accepted as being representative of the overall population who will be affected by the issue under consideration. The dangers associated with 'unrepresentative' engagement can include the unfair prioritization of some discourses over others (Martin, 2008a), and the potential to reinforce already unequal power relations, with elitist values gaining primacy over the values of traditionally marginalised groups (Hodge, 2005, Church et al, 2002).

There are two main challenges to 'representativeness' raised by the literature. Firstly, there is debate about what actually constitutes a representative sample population, that is, whether true representation is statistical (which, according to Contandriopolous [2004: 327] runs the risk of "*producing neutral opinions of dubious validity*") or political representativeness (which produces "*generally valid opinions with precarious neutrality*"). In short, should the engagement focus on who the participants are, demographically speaking, or the beliefs that they hold? If participants in engagement initiatives are left to self-select, there is the danger of engaging a homogenous group of "*acquiescent or financially better-off individuals*" (Martin, 2008a: 36, reinforcing conclusions by Church et al, 2002) which results in only a few voices dominating the discussion. This leads to an even more fundamental question about engagement; what is it that community members are there to do? If service users are being involved in engagement initiatives purely on the basis of their ordinariness (Martin, 2008; Bruni et al, 2008) or their 'lay knowledge' of accessing services, then random selection would be appropriate. As Martin (2008: 37)) points out, however:

"[t]here is no fundamental reason why the descriptive representation of shared characteristics, such as ethnicity or class, promised by random selection should translate into accurate representation on the level of expressed opinions."

The same, points out Bruni et al (2008: 16), can be said "*of the ability of a small number of clinicians or health care managers to represent the complexities of their constituencies' views, much less the views of the public*". Martin (2008) proposes a solution to this challenge; that a pre-engagement survey could be undertaken to first understand the views of particular individuals or groups, and then participants could be selected from this group. This solution, however, is not entirely satisfying when considering a small, discrete

population such as one found in a remote and rural area. In such a community, where mistrust between community members and NHS managers is high (Farmer et al, 2010) and engagement has traditionally occurred through the medium of town meetings at the local village hall, creating such a closed process may serve to only deepen any suspicion already present. Frankish et al (2002) describe representation based on opinion as 'experiential representation', a representation based on shared experiences rather than characteristics. Since, however, one of the goals for engagement identified earlier was that deliberative engagement processes should be transformative and give participants additional knowledge, it is not certain that attempting to find participants who were representative of particular opinions would remain representative in this sense once the process had begun. This focus on representativeness, Bruni et al argue, "*misframes the issue*". There is also a school of thought that inclusiveness may provide legitimacy of process (English et al, 1993), in other words the more participants in a community who are involved in a process "*the better chance that the outcomes will be accepted*" (Webler, 1999:63).

The debate around representativeness also contains an interesting presupposition, that is, that some viewpoints would or could contribute more to the engagement process than others (Collins and Evans, 2002). This leads back to the question of what it is that service users actually contribute to an engagement process. Most of the engagement literature does consider the value of service users contribution to be democratic, that is, they are there to represent the 'everyman', not to have specialist knowledge of the subject of the engagement. This is in contrast with the 'technocratic' contribution of the service managers or practitioners who take part in engagement (Martin, 2008a). This corresponds to earlier discussion of Healy's concept of the 'different languages' spoken by different stakeholders, one being 'fact-based' and the other experiential. Given, however, that many service users *do* have specialist knowledge, either from their own professional lives (Frankish et al, 2002), through their experience of living with a disease or caring for someone who does, or even simply through research of their own (Martin, 2008a), it may be overly simplistic to say that such a clear distinction exists. A number of papers (including Martin 2008a and 2008; Lambert and Rose. 1996) propose a more sophisticated understanding of service user contribution, that is, that service users have the unique capacity "*to bind knowledge of managerial or scientific practice with an*

experiential expertise" (Martin 2008a: 40), in other words, to be both democratically and technocratically representative. It would follow, then, that a process that fosters the educative aspects of community engagement would, by its very nature, create this kind of unique knowledge to contribute towards decision making. Based on the work of Martin (2008a, 2008), this thesis will contend that the combination of aggregated statistical knowledge and the contextual understanding, to create a new type of knowledge that can create improved decision making practices is something to be sought after in an engagement process, to "*gel...axiological concerns with scientific arguments*" (Martin 2008a: 38).

The following table contains a list of the 'best practice' principles as identified within the literature review:

'Best Practice' Principles of Community Engagement (process and outcome)	
Creates and maintains popular legitimacy	Access to Resources
Element of independence / unbiasedness	Cost effective
Strong Leadership	Informs participants
Structured decision making process	Clear, timely feedback
Early Involvement	Incorporates the National Standards for Community Engagement
Clear task definition/aims	Combines experiential and technical knowledge
Transparent Process	Promote equality between participants/empowers
Improves quality of decision making	Increases trust
Incorporates social goals	Fosters ideological debate

Table 3: 'Best practice' principles of engagement (process and outcome)

2.8 Engagement in practice

Engagement Methods

An engagement method, or participatory mechanism, is a technique or procedure that allows people potentially affected by a decision to be involved, consulted or informed about that decision, and ultimately to impact on that decision. Within the scope of the literature review, 63 separate methods for community engagement were identified, either through academic case studies, literature reviews, or engagement method toolkits. Other review articles, including Rowe and Frewer (2005), identify over 100 different methods. Identified methods range from established methods with roots in research such as focus groups (Lowndes et al, 1998), interviews (Scottish Community Development Centre, 2000), surveys (Fiorino, 1990), and questionnaires (Carr and Halvorsen, 2000), to methods from the field of community development such as participatory appraisal (New

Economics Foundation, 1999), Planning for Real (Democracy Network 1998), and participatory strategic planning (New Economics Foundation 1999). Methods with their roots in management include SMART Action Planning, marketing techniques, SWOT analyses, and the creation of community site management plans. There were also a number of methods that are traditionally associated with the political process including polling, the use of ombudsmen, and voting.

There are also a large number of methods that have been created in the last four decades that encourage deliberative interaction including Citizens Juries (Leneghan, 1999), ACE (Act Create Experience - New Economics Foundation, 1999), Community Dinners (Carr and Halvorson, 2001), TalkWorks (Dundee City Council, 2009) and the Delphi Process (Rosener, 1975; Goodman, 2006). There are undoubtedly more methods in existence, and it is highly possible that methods effective in practice have been used to good effect by practitioners but not necessarily reported in the literature. Engagement methods identified ranged from individual methods (such as interview), small group oriented (such as focus groups) or larger group methods (such as community conferences). The methods also ranged in terms of cost, outcome and level of engagement. Within the literature, case studies emerge as the most prominent form of investigation into community engagement methods (Rifkin et al, 2000, Brodie et al, 2009). There is, however, as Rifkin et al (2000) point out a difference between an engagement method and an engagement methodology. As previously mentioned, within the NHS, non-PPF engagement tends to be episodic rather than continual (Ellison, 2000) was borne out in the literature search. While numerous papers discussed individual methods, there were few that described them as part of a wider engagement process, and even fewer that dealt with longitudinal engagement processes.

Typologies

The sheer number of methods described in the literature can be overwhelming for researchers and practitioners alike, therefore it is surprising that there have been so few attempts to classify these methods (and create a more accessible typology for selecting contextually appropriate methods (Rowe and Frewer, 2005; Bayley and French, 2007). A few notable exceptions will be discussed here.

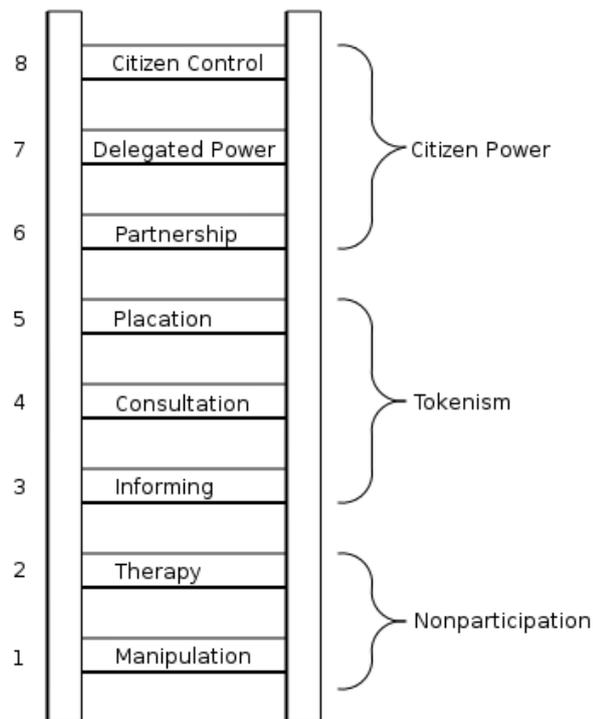


Figure 3: The Ladder of Citizen Participation (Arnstein 1969)

Arnstein’s ladder of citizen participation was an early attempt to classify methods according to the degree to which they allowed an organisation to cede decision making power to community groups (Arnstein, 1969). Arnstein proposed an eight category typology that classified engagement as part of a scale ranging from total ‘citizen control’ at the top end of the ladder, down to ‘manipulation’ at the bottom. This typology based on community empowerment has been highly influential on the way that community engagement has been conceptualised (Collins and Ison, 2006).

In fact, until recently, this strategy for the classification of methods was largely unchallenged (Tritter and McCallum, 2005.) A number of attempts have been made to remodel this basic typology (Wilcox, 1994; Burns et al, 1994; Choguill, 1996; Creighton, 2005), but, according to Tritter and McCallum (2005), classifying methods in this hierarchical manner may be overly simplistic because it assumes that the sole aim of engagement is to empower communities. It disregards other goals unrelated to power, and does not recognise that different methods and levels of engagement may be more appropriate for different purposes. Simply put, it disregards any value that the *process* might have, in favour of emphasising the shift in power that is the desired outcome

(Tritter and McCallum, 2005, Brodie et al, 2009). Arnstein's typology is also overly simplistic in its conceptualisation of power relations in community engagement (Tritter and McCallum, 2005) in that it assumes a dichotomy between powerful organisations and powerless citizens. Collins and Ison (2006) argue that

"[Arnstein's ladder's] enduring appeal lies in its ability to reveal, in pictorial form, the power agendas implicit in many institutionalised narratives and the differences in the forms and strategies of participation that are desired or result"(2).

In reality, however, power relations in community engagement can be far more complex (Reed, 1997). As we have seen from discussions about representation and legitimacy in the literature, power within community engagement is heavily intertwined with rhetoric and discourse. Within a community context, discourse can be used to inform community politics and vice versa. In several of his works, Foucault examines the relationship between discourse and power, looking the ways in which discourse can be used within existing power struggles. He states that *"discourse is not simply that which translates struggles or systems of domination, but is the thing for which and by which there is struggle, discourse is the power which is to be seized."* (Foucault, 1971) According to Martin (2008a), power can operate in participation processes to *"prioritise some discourses and marginalise others"* (36) This does not simply mean that service providers such as the NHS are able to marginalise some voices and promote others, indeed, the complex power relations present in small remote and rural communities can lead to power struggles *within* stakeholder groups, not just between them. Although Arnstein's ladder is somewhat unsophisticated in this light, it has become engrained within the practice of community engagement, and has led to numerous systems of classification based on power relations that are heavily cited within engagement for practice literature such as handbooks and toolkits, however newer versions incorporate the purpose of engagement as well as the degree of empowerment. White's (1996) typology of engagement is different (although also presenting power in terms of a graded scale) in that it considers not only the level of participation, but also the function and the goals for participation. A diagram outlining this typology can be found below:

Form What is the level of participation?	Top-Down: What's in it for the government or associated agencies?	Bottom-Up: What's in it for individuals and communities?	Function: What is the participation for?
Nominal	Legitimation	Inclusion	Display
Instrumental	Efficiency	Cost	Means
Representative	Sustainability	Leverage	Voice
Transformative	Empowerment	Empowerment	Means/End

Table 4: White's Typology of Community Engagement (1996)

In White's typology a nominal level of participation in the health field might be belonging to a patient experience group in which no actions are ever taken forward. In this case the patient participant may feel that they are part of a group and may receive feelings of inclusion from taking part, and the health service may be able to tick a box saying that engagement had been undertaken and therefore lend an air of legitimacy to their undertaking.

An instrumental level of participation is an activity in which cost savings are made, for example in the case of a co-production initiative in which citizens take over the running of a former government service. In this case the government engages because they are making cost savings, the participants take part because they want the service to continue (but at their own cost).

A representative level of participation involves partnership working between service providers and participants, for example in the case of joint decision making. In this instance, it benefits service providers to devolve some power in order to receive more appropriately tailored, sustainable services. Participants receive decision making leverage, and obtain a voice in decision making.

The final level in White's typology is Transformative engagement. White describes this level an empowering and continuous process in which both service providers and participants are able to work together to significantly transform their circumstances and take joint action.

As Brodie et al (2009:19) point out, White's typology is a useful departure from the standard Arnsteinian sliding scale of engagement typology because it *"helps to identify where and under which circumstances different forms of participation can create either opportunities for participation or entrench and reproduce existing power relations."*

Several authors including Webler (1999), Nelkin and Pollak (1979), and Rosener (1975) have all identified a number of characteristics or attributes by which methods can be identified, however, they do not form a true typology, that is, they do not reduce the staggering number of engagement methods (and admittedly fewer methodologies) in existence down to a *“lesser number of classes, within which each mechanism shares certain key attributes, among which each varies”* (Rowe and Frewer, 2005.) Rowe and Frewer (2005) propose an alternative typology of methods that is based on the nature and flow of information that takes place in each method using a large number of variables to classify the methods. They also note that there are three important challenges in classifying methods that have not previously been highlighted within engagement literature. Firstly, there may be a *“functional equivalence”* of the terms used to describe engagement methods (Rowe and Frewer, 2005:256), that is, several methods may be very similar to one another in practice but given different names. Secondly, some of the methods listed within engagement literature as *methods* may not be individual methods in the strictest sense, but rather may be composite-processes made up of different techniques and tools. A public meeting, for example, may also include a question and answer session, the use of nominal group technique, and an informal opinion survey. Thirdly, Rowe and Frewer (2005) highlight the *“uncertain and contradictory nomenclature”* of engagement methods, that is, differing methods may have been described using the same term, causing confusion.

There are, therefore, several typologies of engagement methods to aid in the selection of individual methods, but it is not sufficient merely to identify one engagement method. Engagement is, according to Renn et al (1993), not an exercise but a process. They propose a three step procedure for public involvement in decision making based on formal decision analysis (Raiffa, 1970) but that was modified to include the multi-stakeholder element of group decision making. Since the basis of health care design is essentially deliberative decision making based on available options, this model was both appropriate and flexible enough to take into account a remote and rural context, and formed the basis of the RSF Project’s Action Research framework. Renn et al’s (1993) conceptual model for participatory decision making is essentially as follows:

1. Decide on the issue and criteria at hand.

2. Identify the different potential options

3. Weigh the impacts of the potential models and make a decision.

However, Renn et al (1993) do call for the decision to be made (in the third step) by a selection of randomly selected citizens, which, as previously mentioned, would not necessarily be feasible or appropriate in a remote and rural service context where there is such a small pool of citizens to select from in the first instance. Whilst this is a significant drawback for this model in a remote and rural circumstance, the three step decision making process does, if appropriate methods are selected, manage to combine professional/technical expertise, social interests, and public values to create a simple but flexible deliberative process which could be adapted by altering the third step to accommodate a different final decision making method.

2.9 Conclusion

One of the aims of this chapter was to review the existing literature on community engagement in order to better understand the background, principles and aims associated with engagement, and to identify its roots as a movement. The literature review identified a number of traditions underpinning current engagement including community development, community empowerment, civic participation (or participatory democracy), Action Research, and the neoliberal politics of decentralisation.

Another aim of this chapter was to discover what, if anything, makes remote and rural Scottish communities different as a context for engagement in health service design. A number of contextual factors, including those based on demographics, culture, geography, governance, history, health care service delivery, and the current policy landscape were identified as having the potential to impact on engagement for health care design, although these factors were rarely used within the reviewed literature to form context specific guidance. According to Abelson et al (2007)

“Despite a long history of experimentation, we still know very little about what does and does not work when it comes to designing public involvement processes; what impacts these processes have on public participants, decision makers and

decision making or how these processes are shaped and constructed by the different contexts within which they are implemented” (2116).

This study aims to address this gap by considering in more detail the contextual factors of remote and rural healthcare engagement in Scotland and how they may shape the engagement process and its outcomes.

This chapter also aimed to consider which elements constitute a ‘good’ engagement process, according to the evidence base, and, based on a review of the literature, a database of both process-based and outcome-based ‘best practice’ features were identified. This chapter also aimed to establish key challenges and operational issues around remote and rural engagement for health care decision making and, in addition to those contextual factors identified, the chapter also considered the challenge of representativeness and legitimacy.

Chapter 3: Engagement Methodology

3.1 Introduction

Chapter Two explored the history, theory and political context of remote and rural community engagement in Scotland. This chapter will go on to describe the RSF Project, a two year Action Research project that iteratively tested an engagement process within four remote and rural Highland communities for the purpose of anticipatory health care design. This chapter will describe how this process was conceived, carried out, refined and evaluated using an iterative Action Research framework. The purpose of this process was to establish a way of working *with* remote and rural Scottish communities in an anticipatory way (i.e. pre-crisis), with the aim of considering future primary health care service provision options that have the potential to be put in place in the future, when change occurs (often linked to the retiral or moving of a key health care practitioner).

Within the wider context of the thesis, this chapter will consider what engaging with a remote and rural community for health care design looks like *in practice*. This chapter will describe an engagement methodology that was adapted for use in each of the four communities involved in the study, the evaluation framework that was used to both evaluate and adapt the process, as well as a new engagement method that was created for use within the process.

The aim of the RSF Project was to create and test an adaptable engagement model that would be adaptable for use in each of the communities, allowing the creation of an engagement plan that could be modified to suit each community and their needs. The resulting community-specific plans could then allow the community and service providers to meet their goals around future primary care staffing, keeping in mind that these goals may not always be the same but that both were likely to feature safe, sustainable staffing models. Residents in each of the four communities described in this chapter had experienced different historical staffing models, and had diverse experiences of engaging with NHS management, as well as distinct visions about where their community might go in the future and how health care configurations may contribute to that vision. For the purposes of formal ethical approval, the RSF study was considered by both the University and NHS Highland as falling within the category of service evaluation and development, meaning that no further ethical approval was sought.

In terms of novel contributions made by the process described in this chapter, it is primarily to test the efficacy of particular approaches and methods within a remote and rural Scottish health care context including a better understanding of the 'real life' complexities of engaging with these communities, as well as to develop an appropriate basic and flexible engagement model that could be used and adapted by other remote and rural Scottish communities – or indeed potentially in other healthcare contexts, locally or internationally (including a novel budgetary planning method created specifically for the context). Finally, this chapter will contribute a practice-informed set of recommendations for future engagement in remote and rural health care design.

This chapter will define the approach taken to carrying out and evaluating the engagement methodology, namely an ethnographic Action Research approach. It will go on to describe how the four remote and rural community sites were selected and how engagement participants were recruited. It will also outline the timeline for the research, the engagement strategy used, and the individual methods selected. Finally, the chapter will conclude by considering the evaluation of data collection methods and strategy selected to both refine and evaluate the engagement process as a whole.

3.2 Ethnographic Action Research

As previously stated, one of the aims of this research study was to test a prototype engagement methodology within the remote and rural context and to reach some conclusions around what best practice for engagement in such areas could look like. In order to test this methodology, but also to remain aware of the contextual factors that may be influencing its success, an ethnographic approach was taken. An ethnographic approach is one in which “the researcher studies an intact cultural group in a natural setting over a prolonged period of time by collecting, primarily, observational data” (Creswell, 2003: 14). In other words, it is a context-based process of research that is adaptable to its setting (LeCompte and Schensul, 1999) and allows the researcher to observe a specific local problem or issue in a more holistic, situated manner, to try to understand the complexity of influencing factors. An ethnographic approach, therefore, can be useful in order to immerse oneself in the context, but also to ensure that the methodology was *adapted* to the context, an Action Research framework was employed.

Action Research, a concept drawn from social psychology and defined by Lewin in 1946, has become a common framework for carrying out ethnographic research within a particular setting, with a view to addressing some pre-existing problem or challenge, usually employing a series of iterative loops of diagnosing, planning, taking action, and evaluating, to gradually create a contextually appropriate solution (Lewin, 1946). The emphasis of Action Research, therefore, is not on testing a particular research hypothesis in a sterile environment, but rather on creating practical solutions for real world problems using rigorous, high quality academic research techniques. Action Research is also an approach that promotes involvement in research by those within the context who might benefit from the results of that research. (Greenwood and Levin, 1998) According to Anderson and Herr (1999), change is a central component to Action Research, and change that results in empowerment of the participants is often one of the key goals for the Action Researcher. In this sense, philosophically Action Research aligns with community engagement in terms of its goals of participation, empowerment and contextual problem solving. Indeed, community-based Action Research is becoming an increasingly popular choice of approach for researchers aiming to create contextually appropriate solutions to health care problems (Minkler and Wallerstein 2008, Israel et al 2005) and to address health disparities. This study employed a participatory Action Research framework within the confines of a research project, but also contends that it may be an appropriate framework for health care managers to use when engaging with communities outside of a research-oriented context. In other words, the iterative nature of Action Research may be a neat fit for participatory planning within remote and rural communities in order to adapt engagement approaches to the particular community context. In summary, Hart and Bond (1995) as summarised in Rifkin et al (2000) consider the key points of Action Research to be that it:

- is educative;
- deals with individuals as members of social groups
- is problem-focused, context-specific and future-oriented;
- involves a change intervention (has a specific intervention to seek an identified change);
- aims at improvement and involvement;
- involves a cyclical process in which research, action and evaluation are

- interlinked; and
- is founded on a research relationship in which those involved are participants in
- the change process. (Rifkin et al, 2000)

In order to create a context appropriate solution, Action Research employs a series of iterative feedback loops in which the researcher plans, acts and reflects until a solution is reached (source). An example of an Action Research cycle (based on Lewin, 1946) can be seen below:

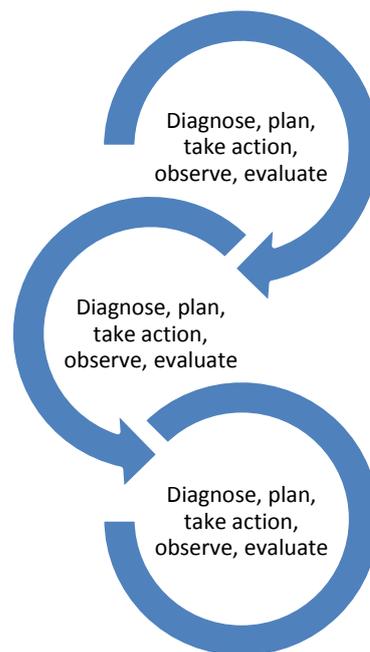


Figure 3.1: The Action Research Cycle

Since most methods employed within Action Research are richly qualitative in nature (Minkler and Wallerstein, 2008) there is also a heavy emphasis on triangulation of data (using multiple methods to limit the potential for bias inherent in the use of individual methods) or the use of multiple methods in order to minimize the potential drawbacks to using heavily contextual qualitative data, and to ensure that there is potential for the results of the research to be applicable to other contexts. (To ensure this, multiple methods of both engagement and evaluation were included in each stage of the engagement process in this study.) Action Research is also uniquely suited to “*bridging the relevance gap*”, that is, the gap that often exists between pure research and practice (Tranfield and Starkey, 1998). According to Tranfield and Starkey (1998) the relevance gap is one of the biggest issues facing researchers today: how can academics ensure that their

research is both contextually suitable and, indeed, still relevant to practitioners by the time it completes its lengthy journey from conception to publication? Action Research (or phase two research) provides a way to bridge this gap between researchers and practitioners that can help to create research that is both applicable and meaningfully situated within a wider theoretical landscape. (Tranfield and Starkey, 1998)

Another feature of Action Research as a methodology is that the researcher is not a detached observer, but rather an active participant in the events being studied. (Herr and Anderson, 2005) There are different degrees of involvement possible and therefore it is important for the researcher to establish his or her positionality with regards to the research as clearly as possible (Ozanne and Saatcioglu, 2008). A further exploration of positionality with specific regards to this research can be found in Chapters 4 and 5. Given, then, that Action Research is both heavily contextual and acknowledges the influence of the researcher over the research; it can be difficult to evaluate an ethnographic Action Research study using traditional measurements of quality such as validity. Rather than relying on positivistic conceptions of validity that focus on whether the correct variables are being measured, most naturalistic forms of research such as ethnography have attempted to measure quality by considering the 'trustworthiness' of research (Herr and Anderson, 2005; Campbell and Stanley, 1963). Herr and Anderson (2005) instead suggest that what is called for in the case of Action Research is a redefining of academic rigor (53). While naturalistic enquiry cannot control the research environment in order to isolate variables, there are still ways of ensuring that contextually based qualitative research such as Action Research is of a rigorous quality and employs the highest academic standards. As such, Herr and Anderson (2005) propose a typology of five forms of validity that can be applied to Action Research. These forms of validity are outlined below.

Type of Validity	Question of quality addressed
Outcome validity	Has the original problem been resolved?
Process validity	Were the methods appropriate to the purpose of the study?
Dialogic validity	Has the research been verified using peer review?
Catalytic validity	Has the research instigated positive change?
Democratic validity	Was the research undertaken collaboratively, including the goals and views of different stakeholders?

Table 5: Herr and Anderson's validity criteria for Action Research

Firstly outcome validity focuses on the extent to which the original problem has been resolved; the extent to which participants have been “*moved towards successful action outcomes*” (55), however, this raises one of the key issues Action Research evaluation, for whom is the project successful and who judges the project to be successful or not? Outcome validity, according to Herr and Anderson (2005)

“Also acknowledges the fact that rigorous Action Research, rather than simply solving a problem, forces a new set of questions or problems. This on-going reframing of problems leads to the spiralling dynamic that characterizes the process of most Action Research over a sustained period of enquiry” (55).

Within the parameters of this study, it was important to acknowledge that outcome validity would likely differ according to the various stakeholders and their priorities and objectives. Therefore, the needs of the key stakeholder groups and what they were likely to consider as a successful outcome was something that had to be considered from the outset.

The second form of validity that Herr and Anderson (1995), (also Anderson and Herr, 1999) propose is process validity which focuses on how the research is undertaken, whether the methods were used appropriately, and whether the methodology, as a whole, was sound. To this end, triangulation (that is, using a range of methods within the

overall methodology to create a more complete 'picture' of the research) or the inclusion of multiple perspectives is emphasised. Thirdly, there is dialogic validity. Dialogic validity is achieved when the research undergoes critical peer review. This could take the form of standard academic peer review processes, or it could involve the project or its writings being reviewed by stakeholders in the research project or colleagues. The fourth type of validity as espoused by Herr and Anderson (2005, also Anderson and Herr, 1999) is Catalytic Validity. Catalytic validity is the degree to which the very research process itself causes participants, including the researchers, to reorient their own views of the situation and to in some way instigate positive change. This form of validity interrogates the "*transformative potential*" (57) of Action Research, not only in terms of the initial problem, but also in terms of the educative potential of such an iterative process.

The fifth type of validity proposed is democratic validity. This is the degree to which research is undertaken collaboratively, the degree to which stakeholders' perspectives and interests are taken into account within the process of Action Research. This form of validity speaks to the research's contextual appropriateness, but also to the extent to which inclusion of multiple voices supports the concepts of ethical and social justice (56).

By applying this spectrum of validity to the Action Research project, it is the intention of this study to maintain academic rigor within a complex and intricate social context. In order to ensure that the study maintains validity in these forms, the criteria for validity were incorporated into both the formative and summative evaluation of the Action Research process (which will be discussed further in the section on evaluation) and, perhaps not coincidentally, these validity criteria dovetail with many the indicators of success for community engagement as identified in the previous chapter, both of which will be examined in more detail in the Evaluation section of this chapter.

3.3 Selection of Sites

The four remote and rural Highland communities that served as case study sites for this Action Research project were selected by NHS Highland (in their role as project partners and based on their intimate knowledge of the health care situation within each area) and were selected as being appropriate for the study for a variety of reasons. Firstly, the four communities were classified as both remote and rural using the Scottish Government's 6

fold Urban-Rural Classification (Scottish Government, 2007) and fell within the jurisdiction of NHS Highland (who, as project partners, had agreed to work in a meaningful and sustained way with the selected communities). Secondly, they were considered to be 'fragile' by NHS Highland, in other words, they were all communities that received their primary health care services from a very small team and if one member of that team were to leave, the service would be difficult to maintain. Additionally, three of the four communities were in the position that they would be experiencing change to their primary health care team within the next 2-4 years, in all three cases this is because a key health care provider in their community was nearing retirement age. One of the communities was different in that local service change had already occurred, which the community strongly objected to, and therefore the health board were interested in engaging with the community to see whether changes could be made that would make the community more satisfied with their service provision.

The final criterion for the selection of the case study was that the case study communities displayed different characteristics of rurality and remoteness in order to ensure that the final methodology would be applicable within a variety of rural and remote contexts. Given these criteria, NHS Highland suggested communities and these were agreed by the researchers. The characteristics of the four case study communities are outlined below:

A and B: Two remote and rural islands situated off the west coast of Scotland, accessible by ferry or weekly aeroplane flights.

C: One remote and rural coastal community in the Scottish Highlands, based on a peninsula accessible primarily by a single track road.

D: One remote and rural community situated on a difficult-to-access peninsula on the west coast of Scotland.

Although these communities all fall within the catchment area for NHS Highland, they also fall into two separate CHPs (Community Health Partnerships), thus local management responsibility was split between two NHS management teams. In addition, the communities also fall into two separate local authority areas, with two falling under the remit of Argyll and Bute Council, and the other two under Highland Council. The result of which was that, in addition to engaging with four separate communities, it was also

necessary to engage with two separate sets of wider, region-specific stakeholders which allowed the study to consider the potential impacts of different stakeholders on similar communities.

Community D was not NHS Highland’s original selection for the fourth community site, however, following an initial visit to the initially selected community it was clear that the project could not progress meaningfully at that time due to pre-existing circumstances. This will be discussed in more detail in Chapter Four. The inclusion of a fourth community was discussed at length by the Steering Group and it was eventually decided to approach Community D about their potential inclusion in the project. The enthusiasm of community members in the area for the project was a deciding factor in including Community D, although due to the initial timing setback, engagement in Community D was perforce later to start and fit within a shorter timescale than the other three communities. This is discussed in more detail in the section on Action Research timelines and actions. A map of the NHS Highland region is included below to illustrate the general area in which engagement was undertaken:

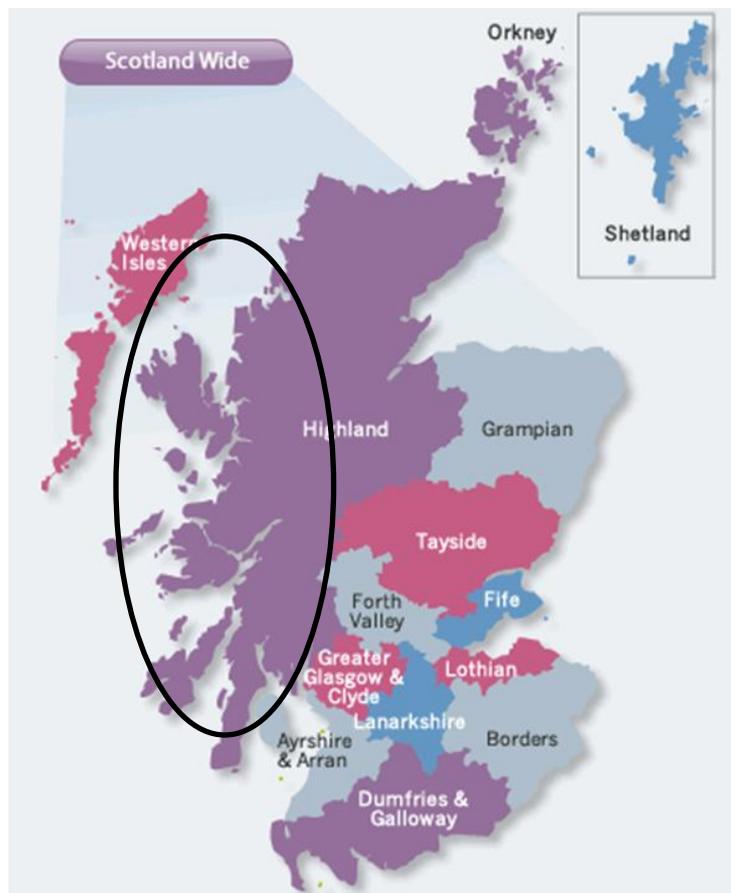


Figure 4: NHS Highland Health Board region (source: NHS Scotland). The four case study communities all fall within the region highlighted by the oval

The following table outlines some of the key characteristics of the four communities, which henceforth shall be identified as Community A, B, C, and D:

	Community A	Community B	Community C	Community D
Population Size in 2008/2009	206	126	483	150
% aged >=65	9.7	25.4	22.7	17.1
Approximate distance (time) from nearest District General Hospital by most common travel means	3 hours by ferry	2.5 hours by ferry	2.5 hours by car	2-2.5 hours by car
Distance to nearest GP practice	In situ	In situ	30-45 mins drive	50 mins drive
Staffing model at start of study	1 ft GP 2 pt nurses; one of these also does social care	1 ft GP 1 PT nurse Various pt carers	Access to GP surgery in neighbouring in addition to weekly local surgeries, peripatetic nursing service available	1 ft GP, nursing team with 2 locally based FT nurses, various carers
Top 5 issues local people attended their general practice (based on 2008/2009 QOF data)	Smoking related conditions Hypertension Obesity Depression Hypothyroidism	Smoking related conditions Obesity Hypertension Asthma Depression	Smoking related conditions Hypertension Obesity Depression Asthma	Smoking related conditions Hypertension Obesity Depression Hypothyroidism

NB. All data obtained from local GP practice, local authority website, or QOF website.

Table 6: Key characteristics of the four Highland case study communities (based on data available 2008/2009)

3.4 Selection of Participants

According to McNiff and Whitehead (2009), Action Research participants are those who will be “*directly involved in the research...the people whose learning you are trying to influence*” (61). In the case of this research study, the participants in the Action Research fell into a number of stakeholder groups including community participants as well as service managers and local service practitioners.

In order to recruit participants to the engagement process, a number of methods were used. As the four remote and rural communities were all unfamiliar to the researcher, initial contact with the community was made by contacting the local health care professionals, usually the local general practitioner or district nurse. The health care professional was usually contacted in the first instance by NHS Highland area managers to describe why they had been selected to take part and to initially ensure that the health care practitioner would be theoretically willing to take part in the engagement process (to whichever degree they were comfortable with). In the case of Community C however, no health care providers were based within the village so initial contact was made with the community council. Once initial contact had been made by the health board, further communication was established between the researcher and these first points of contact. The initial contacts then acted as conduits into the community by recommending further contacts in the form of organisations or individuals, and by placing posters advertising the project in key locations around the communities (such as village shops, community halls, churches, hotels/pubs and other community gathering spaces). Further contact with the local community councils was then made, often involving a formal presentation to the council during one of their regularly scheduled meetings, to present the project.

Following first contact, a snowball sampling method, also known as chain referral (Biernacki and Waldorf, 1981, Vogt, 1999) was used to contact further community members, where possible gaining introductions first from other community members to avoid 'cold calling'. Snowball sampling occurs when a researcher who is unfamiliar with their target populations contacts an initial random sample of participants and gains introductions to further participants from these first contacts, and the process is repeated until a large enough sample is reached. One of the drawbacks of snowball sampling is that it does not yield a representative sample (Biernacki and Waldorf, 1981; Atkinson and Flint, 2001; Kaplan et al, 1987) and that it can be influenced by gatekeeper bias (Groger, Mayberry and Straker, 1999), in other words those making the recommendations may specifically exclude certain potential participants from their referrals. These are valid concerns, however, according to Atkinson and Flint (2001), snowball sampling also provides a method for gaining access to otherwise closed communities and can be useful for 'outsiders' attempting to gain entrance and may help to foster the inclusion of some participants, particularly for the purposes of a qualitative study. In order to minimize

potential bias caused by snowball sampling, the method was only used as a form of initial contact with each community and was later supplemented with other forms of dissemination and advertising in order to inform and recruit further potential community participants.

Initial contact with community members was usually established via email and pursued with a telephone call (except in cases where email addresses were not available). Prior to the first community visit, contact was made with as many community members as possible in order to personally introduce the project and initiate word of mouth advertising. It was perforce a somewhat unsystematic and haphazard recruiting method and it is acknowledged that there may have been a better way to identify, approach and recruit participants, however, as was discussed in the previous chapter, the goal was not to obtain a *representative* sample of community participants, but rather to inform as many potential participants as possible about the project, and to provide options for different levels of engagement that would make the process widely accessible.

All group events such as community meetings were advertised using posters, local media such as websites and newsletters, and community mailing or email lists where available (most often via the local community council). Although effort was made to contact community members for interview if they had been identified as unlikely to attend meetings (due to medical conditions or otherwise), to a large extent participants in both interviews and group events were self-selecting, therefore effort was made to make all forms of engagement as inclusive as possible.

Identification of non-community stakeholders took place in the same manner as the identification of community participants. Prior to the start of the project, a basic stakeholder map was created based on the World Health Organisation's partnership pentagram of stakeholders in the health care sphere (Boelen, 2000). Members of the Steering Group who were involved in service provision to the areas in question were able to identify key service providers both locally and at a managerial level for each of the communities, however, there was an element of 'snowball' sampling to this identification process as well. Key organisations responsible for the delivery of services to the four communities were identified as NHS Highland, the local authorities (Argyll and Bute Council and the Highland Council), Scottish Ambulance Service, and the voluntary sector

(including local informal carers). In addition, groups such as the Scottish Health Council and the Scottish Government were also identified as key stakeholder groups who could inform the process and be informed by the results.

Prior to commencing community visits, meetings were held with as many key stakeholders as possible to ensure that they were on board with the engagement and would be willing to attend events and incorporate results into their future design plans. For most stakeholder organisations, engaging with communities around service redesign is a statutory requirement (Scottish Executive, 2004) and therefore all stakeholders contacted were amenable to taking part in the study to both discover more about local priorities for the case study communities, and to learn about how to improve their engagement practice. The involvement of NHS Highland as a project partner at this stage may well have conferred some legitimacy upon the project in the eyes of other stakeholder organisations. A diagram outlining key stakeholder groups can be seen below.

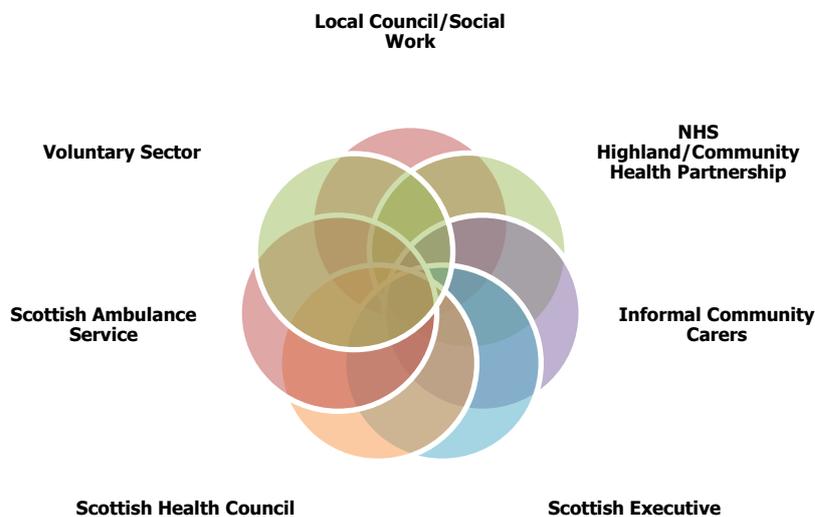


Figure 5: Stakeholder map for remote and rural healthcare engagement (based on WHO (2000) Partnership Pentagram)

Feedback from all stakeholders was used to iteratively refine the process and make decisions about how the engagement process should progress. The majority of early decisions regarding the engagement process were informed by the Steering Group and Service Providers, however the iterative improvements to the process as it progressed

were more heavily influenced by community feedback. The following diagram summarises the different stakeholders that influenced the decision-making process throughout the Action Research study.

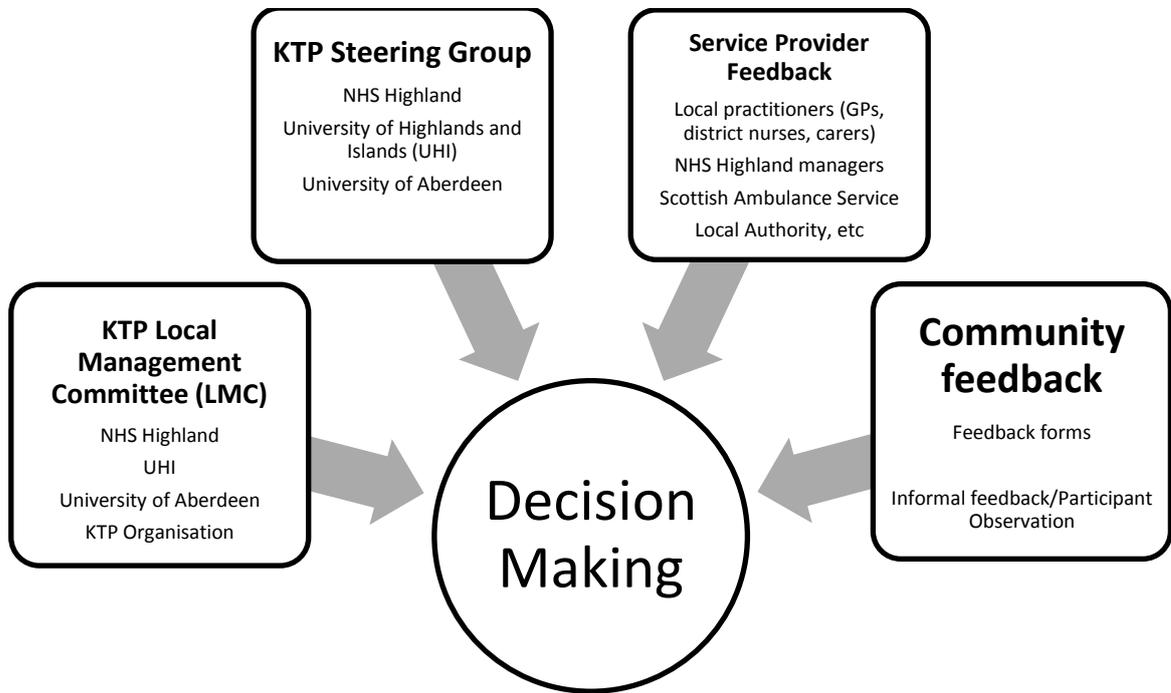


Figure 6: Stakeholder influence on decision making in the RSF project

3.5 The Action Research project – timeline and actions

As has been stated, the iterative nature of the Action Research process allows for continual refinement, leading to a contextually appropriate solution. Within this study, the feedback from each engagement event informed not only the next stage of event within the same community, but also the *same* stage in a *different* community. By necessity the events were staggered to allow the same researcher to facilitate them all, therefore stage one was carried out in Community A prior to the same stage being carried out in Community B, allowing for refinement of each stage, not just of the process as a whole. While some of the changes suggested by feedback were by nature specific to the particular community (for example timings or formats that would clash with other existing events), generally relevant feedback was applied project-wide in order to make the resulting process appropriate to a wider range of remote and rural settings.

For example, in the first session of Stage 4 in Community C, participants were overwhelmed with the amount of information provided in the form of hand-outs.

Although participants reported valuing the depth of information provided, they appeared more comfortable to receive this information from service providers themselves and to keep the amount of paper to a minimum. This was also reflected in the qualitative data obtained through the open questions on the feedback questionnaires in comments, with participants requesting less “form filling” and referring to the process as “overly complex”. Further iterations of the game were streamlined to contain less paper and more manager/community interaction.

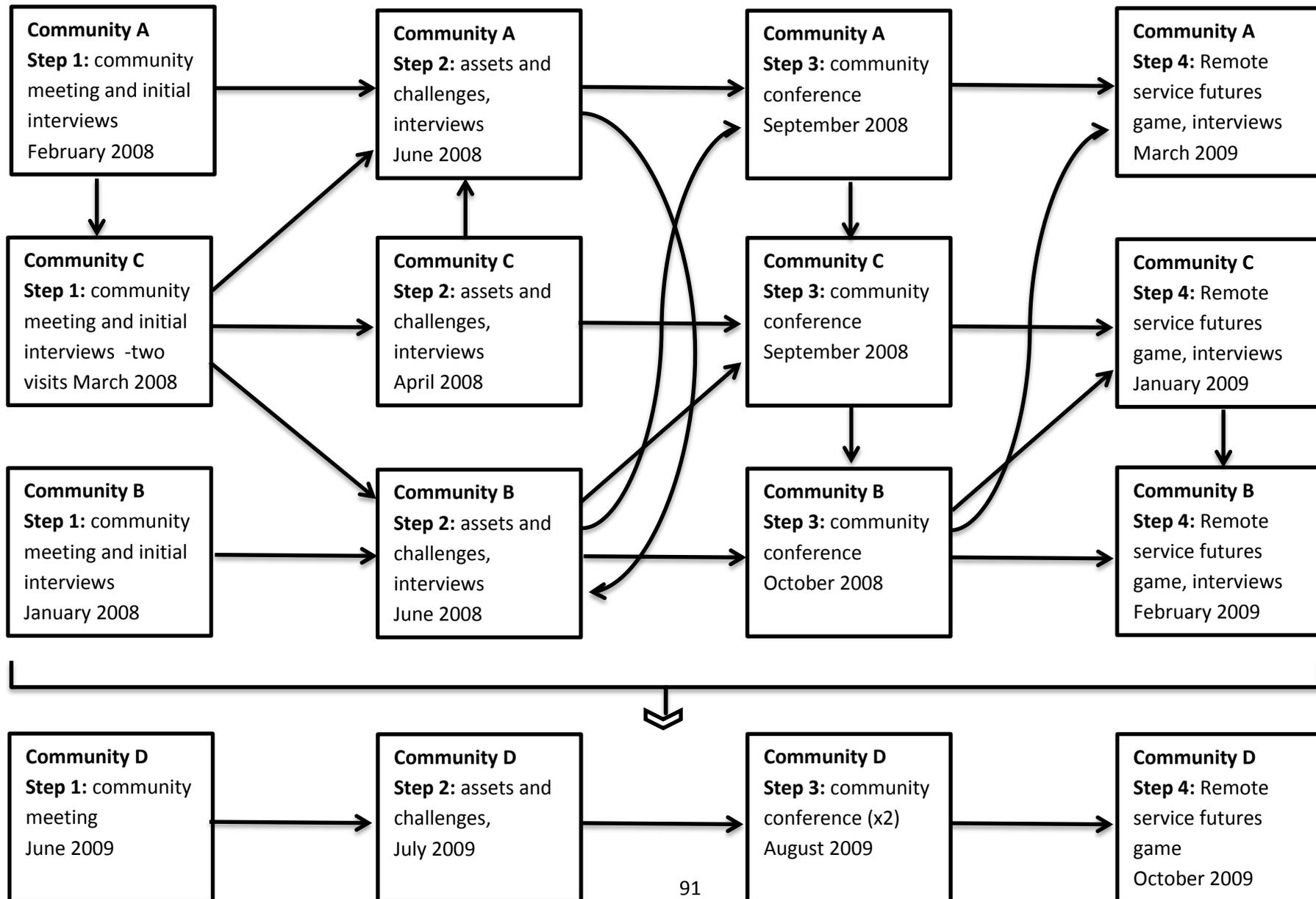
With regards to the overall process, all case study communities undertook all four stages, however these stages did not look identical in all four communities, nor did they necessarily happen within the same timescale. Due to the difficulties encountered in selecting the fourth community (which are explained in full in Chapter 4), the process did not commence in Community D until after the entire process had been completed in Communities A-C (please see figure 7 for accurate timescale). In order to implement the process within the remaining time, but also ensure it remained appropriate to the needs of the community, the following alterations to the basic framework occurred in Community D:

- A small core group of participants was formed using interested local community members including those who were part of existing community groups (including the community council) and local health care practitioners. This core group formed the basic engagement contingent throughout the process. All meetings were still public in that any local residents were welcome to attend (and posters were displayed locally to advertise all gatherings) however the events were not as aggressively advertised and no interviews were requested by community members.
- Community members in Community D were keen to capitalise on the opportunity to meet with local service providers and therefore stage 3 (meet your service providers, think about the future) was extended to two sessions rather than one.
- All stages took place over a three month period, rather than over the course of a year as was the case with Communities A-C.
- Costing information was not gathered for Community D as early on in the process it was determined by the community group that they had already decided how

they would like to use the engagement process (i.e. to formulate a job description for a new role) which would not require costing.

The totality of the Action Research project took place over the course of approximately 17 months (12 months in Communities A-C and 5 months in Community D). Each community visit lasted between 1 and 4 days, with the longer visits occurring in Communities A and B due to their distance and lack of transport options. Although visits to Communities C and D were often shorter (either a day visit or an overnight stay), they each received one additional visit due to their closer proximity to the University. In Community C, this took the form of an additional visit to undertake additional interviews, whereas in Community D it took the form of an additional community conference in stage 3 to accommodate all the service providers participants were interested in hearing from. The following diagram outlines the Action Research process, using indicating arrows to demonstrate the flow of iterative improvements between both the communities and stages.

Figure 7: Action Research diagram illustrating how feedback from each stage was used to inform others



3.6 Engagement Strategy

Based on the literature review described in the previous chapter, a number of best practice principles for engagement were considered. Although, as McTaggart (1991) points out, the reliance on guiding principles in an Action Research process runs the risk of being reductionist, overly prescriptive, and of distracting “*attention from authentic caring about the lives of people,*” (168) McTaggart also asserts that they can be “*an effective way of distilling knowledge accumulated in the practice of participatory Action Research*” and can “*perform an educative function*” about the way that previous practitioners have experienced success or failure. Therefore, in order to draw on this previous experience, but also to meet the specific goals of project stakeholders identified in early discussions and meetings, supplementary criteria were added to the creation of a subsequent engagement process that would allow the research to meet the KTP project objectives. Therefore, in addition to the ‘best practice’ criteria outlined in Chapter Two, in order to achieve the overall aims of the project, the research methods included were selected on the basis that they:

1. were relatively simple to carry out and required no real specialist skills that would not be held by the average health care manager (for example, those that required advanced statistical analysis would not be suitable).
2. would not be unduly time consuming, and
3. would be inexpensive to carry out.

These three criteria were necessary to ensure that the final methodology would be easily repeatable within an NHS Highland context. There was also a strong element of pragmatism attached to the selection of methods as they had to be achievable by practitioners with no previous experience of engaging communities, and they had to be selected quickly to fit in with the timescale of the project. It was therefore necessary to strike a balance between theory of best practice, contextual factors, and practical criteria for application.

As a basis for the Action Research, a basic engagement methodology framework was created, the aim of which was to provide a decision-making structure, but to remain adaptable enough to be used in a variety of remote and rural contexts. Based on the literature review, the RSF Project Steering Group favoured the Renn et al (1993) planning model of problem definition, option identification, and decision making. To reiterate the aims of the four stages (based on Renn et al's planning model) were as follows:

Step 1: This stage was supplemental to Renn et al's 3 stage planning model but was considered important as the researcher/facilitator was an outsider with no prior knowledge of the four communities. It was considered important at this stage to establish three aims:

1. To get to know more about the individual communities, through the use of secondary data, but also by spending time there and gathering contextual information to inform the remaining stages of Action Research.
2. To introduce the study to the communities and ensure that they were happy to take part and identify *their* goals for the research, and
3. To build relationships and trust with the communities so that the study could move forward positively.

Step 2: The main aim at this stage was to define the problem. In other words, to understand the context more fully and to understand exactly what kind of change was on the horizon for each community and what the impact of that could be. To do this, it was decided that it was important to explore the communities challenges but without neglecting the opportunities present within the context. This approach draws on the principles of asset-based community development in that it is focused on the assets present within a community as the starting point for considering future services (Cunningham and Mathie, 2002; Pan et al; 2005), but at the same time aims to not discount the legitimacy of community members' desire to air past grievances in order to more fully understand historical circumstances and relationships within the community. This would not be limited to a purely health care context because (as the previous chapter suggested) remote and rural services are interdependent and it was felt that it would be disingenuous to discuss the healthcare situation without understanding the

wider community context which could include infrastructure, social services, transport, population, etc.

Step 3: At this stage the aim was to understand the options available for each community. This meant finding out what the community would like, but also making the community aware of the ways that other communities were addressing similar issues, but mainly by looking at potential services and schemes that they themselves showed interest in in the previous stage. It was important at this stage to allow the community (along with their service providers) to examine potential schemes or services more closely to see if they would fit within their particular context. This stage is about showing, not 'selling' ideas.

Step 4 – At this stage, the aim was to facilitate the community and their service providers to make decisions about their future services based on all the information gathered in the previous stages. In addition, this decision making process should combine technocratic and democratic contributions and lead to a useable health care plan, as well as more highly informed participants.

Following a review of available methods as described in academic literature and available practitioner guidance (including engagement toolkits) the following methods were selected based on a mixture of practical necessity and adherence to the above criteria: for stage 1 a community meeting, for stage 2 a community workshop including SWOT analysis, for stage 3 a community conference and information road show, and for stage 4 a new, fit-for-purpose budgetary card game was created which was subsequently called the RSF Game. To supplement all four stages, and to ensure that the process was as inclusive as possible, individual interviews were made available at each stage for participants who were unable to attend or unwilling to participate during group engagement activities. In addition, a communications plan for each community included continuous email contact, notes and minutes from each event which were circulated to the communities for agreement, a project website with interactive comment board, as well as phone calls, posters and the use of local news releases to advertise events.

3.7 Engagement steps and methods

This section will describe the individual methods selected for each stage of the four stage engagement process in more detail, however, since this Action Research project was undertaken as part of a wider, joint project, this section will also aim to clarify the circumstances around methodological selection.

The engagement methodology carried out as part of the Action Research project is summarised in the diagram below. Each stage was assessed using a combination of participant observation and formative mixed method feedback questionnaires and this feedback was iteratively employed to refine that stage but also to inform the following stage and, if necessary, alter it to be more contextually appropriate (more on this in the Evaluation section of this chapter). In order to offer more engagement options to participants and ensure that the process was as open and inclusive as possible (including to those who were unable to leave their own homes), individual interviews were offered within each community. Each stage featured a group engagement event, individual interviews, and often informal discussions and observation within the local communities that occurred as part of the ethnographic Action Research process. These informal interactions are considered for the purposes of this project to fall under the auspices of participant observation and attempts were made to capture the substance of such discussions within the field notes. A further discussion of participant observation can be found in the Evaluation section of this chapter. The following diagram outlines the overall engagement process and is followed by a more detailed explanation of the individual methods in turn.

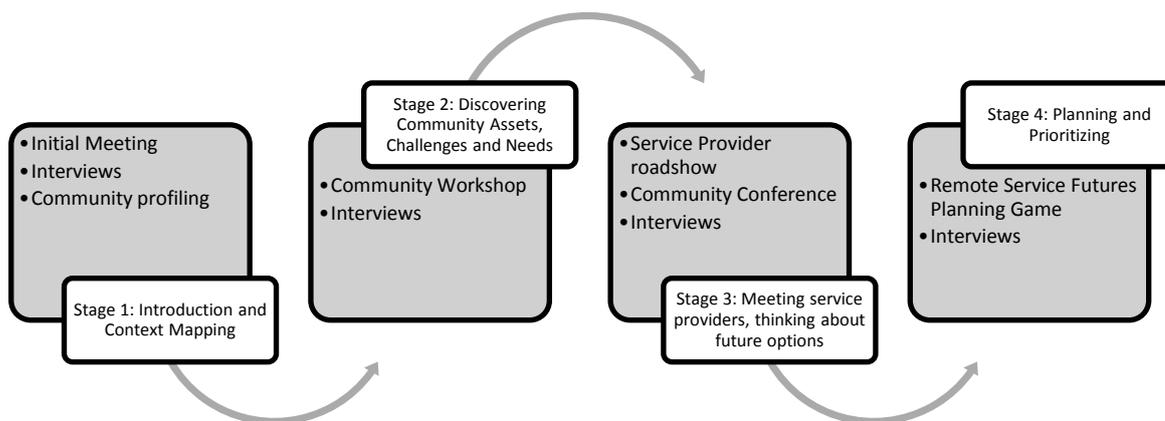


Figure 8: Action Research engagement methodology process diagram

3.8 Interviews

Interviews, as defined by Kahn and Cannell (1957), are purposeful discussions between two or more people, and are one of the most commonly used qualitative data collection techniques in the social sciences (Holstein and Gubrium, 2002). The benefits associated with using interviews as a research technique are numerous. They can allow for the collection of rich, contextual data on a particular topic, they can help to explore new topics and gain access to a level of participant knowledge that may be difficult to obtain from other, more public forms of information gathering. On the other hand, a number of data quality issues are also associated with interviews and must be addressed. One such challenge deals with the issue of ‘perception’, whether or not interviews “*give direct access to ‘experience’ or as actively constructed narratives*” (Holstein and Gubrium: 45). In other words, it is difficult to judge the extent to which the account given in an interview represents the actual feelings of the respondent on a particular topic. This is an important issue to consider, especially when discussing a potentially sensitive subject in a small community setting. To attempt to combat this issue, a large number of interviews were held which helped to create a wider overall ‘scope’ of opinion, although the issue of

capturing a 'representative' sample of public opinion remained challenging. This issue is further examined in Chapter 5.

Because the purpose of the interviews was exploratory, that is, to find out from community members in a non-prescriptive way what they thought about their local health care services, and allow them to contribute to the wider engagement process, an unstructured interview format was used. Unstructured interviews (also known as in-depth, non-directive informal interviews) are traditionally used to "*explore in depth a general idea...with no predetermined list of questions*" (Saunders et al, 2007: 312). They are also known as respondent interviews (Robson, 2002; Powney and Watts, 1987) because the interview is guided primarily through the perceptions of the interviewee. Using unstructured interviews can also be helpful in avoiding interviewer bias towards what are perceived to be the important issues. In total 39 interviews were carried out, either alone or with the assistance of another researcher who was present to provide support in the facilitation of group events.

In addition to the individual interviews, five group interviews were also held with community members and health care professionals. The group interviews were, like the individual interviews, unstructured, and they were often held on an ad hoc basis when, in the course of an individual interview, several other participants joined in. These events have been classified as group interviews rather than focus groups because, although there was often some interaction between participants around a particular topic, they never consisted of more than three participants, which, according to Krueger and Casey (2000) is one of the defining characteristics of the focus group as a method.

Individual and group interviews were carried out during all stages of the engagement process concurrently to the group events in order to accommodate as many as possible and also to capture any potentially changing views that occurred over the course of the research. It was important for the purposes of including all possible voices to be able to offer a more accessible and confidential alternative to the public meetings. When the research began, interviews were primarily used to ensure that people who were physically unable to attend the public events, for whatever reason, were not excluded. As the project progressed, however, interviews also proved to be a valuable way for

community members to express themselves who *were* technically able to attend events but simply did not feel comfortable expressing their opinions in front of their neighbours.

The range and number of interviews that were conducted allowed coverage of a wide variety of perspectives in each community. The unstructured nature of the interviews allowed participants to steer the interviews and, occasionally, led to some surprising information that would not necessarily have been obtained using a more prescriptive approach. Interviews were recorded only if participants consented, which was only in nine out of the 39 individual interviews. The majority of participants appeared uncomfortable with the idea of being recorded; possibly reflecting how sensitive a topic health care can be in small communities. In cases where the interviews were recorded, a written consent process was used, including an information sheet which was provided beforehand and written consent forms which were signed by both myself as the researcher and the participant. When interviews were not recorded, verbal consent was obtained from the participant and the researcher gave verbal reassurance that the information gathered would be kept confidential and any excerpts used would be anonymised. When interviewing without a recording device, an additional researcher was also present to take notes so that these notes could be compared during analysis to attempt to minimize translational bias. Interviews were later coded and analysed using an NVivo software package and a grounded theory approach in order to identify dominant themes. These themes were used to guide future iterations of the engagement process, as well as to feed back to managers about the needs and priorities of community members.

3.9 Stage One: Community Meetings

Within the surveyed literature, it was difficult to find a more anecdotally maligned form of community engagement than the 'traditional' public meeting or community meeting. Public meetings are, according to Mullen and Spurgeon (2000), "anachronistic": their time has passed. It is true that public meetings, as a method, have a number of drawbacks as identified in community engagement literature including the fact that they tend to provide a draw for particular demographics over others (Phillips, 1995) and are vulnerable to lobby groups (Edwards, 1995). As Campbell points out

“A citizen looking for opportunities to engage finds public meetings as one of the few known ways to become involved. Unfortunately, although this is the most commonly utilized strategy for public involvement, it is not the most effective way of including citizens or fostering civic engagement” (Campbell, 2005: 693).

However, within remote and rural communities, they are the traditional method of service provider engagement and, they are also one of the most straightforward ways to communicate information to a large group. According to the Scottish Health Council’s 2010 publication *The Participation Toolkit*, *“in some cases people may not feel that they have had their say on matters of importance to local communities unless a public meeting has been offered.”* (51) Therefore, the public meeting was selected as a method of introducing the research to the community in a public forum, and it provided a public medium, an ‘open space’ in which the community could ask questions about the research and discuss any concerns or issues in a familiar setting (most often the village hall). During this first visit to each community group and individual interviews were also carried out but, in order to maintain a level of openness about the process, it was vital to also provide a public means for the community to express concerns, research goals, or, indeed, communicate whether or not they were interested in taking part as a group. It was also considered important at this stage for the researchers (myself, along with another researcher from the Centre for Rural Health to provide co-facilitation during large group events) to stay overnight either before or after the meetings in order to obtain a more thorough contextual understanding of each community.

The inclusion of the public meeting as a method was also useful because it allowed for comparison between ‘traditional’ engagement methods and the other engagement methods used. It also provided a transition point for all stakeholder groups; moving from an event that was a comfortable and known (if not always helpful), to potentially more unfamiliar formats.

3.10 Stage Two: Community Workshop: Assets, Challenges and Needs

In order to establish the second stage of the adapted Renn et al (1993) decision making model, a workshop was held to establish the position of the community, that is, how did

the community feel about their current local health care services and what was likely to change about that service in the future? The content of the workshop was based around the business analysis concept of the SWOT analysis. A SWOT analysis is a form of analysis, used predominantly in business planning but which has also made its way into the community engagement and community development spheres, in which one analyses the strengths, weaknesses, opportunities and threats that a group faces in order to position more effectively for the future (Kotler and Keller, 2006). The SWOT analysis was chosen as the focus of this workshop in order to avoid a preoccupation with negative issues and to provide a balanced picture of the community's views. According to Minkler and Coombe (2005) SWOT analysis can be a powerful tool for communities to "*develop organising strategies*" (445) and map out their position with regards to specific issues. It was felt by project participants from the NHS that group engagement events often focus on the negative aspects of the community, in a way that could be limiting health care managers' holistic understanding of the community and its services. The SWOT analysis, therefore, was simplified slightly, in order to provide a balanced view, and asked the community to consider what its challenges and its assets were. The exercise was performed as a traditional SWOT analysis related to the local communities and their health, however, the term 'challenges' was used to encompass weaknesses and threats, and the term 'assets' was used to encompass strengths and opportunities.

Each workshop was held in the evening (in each of the four communities) and took place in a public area, most often the village hall. The space in the hall was arranged into an open ended circle with three large flip charts at the open end. One flip chart was to record community 'assets' which was explained as strengths and opportunities present in the community. The second flipchart was to record community 'challenges' which was explained to include potential weaknesses and threats facing the community. The third flipchart was to record any concerns that were immediately actionable, for example if the group wanted data on a particular topic, or find contact details for a particular service provider, or had a minor concern that could easily be dealt with. This was in order to allow the group to focus on the future without feeling that there were no immediate benefits to be derived from the process. The workshop facilitator (myself) acted primarily as scribe during this process, only providing prompts if the discussion became overly focussed in one area. The workshop was, therefore, driven predominantly by participants.

Following the workshops, the flip chart notes were typed up into a short document which was circulated to all stakeholder groups for feedback and comment, to ensure that all the concerns or feelings of the community had been represented.

During this stage, community members were also asked if there were any services, schemes or new technologies that they would like to learn more about with a view to potentially enhancing or augmenting their current healthcare service. These suggestions were taken forward to the next step and informed the guests who were invited to present at the stage 3 Community Conference.

3.11 Stage Three: Community Conference

Meet the Service Providers, Think about the Future: Community Conference

The community conference is a method taken from the Communities Scotland Community Engagement Toolkit (2000). The purpose of such an event is to inform local people about particular topics and receive feedback about them. It takes the form of a group event characterised by a series of presentations followed by debate and general discussion around the topic presented on. This seemed an appropriate method to introduce communities to a range of different potential services, to let them know what other communities with similar concerns are doing, as well as to assist them in getting to know their service providers and service provider managers who, more often than not were based outside of the community. Presentations at these events were based on topics that were either directly requested by the community or topics that could address specific challenges that the community had expressed in Stage 2: the assets, challenges and needs workshop. The aim of this conference was to learn about potential future services and to discuss, in an open way, whether they would be appropriate or desirable in the local context. The four community conferences were each held in the evening, with wine and cheese served as refreshments (a suggestion from several community members at the previous stage which proved popular!) to encourage mingling and discussion between the different stakeholders. Examples of presentations given in the different communities include:

- NHS general managers, nursing and midwifery managers: usually including discussion of community health nurse roles.
- Local authority social services managers and providers; for example about generic health and social care workers and telecare.
- Scottish Ambulance Service talking about emergency services provision, community first responders and the Heart Start Programme.
- Representatives of the voluntary sector talking about volunteer and community transport schemes, good neighbour schemes, timebanking.
- Staff from Scottish Centre for Telehealth talking about telehealth and telecare initiatives.

It should be noted that this event was not about service providers or other organisations *selling* different ideas to the community, rather, it was about informing community members (and indeed other stakeholders) about existing options and new practices, and generating a debate about how things *could potentially* work in the future.

Information Road-show

The information road-show (Scottish Executive, 2001a) was held in conjunction with stage three or stage four of the process, according to when it was possible to get the most service provider representatives to attend. The road-show is a method that is also known in the Building Strong Foundations Toolkit as the Open House/Exhibition. According to communityplanning.net, the road-show/open house/exhibition is “*less structured than a workshop and more informal than a traditional exhibition*” and is an ideal format for presenting information in such a way that facilitators are present to “deal with queries and engage in informal debate” (communityplanning.net/methods/open_house_event.php).

The format of the road-show was as follows: in each community, a central space was selected (usually a community hall) and for around 4-6 hours, booths were erected in the space giving information about different health care services available to the community. People manning the booths included local NHS Highland managers, Out of Hours managers, Scottish Ambulance Service staff, representatives of NHS24, and representatives from other local organisations. The road-show also provided an

opportunity to present the detailed data obtained during the initial community data mapping stage. In this way, community members were able to attend and ask detailed questions about their services and receive answers from representatives from a variety of agencies. This was also an opportunity for an informal chat ‘over a cup of tea’ with service provider managers or myself as the project researcher. Information in these booths was presented mainly in the form of posters which were also made available at the subsequent meeting. A summarised version of the community mapping data was also made available to any individuals who requested it, for example those who were unable or unwilling to attend group events. The image below illustrates the study’s booth detailing the information obtained through community mapping in Community C.



Figure 9: Displaying information at the road-show in Community C

At these events seating was available for community members who chose to stay for a longer conversation, however it was also possible for community members to come and observe the boards without interacting with service providers or myself if that was their wish. Refreshments in the form of coffee, tea and biscuits were also provided, along with seating, to encourage a relaxed atmosphere and sustained conversation.

3.12 Stage Four: Remote Service Futures Card Game: design and implementation

As previously mentioned the Knowledge Transfer Partnership project, on which this engagement was based, made use of a steering group to guide the project. From the start of the study, this steering group was also keen on the creation of a new fit-for-purpose method to be created as part of the methodology. Although this was not explicitly part of

the remit of the project, the steering group consisted of members who had undertaken significant remote and rural community engagement for healthcare planning in the past and felt that there was a need for something more suitable to this particular planning context. This experiential knowledge was confirmed by the literature review which failed to identify a contextually appropriate budgetary planning method. To address the final stage of engagement, that of prioritising and planning, it was necessary to find a deliberative engagement method that would be suitable within the context of the work that had gone before. From the systematic review of engagement methods from international literature, a number of deliberative methods were discovered including such events as citizen juries (Leneghan, 1999), discrete choice experiments (Ryan et al, 2008), planning for real (Democracy Network, 1998), and charettes (Sanhoff, 1999). Although these methods may well be appropriate within a planning context, ultimately, it was felt by the steering group that none of them appropriately addressed the unique issues involved in engaging remote and rural Scottish communities for service design which have already been discussed, nor did they address the key criteria of the knowledge transfer partnership project. Many of the deliberative methods found required a certain minimum number of participants which would be difficult to obtain in a rural area, had a relatively high cost to execute, or required a large amount of complex data analysis in order to interpret results. Most importantly, none of the reviewed methods appeared to effectively *combine* the viewpoints of all the different stakeholders, that is, to effectively overcome the ‘language barrier’ described by Healey (2009) in the previous chapter. Healey explains that one of the fundamental difficulties of engaging communities for service design is the tension between the way that health care professionals and community members see the service, how they prioritise and classify the services the community receives. As previously discussed, within traditional engagement processes the input of community members is often “*situated and experiential, rather than generic and abstract*” (Healey, 2009) and there is a danger of user opinions being dismissed by managers as “trivial” or “anecdotal”, not based on “facts” such as budgetary information, regulations and weighted needs analyses. In short as groups, community groups and NHS representatives often find themselves in the situation of speaking the equivalent of two different languages and the available methods did not appear to appropriately bridge the language gap.

The review of methods did uncover several of the engagement methods from the arena of physical community planning (such as charettes or planning for real) that were successfully able to combine local and external expertise for planning purposes, although the actual content of these methods was too rooted in the specifics of physical planning to be directly applicable for service design. As part of the review, one other method stood out, that included the use of simple cards for budgetary planning (Weymouth, 1998: personal correspondence). Although the game itself was not appropriate for use in the study (it was, again, based on physical planning rather than services and it was overly broad and simplistic for this purpose), the idea of a budgetary card game appeared to offer a simple way to illustrate trade-offs in a planning context.

It appeared therefore, following the method review, that there were aspects of the existing methods that could be applicable in the context of remote and rural Scottish health care planning, but not necessarily one existing method. It seemed more appropriate to isolate these aspects and combine them into a new fit-for-purpose method, rather than to try to shoehorn a less suitable method in to the methodology. This was also very much the attitude of the steering group and, although it was not specifically part of the remit of the Knowledge Transfer Partnership Project, there was a strong desire amongst the group that a new, contextually appropriate, method emerge from the study. It is fully acknowledged that using a new, previously untested method has both advantages and disadvantages. Of the disadvantages, it could be more difficult to argue that the findings from using the method were generalizable when it had not been used in other communities prior to this. On positive side, since the method was created and trialled iteratively *within* remote and rural communities, it could also be argued that this method had the potential to be uniquely fit for purpose, which directly informs one of the original research questions, specifically, which methods are most suitable for remote and rural Scotland.

In order to create something that would combine the best elements of the existing deliberative methods, as well as include the elements that appeared to be missing from these, it was essential to go through an iterative design process previous to trying the method in the communities. A list of necessary characteristics for the new method was drawn up based on the literature review, and this information was combined with initial

informal interviews with stakeholders who had previous experience of engagement in remote and rural areas in order to ensure that the aspects of the method would be appropriate to addressing specific contextual issues. It was decided that the final engagement method should:

- be relatively simple to carry out (not requiring too much explanation or paperwork)
- in some way make use of the engagement work that had gone before
- result in straightforward data that could potentially be directly implemented
- include real world elements of planning including making difficult trade-offs
- be as informed as possible about potential options
- combine, in a *meaningful* way, information that managers use to make decisions (such as needs profiles, budgetary information, and employment regulations such as the European Working Time Directive) with community priorities (as identified by the community themselves, based on their actual experience of using the service), thereby addressing Healey's 'language barrier'
- be flexible in its execution to accommodate different types/levels of users
- be flexible in its outputs, that different 'versions' of the method could be used for different results (from shared learning, to priority setting, to full cooperative planning)

Combining these elements, it was possible to produce a basic prototype engagement method, based on the simple card game format that attempted to incorporate the above elements. Whether this was done successfully or not will be addressed later in this chapter.

Trialling the New Method

This new method (which we will now call the RSF Game) was first iteratively tested using a sample population out-with the four communities involved in this research. A trial for the method was held at the Centre for Health Science in Inverness, using a group of participants invited from the University of the Highlands and Islands, the University of Aberdeen, and local health and social care organisations including NHS Highland, the Highland Council, the Scottish Health Council, and the Scottish Ambulance Service. This group deliberately included participants with no previous experience of health service

planning or community engagement, as well as those with experience in both fields. It also included people who were known to live in remote and rural communities.

Using a profile of a fictitious community (based loosely on data similar to that of the four case study communities), participants were split into teams and asked to use the tool to plan future services for the community, following a deliberative process. As the teams went through the exercise, the study researcher (myself) or a co-worker took detailed notes on their progress and any areas of the process that were proving challenging or unpopular. Once the exercise had been completed, the teams were brought back together to discuss their experiences and offer suggestions for improving the format. Notes were also made on this discussion. Following the discussion, the participants were given feedback questionnaires to fill out. This also provided the opportunity to trial the mixed method feedback questionnaire prior to its use in the community setting. Following the trial, all information gathered in the form of participant observation, data recording and the feedback questionnaires was used to iteratively refine the planning tool prior to its use in the first community (Nimegeer et al, 2011).

The Remote Service Futures Game

The resulting planning tool, the RSF Game, is carried out in the following way:

The exercise begins with a discussion about what the needs of the community are. As well as community members, service provider managers and local health care practitioners are also present (except in the case that this was deemed inappropriate by the individuals themselves). If enough people are present, participants are split into groups for the remainder of the exercise. Participants are encouraged to take into account all the information gathered throughout the entire process, including both quantitative activity and costing data and the results of the qualitative 'assets and needs' discussions held with the community. From this discussion a set of 5-10 of the 'most important community needs' is produced and agreed upon.

Based on this needs assessment, the groups are then asked to pick the top ten *skills* that were required in the community to address these needs, using a set of simple skill cards

(based on professional competencies from a range of health and social care practitioners who are currently available to work in remote and rural areas).

Community members are then asked to decide on the practitioner(s) whose *skill set* best matches the skill mix that they prioritized in the first part of the exercise. These practitioner cards are left deliberately anonymous (named Skill Set A, B, etc.) in order to minimize bias towards any particular type of practitioner (see Figure 10)). Cards were also included to represent voluntary services or telehealth options.

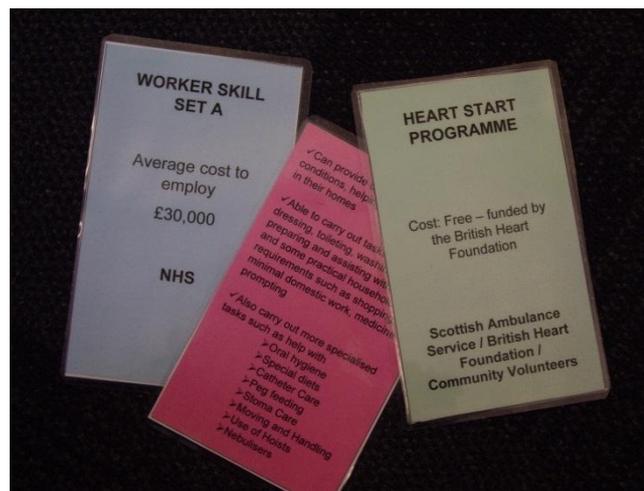


Figure 10: A sample of 'practitioner' cards from the Remote Service Futures Game

Then, based on the community's budget and current legal and employment restrictions, each group is invited to create a health care provision plan for their area that is both appropriate to needs and within budget. At this stage it must be ensured that service managers are available to each group to be able to inform in discussions about which plans would be safe, sustainable, and achievable under current employment laws and regulations.

At the end of the exercise, the community groups are brought back together as a larger group and invited to debate the advantages and drawbacks of each particular plan along with their health care managers and, if possible, reach a consensus. This is followed by a short 'action planning' discussion between all stakeholder groups about what should happen next, how the hypothetical 'designs' would or could be used, and who is responsible for which actions. It was also possible for communities to use the game in a

variety of other ways according to their needs by playing a shortened form and this was done by Community D, the results of which will be discussed later in this chapter.

When the game was carried out in the four case study communities, as with the 'Assets and Challenges' workshop, notes and results from this exercise were written up and sent out all stakeholders for comment and to use as a discussion point for future planning work.

3.13 Evaluating the methods

The concept of evaluation is key to Lewin's (1946) original definition of Action Research. Action Research, by its very iterative nature, calls for continual evaluation throughout the research process. In order to evaluate the individual methods, as well as the methodology as a whole, indicators for success were drawn from a number of sources. Using a summary list of success indicators from Boutillier et al (2001) as a starting point, additional indicators were added according to the criteria for validity and the aims of the RSF Project. A summary of these indicators can be seen in the diagram below:

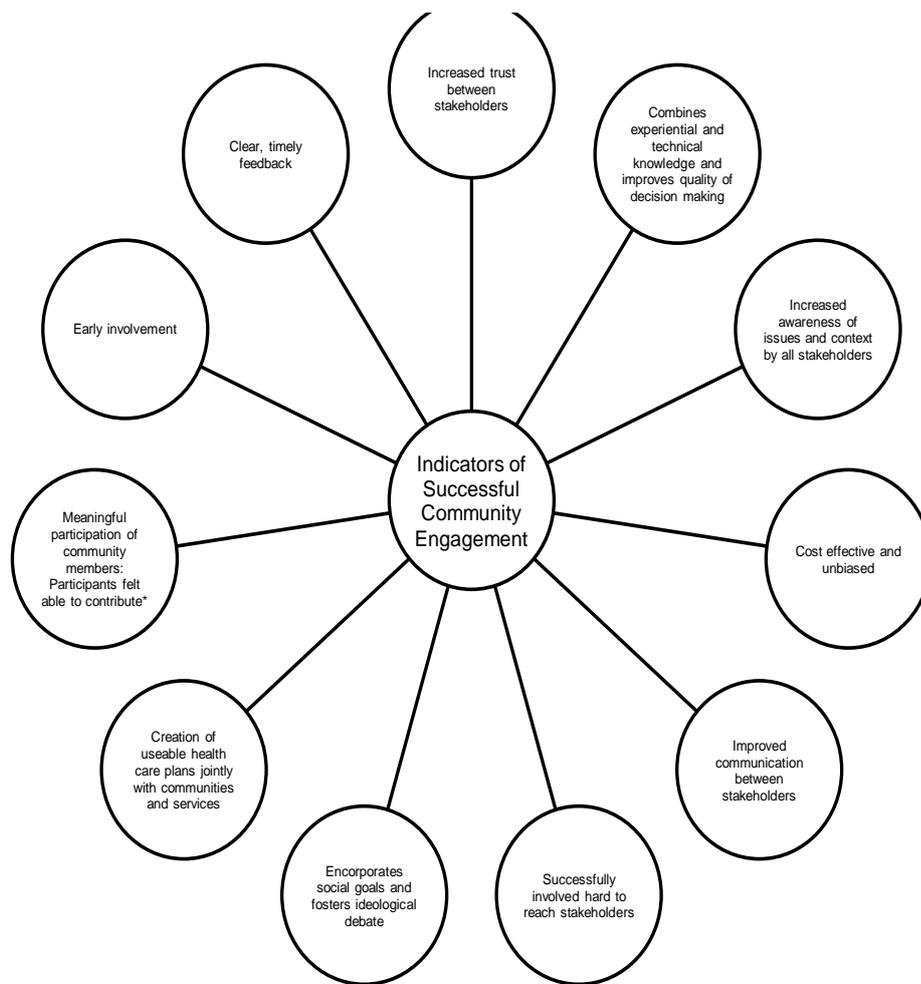


Figure 11: Summary of success indicators used, based on Boutillier et al (2001)

Having considered a number of evaluation frameworks, the Steering Group elected to use many of the indicators of successful community action campaigns as collated by Boutillier et al (2001) whose framework of indicators was compiled based on previous community engagement initiatives. It was felt that Boutillier’s indicators encompassed the majority of best practice principles from other comparable frameworks. Additional to these indicators are the principles that aligned with the RSF project’s aims and principles. In the following diagram, all those indicators marked with * are original indicators as listed in Boutillier et al (2001). Other indicators are derived from the project’s original aims and principles. It can be tempting for participants in an engagement initiative to view the process as successful only if their particular view has been adopted. Measuring the success of community engagement initiatives using only one or two specific outcomes as a yardstick of success has been referred to as *“using a ruler to measure a sphere”*

(Boutilier et al, 2001): insufficient to capture the complexity of goals and aims of all stakeholders. In order to effectively measure the success of the engagement activities, a multi-layered evaluation approach was taken for each engagement method that was used in the process, including feedback questionnaires completed at each stage, interviews, attendance, and participant observation that included informal participant/stakeholder feedback. Although this evaluation criteria considers the aims of the engagement methodology, in addition to this, as the methodology was delivered within an Action Research framework, it will also be evaluated according to the validity criteria outlined in this chapter. The methods for evaluation, participant observation and feedback questionnaires, are outlined in more detail below the following sections.

3.14 Participant Observation

Participant observation is the *“observation, recording, description, analysis and interpretation of people’s behaviour”* (Saunders et al, 2007: 282) that occurs during events that the researcher is participating in. According to Savenye and Robinson (1997) *“the hallmark of participant observation is interaction among researcher and participants”* (1177) and that these interactions allow the researcher to observe the subjects and *“verify perceptions and patterns.”* Participant observation, as a methodology, originated in the field of anthropology (Saunders et al, 2007) but has been widely appropriated by any and all social disciplines in which some level of ethnographic emersion occurs. Data is collected in the form of descriptive or narrative accounts of activities the researcher has participated in (in this case, the Action Research project described in Chapter 3) and these accounts are written up in the form of field notes. Data collected as part of participant observation can occur in three forms (Delbridge and Kirkpatrick, 1994): primary observation, in which notes are made of events or discussions that the researcher was present for; secondary observation, in which notes are made on what other participants relayed as having happened or been discussed; and, finally, experiential data, which is data relating to the researcher’s thoughts, feelings and understanding of what has happened. These three categories of data may not be neatly defined within field notes but all three will inevitably influence the researcher’s perception of events.

There were many opportunities for observation during the course of the research in the four communities, not only at the engagement events themselves, but also during the time that was spent within the community whilst carrying out interviews and in between events. Even trips to the community store or having a meal in the local pub provided opportunities to observe the dynamic and mood of the individual communities. Participant observation, as a form of data collection, was able to yield several different types of data, from such basic primary data as numbers of participants at events or whether participants arrived late or left early, secondary data based on discussions with community members or service providers, to more esoteric and complex experiential data such as an impression of how successful an event was, or what the 'mood' was during an interview. Participant observation also allowed for the notation of physical, non-verbal factors and cues such as what the surroundings were like during an event or any body language that participants displayed. It also allowed background, contextual data to be recorded that helped to 'flavour' the remainder of the research, as well as to help understand the success of particular elements of engagement.

Participant Observation Methodology

Data (primary, secondary and experiential) were recorded in the form of a series of short field notes to record observations and, although Saunders et al (2007) indicate that analysis is an important part of participant observation, it should be noted that this often happens concurrently to recording because, as researcher, observer and participant it is difficult not to attach some meaning to events using analytic reflection. Despite any personal attempts to record observations without editorialising, there is an obvious potential for bias in qualitative participant observation and therefore it was important to be as reflexive as possible. Field notes were used primarily to note down events or occurrences that appeared significant and therefore took the form of short notes rather than comprehensive diary accounts. These notes were occasionally written retroactively, after leaving the community and having had time to reflect, or else were recorded during the community visits.

3.15 Formative Feedback

Questionnaires

The feedback questionnaire was a simple anonymous form (see Appendix), consisting of eight questions which contained a mixture of closed and open questions. The purpose of the questionnaires was to feed into the evaluative framework and to address the basic questions of:

1. How useful did participants find the event?
2. What did they find most/least useful?
3. How easy did participants find it to contribute to the event?
4. If participants found it difficult to contribute, why?
5. To what extent did the event increase the participant's awareness of the issues discussed?
6. What would the participant like to see more or less of at the next event?

Results from the feedback questionnaire were collated and a very basic content analysis was conducted on qualitative responses using NVivo software to highlight key themes. Data from the questionnaires was used to iteratively improve the engagement events but was also presented back to the communities at the information road-show in order to give each community a sense of how other members of their community, as well as members of the other communities, had responded to the event in order to stimulate discussion about the overall process of engagement.

This chapter has outlined the engagement process that took place in the four remote and rural communities, including the approach, process, timeline and individual methods used. The following chapter will describe the results of this engagement process and discuss recommendations for future engagement practice.

Chapter 4: Engagement Findings

4.1 Introduction

The previous chapter described the methodology that formed the basis of an Action Research-based community engagement process in four remote and rural Scottish communities. This chapter will go on to outline the results of this engagement process, describing the participants, the findings and outcomes from each of the engagement stages, and general conclusions and recommendations for future engagement practice in remote and rural Scottish communities. This chapter will also consider the contextual application of the methodology and whether there are lessons in this pertaining to the reality of Scottish remote and rural engagement for health care design. The chapter will conclude with an evaluation of the methodology, make recommendations for future engagement practice, and conclude with a discussion of the challenges of engaging remote and rural communities.

4.2 Participants

Following the snowball sampling method (Biernacki and Waldorf, 1981) of participant selection as described in the previous section, 39 interviews were carried out across the four communities, nine of which were digitally recorded. As the interviews were unstructured and participant led, topics of discussion ranged from local services, local service providers, personal health concerns, and the community in general. These topics were not unexpected given the overall topic of local health care provision that was suggested to all participants. The qualitative data from the interviews (either in the form of recording transcripts or written interview notes) underwent basic thematic analysis using NVivo software, the results of which were either passed on to service managers where this was the wish of the interviewee and they did not wish their fellow community members to hear their views, or added to event minutes where appropriate and in cases where the interviewee wished to inform the wider community discussion but was unable to attend group events.

Participants in the interviews ranged from those who were physically unable to attend events due to other commitments such as shift-workers or parents with young children, those with debilitating social or physical condition, such as the housebound elderly, the

significantly obese, and those with agoraphobia, to those who were simply uncomfortable expressing their views in a public forum. Although no formal attempt was made to capture the ages or other demographic information of the participants, they appeared to vary in age from 20s/30s to approximately 80s and covered a range of occupations. Some respondents were active in their communities, others were not, some had recently moved to the area and others were long term residents. Due to the focus of this process on inclusion rather than representativeness (as outlined in the previous chapter), it was not considered vital to capture these characteristics in order to obtain a range of demographic differentiation.

Data on the participation at the various stages is addressed in the individual sections to follow. It should be noted, however, that attending numbers at each event were higher than is reflected in the feedback questionnaires as not all participants elected to complete the form at the end of the events.

4.3 Mapping outcomes

According to Hawtin and Percy-Smith (2007), providing communities with accurate profiling information is a vital step towards informed decision making. Early on in the Action Research process it was decided to begin gathering data about each community that could assist participants in that area in making informed decisions about which future services they would prioritise. The RSF Steering Group preferred that this process should commence immediately in case of delays in the course of information gathering. In addition, it was thought by the Steering Group that this information could prove an 'early deliverable' for the communities as previous visits to several of the case study communities prior to the start of the project had indicated that they were interested to know more, specifically, about their local health care budgets. The specific information required was discussed with both community members (to discover their informational priorities – in other words, what were community members interested in knowing more about?) and service managers (to ensure that the information given to communities would be comparable to that which would be used for service decision making). Initial data gathered on community morbidities was presented to the communities at the first,

introductory meeting to see if there was any other information that they would find helpful.

Information gathered as part of the profiling process included demographic information about the community (age distribution, indices of deprivation, common types of illness present in the community via the Quality Outcomes Framework or QOF) a profile of health and social care services community members receive, how often they access these services (including information on out of hours services, number of ambulance call outs) what these services cost (both in total and per head of population), as well as the overall budget for health and social care in the community. This was one of the few points at which quantitative data were gathered during the project and only secondary quantitative data were collected at this stage.

Direct information about service use and costing was obtained with requests to the relevant agencies (which included NHS Highland, Argyll and Bute Council, Highland Council and the Scottish Ambulance Service). Additional information required from NHS Highland was obtained from the ISD (NHS Scotland's information services division) website and additional information about community demographics was obtained from a combination of the ISD website, the Scottish Neighbourhood Statistics website and the Scottish Public Health Observatory website (Scotpho). Comparable data were also attained, where possible, for the whole of Scotland and/or the region of Scotland covered by NHS Highland's remit to give some context and comparison for health indicators and costs.

All information including detailed budgetary information was made available at the local community information road-show in which data was presented in the form of posters and graphs, and at which local health and social care managers (where possible) were also available to give context and additional information about the data for those who requested it. The information display was later made available again both in its full form (including posters and graphs) and in a summary handout as part of the RSF card game in stage four.

While information including costs pertaining to the two island communities were relatively easy to obtain, this was not the case with the mainland areas, at least partially because they were not discrete bounded regions. For Community (C) in particular, obtaining accurate costings proved to be, if not impossible, then particularly challenging. Due to the way in which data were collected within the particular Community Health Partnership (CHP), a profile for particular communities had to be derived from data pertaining to the *entire* service area (for example the entire council area or entire NHS CHP); because data were not stored, recorded or available at a local community (neighbourhood) level. It was found that there was no uniformity of data collection techniques (or indeed type of data collected) across the two CHPs and the health board and that, in one CHP, data were held at such a large area level that it was not possible to extrapolate area-specific data pertaining to any one community. This was particularly challenging as the community in question had made allegations of inequity with regards to service distribution across the local communities which was, essentially, impossible to prove or disprove by looking at the data. Ultimately, data were extrapolated on a per head of population basis from general, often Highland-wide figures which was not thought by any of the participants to be particularly accurate or representative of the actual spend. This affected the veracity of the resulting service recommendations from the community as their choices were unable to be based on accurate budgetary or service delivery information.

Another challenge with regard to having accurate data was the sensitivity of revealing salary information for remote and rural health care staff. In a community with only one GP, for example, revealing salary information would have been intrusive for individual practitioners. Additionally, in a remote and rural community with few high salaried jobs available, it was frequently the case that the local doctor may be drawing a salary much higher than anyone else in the community which could be uncomfortable for a practitioner who must carry on living within the community. There are, it seems, ethical considerations about the provision of such information since the provision of budgets was, in some cases, tantamount to revealing individual salaries, however as the information was available under the Freedom of Information act and had been specifically requested by community participants, it was decided to provide the information in as

sensitive a manner as possible. Members of NHS Highland management in one CHP in particular also appeared uncomfortable with providing budgetary information of *any* kind. Ultimately, the CHP in question provided very little specific or useable information. The lack of information was viewed with suspicion by local community members who had specifically requested such information and it made it challenging for community members to make an informed decision that would be implementable. The feeling amongst some community members was that information was being withheld deliberately. Participants in the two communities that did receive detailed costing and service information reported finding it useful and, occasionally, surprising (most participants, for example, severely underestimated the cost of an air ambulance call out to their community). It was found, perhaps not unexpectedly, that the detailed service delivery and costing information was essential in facilitating community members to make informed decisions resulting in useable health care plans. This supports earlier findings by Abelson et al (1995) that high quality, precise data is a cornerstone of informed participatory deliberation and planning with regards to health care.

The following table summarises the types of data that were gathered on behalf of the communities in this study, and where these data were obtained:

Table 7: Data gathered on behalf of communities

Data	Source
Population numbers	Electoral register, local GP practice
Health and social care services available in the community	Local managers, community, local practitioners
Cost of community health services (in general and per head) - including, where possible, distinction between staffing and non-staffing costs	www.isdscotland.org or local NHS managers
Cost of community health services per head average for Scotland	www.isdscotland.org
General Medical Services (GMS) budget (total and per head population)	Local NHS finance department
GMS budget per head average for Scotland	Local NHS finance department or www.isdscotland.org
Social Care budget (in general and per head)	Local Council
Social Care budget per head average for Scotland	Local Council or Scottish govt website
Number of out of hours call outs for community in the last year	Local GP Practice
Number of ambulance or air ambulance callouts in the last year (and cost of these)	Local Scottish Ambulance Service contact
QOF Data: Disease prevalences	www.gpcontract.co.uk
Demographic info, indices of deprivation, other area statistics	www.scotpho.org.uk www.sns.gov.uk

4.4 Stage One: The Community Meeting

The objectives of this stage (which was supplementary to Renn et al's (1993) three stage model) were to introduce the project to the communities, answer their questions, and to "get a feel" for the general contextual situation. In order to do this, an initial public community meeting was held. In all four communities, the first meeting had a good turnout relative to community population, although due to the lack of formal evaluation forms used at this stage, an estimate of actual attendance numbers must be made. Within Communities A and B, approximately 20-30 participants attended the meetings with slightly lower numbers attending in Communities C and D. This may initially have been due to suspicions about the motive of the study as it was discussed during the course of these meetings that previous incidences of outsiders coming in to talk about health care services had previously been a prelude to suggestions of cutting, replacing or changing services. There was a strong feeling at the beginning of the study from Communities A, B and C that the researchers were in some way 'agents' of NHS management, rather than the independent facilitators we stated that we were. In fact, all four communities demonstrated high levels of mistrust towards their local NHS Highland managers, who at this stage were not present. The meetings often began with the relation of a history of poor relationships with local NHS Highland management, as well as the local authority, and also often featured stories of previous community engagement that had been considered unsuccessful by the community. This echoes findings by Bruni et al (2008) that engagement participants who have taken part in previously unsuccessful engagement activities only to "*later find that their views have been ignored*" (16) are likely to exhibit anger and cynicism. As a facilitator, it has to be admitted that the community meetings often had a mildly hostile or accusatory tone, at least at the start which made them uncomfortable to facilitate. The exception to this was in Community D in which there was a smaller group of community participants including a number of local health care providers. It is possible that, as these practitioners (or the other members of the group) were very respected members of the local community, that the tacit approval of these practitioners lent the study a respectability that it lacked in other communities. On the other hand it may have indicated that participants were more inhibited in

expressing distrust due to the presence of these practitioners. Based on later interactions this did not appear to be the case.

At this stage it was clear that community members were unaware of the cost of the services they received, and unaware that there was a limited budget for their specific geographical area. A discussion around data gathering caused people to consider their individual cost to the service and there was discussion in all communities about making individual health decisions and how these can impact the community budget. These discussions often dealt with the morality of cost decisions, and whether it was right, for example, to disallow people with complex and deteriorating conditions from joining the community if it greatly reduced the budget for other residents. In this way, the profiling facilitated an ideological debate within the three communities that received information on their local budgets.

In addition to being information sharing events, these first community meetings gave participants a chance to state their position. The interviews and informal discussions held at this stage illustrated the complexity and breadth of opinion on the subject of rural community members' relationships with their services. Staying overnight in the community proved particularly helpful in gaining contextual understanding as it gave the researchers the experience of using the local infrastructure and services and a chance to speak to community members in an informal setting, often in the context where a health-related event had actually occurred.

At this stage members of all four communities reported a liking for the objective information fed back from the context mapping exercise and found it informative. Context mapping also provided an early 'deliverable'; something tangible that the community could take away from the anticipatory process. On the other hand, it proved difficult in Communities A, B, and C to 'sell' the idea of anticipatory planning. The sense of uncertainty that had driven many community members to attend this first meeting appeared to have been mainly assuaged during the course of the meeting, however, particularly in Community C where the current service was considered unsatisfactory; there was frustration that change would not necessarily be an imminent part of the process. At this stage, although the majority of community members appeared to accept the idea of the study and reacted positively during the meeting, some still expressed

distrust with their local NHS Highland manager, or with the more amorphous concept of 'the NHS' in general. These first meetings also proved useful in terms of tailoring both the content and the communication around future meetings to the needs of the individual community, for example locations and times for future meetings, and additional people who should be contacted individually to attend. This finding is very much in line with the Scottish Community Development Centre's recommendations for remote and rural engagement practice (Scottish Community Development Centre, undated) around recognising local cultures and traditions.

In a sense, the community meeting proved less anachronistic in the remote and rural context than had been anticipated, although this might not have been the case if it had been facilitated by a service manager rather than an impartial (or intentionally impartial) third party facilitator. The community meeting was successful in achieving the aim of introducing the project and was successful in germinating some ideological debate around the ethics of health care planning and budget allocation, but it also created an 'us vs. them' situation in which discussion was aimed *at* the facilitator, rather than occurring between participants. As the primary goal of this first meeting was to introduce the study to the community and obtain their consent to continue (insofar as that was possible), formal feedback questionnaires were not used, rather iterative improvements were made on the basis of participant observation and informal participant suggestion. Further research or evaluation at this stage was deemed to be inappropriate as there was a desire at this stage to retain a sense of normality and create a feeling of comfort with the project and researcher.

4.5 Stage Two: Assets and challenges: a SWOT-based community workshop

As was described in Chapter Three, the aim of the second stage of the core process was to identify local assets as well as challenges in each area by undergoing a health-themed SWOT analysis with local community members. This was to form the basis of the 'problem identification' stage of Renn et al's (1993) decision making model, but simultaneously maintaining a positive approach by drawing on asset-based community development.

This second meeting was generally not as well attended as the first meeting in Communities A-C (with around 4% of the population attending in each area), and in these communities attempts were made to increase interview numbers at this stage in order to combat lower participation at group events, primarily by contacting previous interview participants or attempting to recruit new ones using community contacts. Low participation was noted in the feedback questionnaires from Communities A-C as one of the biggest weaknesses of this stage. Since a core participant group had been formed within Community D, participation remained at relatively steady numbers throughout the Action Research process. Within this workshop, participants found that identifying assets and challenges to be an interesting exercise and particularly valued hearing the views of their fellow community members. Between the four communities there were a number of common issues raised that are summarised in the table below:

Table 8: Common community-related assets and challenges emerging from Stage 2

Common Assets	Common Challenges
Community spirit, people look out for each other	Fears for security in an emergency situation due to remoteness/ weather
Resourceful, adaptable community members	Older people have to leave community if their care needs become too great
Low crime, beautiful scenery, a safe place to raise children	Lack of affordable housing (which makes it difficult to attract new health and social care practitioners to the area)
More online and remote working has allowed working people to settle in the communities	Current practitioner about to retire, concern about finding someone to replace them
Personalised continuous care from local health and social care practitioners	Current practitioner provides services that are “above and beyond the call of duty”: fear that replacement will not provide a similar service if not contractually obliged
Local health care practitioners are social assets and provide preventative health care	For practitioners providing 24/7 service, concern that they might be getting insufficient support, issues of stress and isolation
Flexible, resourceful health care practitioners who think and act ‘out of the box’ when necessary	Poor access to patient transport to outpatient facilities in distant hospitals
Responsive air ambulance service connecting community to acute care in emergency	Confusion about current health services provision: who does what, who to call, when

The use of the SWOT format was useful in focussing meaningfully on key concerns of the community without the workshop being overwhelmingly negative which corresponds to the principles espoused by asset based community development (ABCD). ABCD is an approach to community development that attempts to move away from a focus on deficits in communities, on what is *missing* and instead concentrates on a community's assets. According to Pan et al (2005)

ABCD represents a fundamental shift from a traditional focus on assessing needs and deficits within communities to a focus on identifying and mobilizing local strengths or assets. The goal is to bring together the assets within a community and use them to solve problems and build a stronger community. (1185)

At this stage some of the principles of ABCD were adopted, but the process did not completely avoid discussion of problems or needs within the communities. In essence this stage functioned as a segue from the traditional community meetings, which have been characterised as unhelpfully negative (Scottish Health Council, 2012) towards the considering of options in Stage Three.

Participants also noted that they valued the format for its ability to clarify issues within the community, with one respondent reporting the most useful aspect of the event being that the facilitator "*listened to us and gauged quickly the important points.*" On the other hand, this event proved less satisfactory for community members who wanted action rather than discussion – as in the previous stage. One respondent felt that the "*urgent process [of service change] seems to be very slow in happening despite meetings.*" Some participants felt frustrated by having to define a 'problem' that they felt was self-evident, although it was not necessarily self-evident to non-community stakeholders, or indeed to all community members as one respondent noted that this was their only opportunity to date to present their views on health care to other community members, and another respondent mentioned that they were new to the area and this was an opportunity to get to grips with local issues. The feeling of covering old ground, however, was reflected in the relatively low average scores in some communities for 'increasing awareness' in the evaluation questionnaire. Other participants found it challenging that the project would not immediately result in substantive changes to their health care service and were used to taking part in engagement when an immediate problem was at hand and therefore

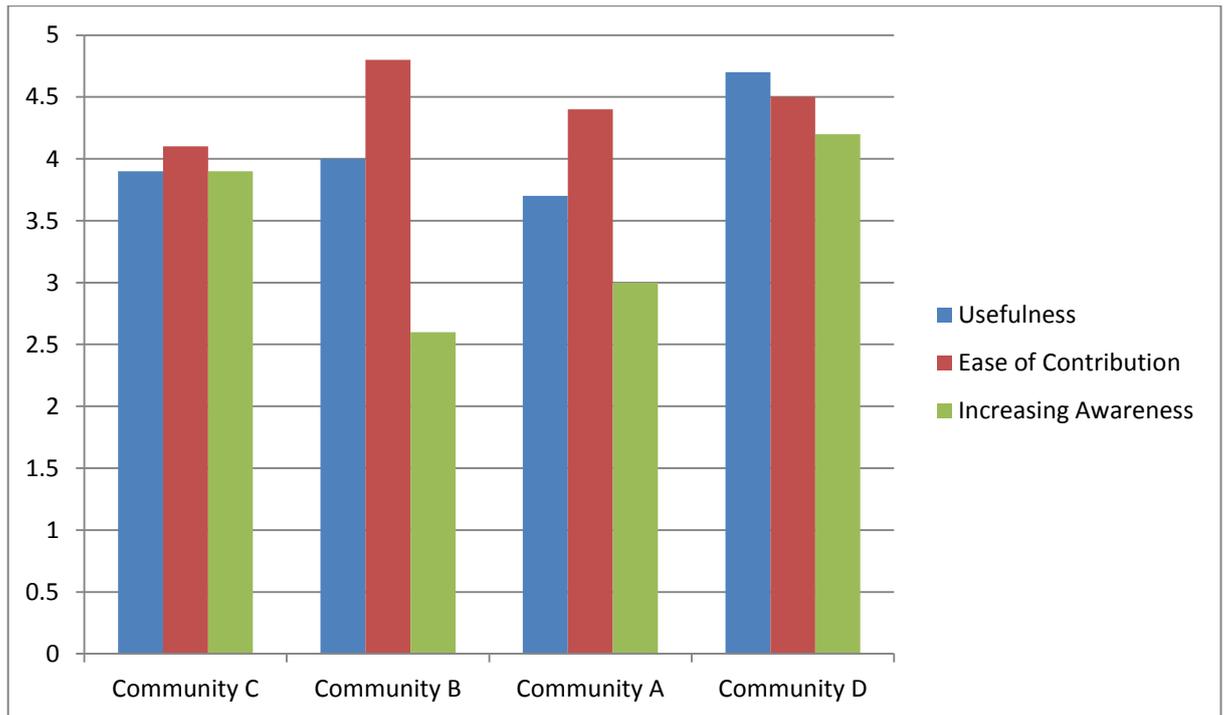
were unconvinced about the need to engage as this would just be another meeting; more “bits of paper”.

Another challenge in this event was moving the discussion beyond ‘posts and people’. The majority of community members found it challenging to discuss needs in terms of health care needs rather than a need for a particular role, job or post (generally doctors and nurses) in a community. For example, when discussing needs, the researcher presented data on the most predominant conditions seen in general practice in each area to try to stimulate a discussion around what types of need there was in the community but the most common response was, “we need a doctor/nurse”. There was some indication that participants were uneasy moving away from discussing their needs in terms of a particular ‘post or person’ lest they give the impression that their service could be delivered in another way.

This workshop was undertaken first in Community C, and when it was first undertaken, attempts were made to make these events slightly more formal and structured than an open community meeting, however this approach was rejected as being inappropriate to the participants and not ‘how things were done’ locally. Respondents strongly disliked the use of an agenda and “*the rules at the start*” which refers to an attempt to apply ground rules to the process. This feedback was used to rethink the way that subsequent events were structured, as well as the communication style that was used. The following table represents the quantitative feedback obtained from feedback questionnaires, addressing the questions:

1. On a scale from one to five, one being not useful at all and five being very useful, how useful did you find today’s event? (represented in blue)
2. On a scale from one to five, one being not easy at all and five being very easy, how easy did you find it to contribute during today’s event? (represented in red)
3. On a scale from one to five, one being did not raise awareness and five being significantly raised awareness, how much did you find today’s meeting raised your awareness of the topic discussed? (represented in green)

Figure 12: Quantitative feedback from Stage 2



As can be observed in this chart, participants in Community D appeared to find the event the most useful, whereas participants in community B found the event the least awareness raising. Scores for increasing awareness, as previously mentioned, were lower than other indicators in all four communities; however this was contrasted with the qualitative feedback in which the majority of respondents noted that they valued uncovering the previously unknown opinions of their fellow community members which is significant, given that participants had also expressed that they felt the *issues* were self-evident. This illustrates that although the issues may have been familiar, the perspectives of their fellow community members were not.

4.6 Stage Three: Community Conference: meet your service providers, think about the future, and the Information Road-Show

At this stage of the Renn et al (1993) model, the goal was to inform participants about the decision making options available to them, and, in particular, to provide information about specific services or schemes that participants in stage two had requested, or that other communities with similar challenges or assets were currently using. Depending on the timing of the events, the information road show was either held in conjunction with

this third stage of the process, or with the final stage. The findings from the road-show will be presented here as both the road-show and the community conference were concerned with providing participants with information that would inform decision making in the final stage.

The Information Road-show

At the road-show community members and service providers were able to meet and ask each other challenging questions about potential services and schemes. As the road-show was often (although not always) undertaken in the same week as the community conference, a variety of formats were available during this stage of the Action Research process in which stakeholders could interact. This range of formats (including a mixture of formal and informal events) allowed people to share their stories and obtain information in an environment in which they were comfortable. Participants who had formerly refrained from contributing during group events appeared comfortable talking to managers about their service experiences 'over a cup of tea' (quite literally in some cases) at the road-show. It was, however, challenging to convince service providers to attend road-shows in all communities and those taking place in more accessible communities had access to more service providers. Another challenge faced was the varying quality of facilities available at the different communities. Although it may seem a small inconvenience, it was the belief of those taking part in the road-show that attendance was compromised in the Community A by the inhospitable village hall facilities. As the event took place on a cold, wet day in this particular community, the damp, poorly heated hall was a particularly unwelcoming venue which may have contributed to only *one* community participant attending. As with the other events, formal attendance at the road-show was not taken, but based on an estimation by the researcher, attendance averaged around 20 people in Communities B and C. As the same data were not collected for Community D, a road-show was not held, but rather an additional community conference was provided. Specific information about service use and conditions within the community (based on QOF data) were instead presented during the final stage, prior to playing the RSF Game.

Community Conference

Participation at the community conference events was slightly higher than at the previous stage, possibly due to more proactive advertising of the event within the community. Attendance in Community C was around 5% (n=25) of the area population, with around 7% (n=15) attending in Community A and around 6% (n=8) in Community B. Attending in Community D was approximately 8% (n=12) of the local population for the first community conference and 10% (n=15) for the second. Again, figures are approximate due to the less than total completion rate of the feedback questionnaires at all events.

At the community conferences, representatives from a range of services were often present which meant that cross-sectoral challenges were discussed and could start to be addressed. It was observed that this event provided a useful forum for discussion without the opportunity for 'buck passing' between services present in single-service engagement events (for example one hosted solely by the NHS). Community members reported that it was a valuable experience to have the service providers present in their community to gain an overall holistic picture of the health care of the community, but also to hear about new services and ideas. The conference format also provided a way of examining what was going on in other communities, which allowed participants to consider whether service options could work in their remote and rural context.

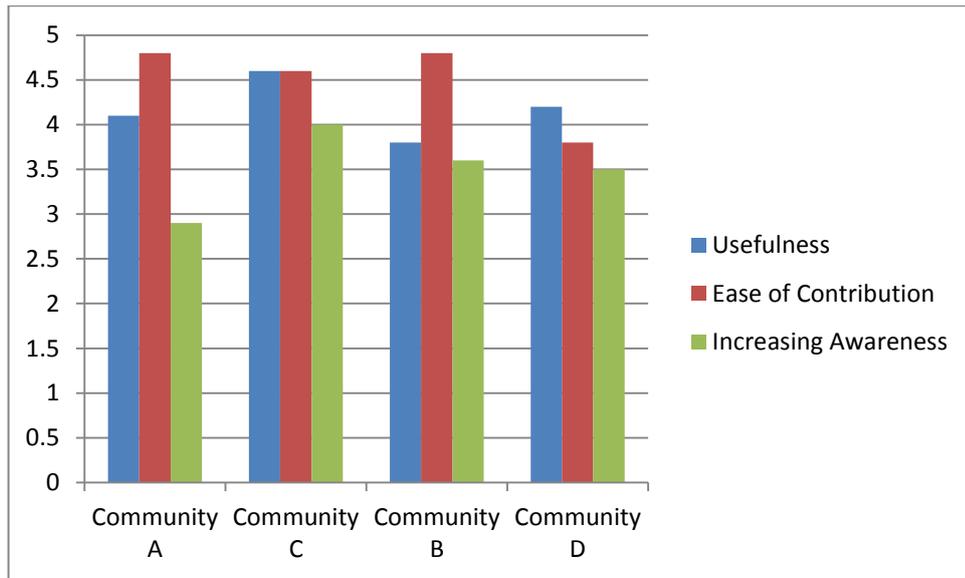
The process was driven by communities in that the presentations and services present were suggested by community members in the previous meeting. This meant that in many cases the community felt ownership over the process and were perhaps less suspicious to new ideas being presented than if they had been introduced by the NHS or other organisation. Indeed, thematic analysis of the qualitative feedback from this event yielded a high number of comments that corresponded to notions of increased trust, and used terms such as "*partnership*" and "*has our interests at heart*" to describe local NHS Highland managers. This corresponds to findings by Slovic (1993) that the process of engagement can be key to overcoming existing issues of mistrust. (Beierle, 1999), and Dolan et al (1999) found that taking part in a deliberative engagement process can make community members more sympathetic to health care service managers. It should be

noted, however, that indicators related to trust were higher in some communities than others, specifically participants from Community C reported valuing the input from non-NHS presenters but specifically mentioned presentations from their NHS locality manager as being “*not specific enough*” and found the talks “*vague*” and “*woolly*”. This was particularly interesting as NHS Highland locality managers had been invited to all communities to present on the same topic, namely a potential new nursing role. Given that the only difference in this area of the community conference was the presenter, it leads to the conclusion that the ability of individual engagement practitioners to be communicative, frank, open and knowledgeable had a very real impact upon the process and participants’ experience of the engagement activity. Communication styles and how information about services was conveyed, varied greatly between these two service presenters. In Community C, the manager was hesitant to mention any potential negative aspect of the new nursing role, and drew heavily on management and policy terminology which was clearly impenetrable to non-NHS participants. In this area community members expressed less trust and more frustration with the presenter than in Communities A and B in which the locality manager was clear, open and attempted to give frank answers to community members specific questions, even those to which the answers were unpopular.

Similarly to the information road-show event, at this stage it proved very difficult for certain service providers to attend at some of the remote communities, possibly due to the substantial time commitment required for travel and, occasionally, overnight stays. However, failure to attend and, in particular, backing-out at the last minute resulted in service providers losing credibility in the eyes of community members. This was noted in the feedback questionnaires as one participant noted that the least useful aspect of the event was “*as usual, lots of apologies from the no show panel*”.

As with Figure 4.3, the following chart displays quantitative feedback gathered via the post-activity questionnaire. The scale on the x-axis represents the five point Likert scale with 1 representing the negative value of the quality at hand, and five the positive:

Figure 13: Quantitative feedback from Stage 3



Scores for usefulness of this event were high, particularly for communities A, C, and D, with respondents particularly appreciating the open approach, breadth of information available, the opportunity to make service provider contacts, and the focus on “*practical info[rmation], not just waffle.*” Aspects of the event that participants found least useful were specific presentations (as mentioned above), a lack of formal structure for discussion following presentations (although this was only noted in Community C where attendance was particularly high and the discussion lasted longer than in other communities), and poor facilities (again, the inhospitable village hall in Community A).

4.7 Stage Four: Playing the card game

Findings on the efficacy of the RSF Game differed in each community depending on a number of factors including the current state of primary care services, community trust, level of previous engagement with the study, and interest. In Community A, for example, only a small number of participants attended (one community member and two service providers); in this community, we asked individuals to play the game on their own, sharing and discussing their findings at the end. Although it was agreed that plans created by such a small subset of the community would not be accepted as legitimate by the wider community, it was found that the session was educational for participants and that the game can be used as a tool to learn about health care provision and service planning.

Another community completed stages 1 and 2 and then sought to create a hybrid health professional with skills and competences from more than one current role. These different potential uses for the game proved valuable in dealing with such varied communities and contexts. This section will explore the use of the RSF Game in the three communities in which turnout for the game play involved two or more community members, by describing how the events played out. Participation in Community A, as already stated, was limited to one community member and two service providers, however turnout in Community B was approximately 12% (n=15) of the population, in Community C it was 3% (n=15) of the population according to the number of completed feedback forms although the number of participants was observed to be significantly higher than this. In Community D, around 5% (n=8) of the population attended, which was mainly comprised of the core group of attendees that had participated in the whole process of workshops.

The following vignettes will describe how the event transpired in each of the four communities:

Community A

As previously noted, the turnout in Community A was very low at the time of game play. Participant observation and discussion with local service providers suggested that this may have been due to high community satisfaction with the current service configuration and fear of entering into discussion about future alternative configurations. Alternatively, it may have simply illustrated disinterest in the event, although given the healthy turnout for other events in the community this seems unlikely. It should also be noted that the venue in Community A was particularly inhospitable, with very poor heating on a cold and windy day, which likely did not encourage attendance. The game in this instance was used by the small group of participants to reflect on their own individual priorities for future service design, after which their configurations were compared and a short discussion was held. Participants felt the exercise had been *“educational”* and helped them to consider trade-offs as well as *“finances and skill mix”* required to staff a remote and rural community. Although the turnout was disappointing, the experience of playing the game at an individual level illustrated an alternative use for the game: education about the process of health service planning.

Community B

Participants were asked to arrive at 10 am. A substantial group arrived on time and this group was comprised of a number of community members that had been to all the previous meetings/stages of the study. Several more people arrived between 10am and 12 noon and were formed into a second group which consisted of people who had not consistently attended the previous engagement events. At the end of the game, the two groups had very different outcomes and feelings. The first group, who we will call Group 1, examined their options in depth, discovered that they were potentially open to considering non-traditional professional roles and spending their budget on a combination of different professionals, social carers and establishing ways that the local community would work with service providers. Feedback from this group included comments about what group members had learned and this included “*an appreciation of NHS budgeting*”, “*the amount of information available*”, “*finding out the costing for [local services]*”, “*I found the whole exercise fascinating...we are very grateful*”. In contrast, the second group (Group 2) refused to engage with any discussion that might lead to consideration of alternate models of service provision. A large proportion of their time was spent with the practitioner cards trying to ascertain which of the anonymous practitioners corresponded to their current service. When Group 2 commenced the game, the position of their most vocal members was clear: that certain aspects of their service could not change but other aspects were inadequate. Interestingly, when it came to the final stage of the game, Group 2 chose to recreate their service exactly as it was, *including* the aspects that they had previously noted as inadequate. Group members were accusatory and occasionally aggressive to their facilitator and, as the feedback forms were collected at the end of the event, forms were marked with either a 1 or a 2 according to the group that the participant had been part of. The difference between the two groups of feedback was marked. In contrast to the positive responses from Group 1, responses from Group 2 participants included comments such as “*I didn’t find out any more information*” and “*fail to see any benefit from this exercise*”.

What the findings in Community B indicate is that it is *key* to engage community members in a *complete* process (i.e. stages 1-4) where information is shared, questions can be asked and answered, relationships built, and planning takes place only as the final stage.

Additionally, it was found to be important for community members to have access to a NHS manager who could openly answer any questions as they arose (in this community, Group 1 had more frequent access to a NHS manager during their deliberations). It may also have been the case that there were members in Group 2 who were interested in further discussion about their services but felt unable to do so due to dominating voices within the group. To this end, it might be possible in future use of the game to make the planning part of a more open space event to allow movement between groups, although this does run the risk of impacting on the positive learning experience of other groups.

Community C

There was a reasonable turnout for the planning game in Community C, and a large number of service providers and managers were also able to attend. As such, the community split into two large groups to play and the service providers and managers (from various agencies including the NHS, local authority and Scottish Ambulance Service) formed a group of their own. Prior to the game, most members of the community had stated their feelings about the manner in which they preferred to access services in their community, based on what they had experienced previously (namely, via a District Nurse). At the discussion session following game play, it transpired that the community teams both opted for the same type of health professional to provide local services. This professional was a different role to that which had historically delivered services locally.

Interestingly, both community groups and the service provider group were largely in agreement about the needs of the community, and which skills were needed to address those needs. When it came to planning their services, the two community groups preferred to receive their services from one multi-skilled or generalist worker, based in the community but supported by outside professionals. Conversely, the service provider group opted for the skill-set to be delivered by a multi-disciplinary team that was based outside of the community.

The exercise in Community C illustrated that the same skills might be delivered by more than one service model. However, even though their health and social care needs would have been met, technically, by an outreach team service configuration, this was not preferable to community members. It appeared, from community feedback, that it was

very important for community members to have a locally-resident health worker, who provided local generalist services. This was linked to confidence that an appropriately skilled provider would be available should they be needed, in an emergency. This reflects findings by the Scottish Health Council in a 2008 report on public involvement in service change, in which they found that local engagement participants *“felt strongly that local accessibility was more important than access to specialist capacity even when the services provided were of a lesser quality”* (20).

Community D

In Community D, the community/service provider group had spent time already, examining their needs and had general agreement about the type of professional that they would like, in conversation with their NHS locality managers. To avoid recovering previous discussions and to address their planning needs, this community used the game in a different way. Following a discussion of needs, the community group along with the service providers present, used the skill cards to form a ‘job description’ for a new generalist health worker role. The intention was that this role could be developed for their community jointly, between the NHS and Scottish Ambulance Service. Subsequent meetings were planned between a local community group and the appropriate NHS Highland locality manager to progress the plans. This appeared to be an exemplar of co-design, with all of the stakeholders being open to new ways of working and delivering services according to the needs of the community. The way in which the RSF Game was used in Community D indicated that different communities are at different stages in their thinking – some are very open to new ideas and ways of working. If, simultaneously, their service managers are open and committed to seeing these ideas through, the game can be used to facilitate this.

Unfortunately, just over a year following the completion of the study, the researcher (myself) was contacted by a member of the community to say that the locality manager had never returned to the community and had reneged on taking the co-designed plans further, citing health and safety issues with the plans. Rather than returning to the community when this roadblock emerged, the manager instead made a unilateral decision not to replace the retiring practitioner. The result of which is that the community has since become radicalised and formed an action group which is now battling the health

board in the national media. They have also abandoned a successfully functioning volunteer scheme established to support the potential new post and trust has been shattered between community members and the local NHS board. Although this occurred out with the 'life' of the study itself, this strongly illustrates the importance of viewing engagement as an on-going conversation, rather than an episodic piece of work to be completed and abandoned. It also highlights one of the key contradictions/paradoxes for engagement within a Scottish health care context: although service providers are obliged to engage with communities on the subject of service design, they are not obliged in any way to implement any joint decisions made as part of an engagement process. Although in this instance plans had been made between stakeholders to continue the process started with the RSF Game, there was no onus on participants to honour those commitments. It brings to mind the statement made by Beierle that public trust is "*far easier to lose than to regain*" (Beierle, 1999).

Overall findings for the Remote Service Futures Game

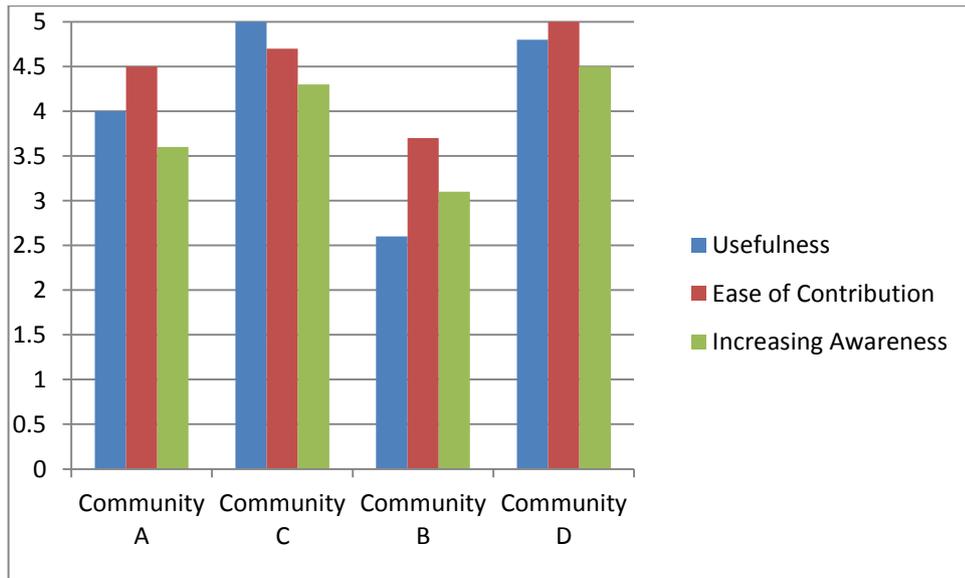
The planning game received positive feedback from the majority of community members and service providers, apart from a small subset from Community B. A particularly successful element was providing the budget and asking community members to make choices under the same constraints as NHS and local authorities' managers which allowed community members to experience the challenge of making trade-offs and working with limited resources within stringent guidelines. Community members reported more understanding of the difficulties that managers face when making decisions about staffing and resource allocation.

The flexibility of the game format was useful in adapting to different numbers of participants and what different communities wanted to achieve. In Community A the game was used mostly for educative purposes, in Community C it both created service plans and illustrated the differences in priorities of community and service providers, and in Community D it was used to create a job description for a potential new practitioner. As well as playing with mixed groups of service providers and community members, this stage demonstrated that game can be played to juxtapose their responses, potentially revealing different motivations and agendas.

The iterative nature of how the game was trialled (with the different communities and with other participant groups) indicated that the final version had been adapted *by* remote rural communities *for* remote rural communities, making it uniquely fit for purpose. Initial feedback for early iterations of the game indicated that it was too paper-based and complex and that people preferred to learn about rules and regulations of planning from a manager, rather than reading it to themselves as this generated more in depth conversation. Community members reported holding in-depth discussions about areas of health care planning that they had never considered before and service providers were able to gain in depth information about specifics of community preferences that had not emerged through previous engagement methods. In this way, both service provider and community member participants reported increased understanding of the priorities of the other group. In addition, making trade-offs through the game resulted in novel approaches to service provision being considered by both community and service providers.

It was clear that RSF Game must be played as part of a process of information and relationship building and that it is important to provide equal access for all participants to knowledgeable professionals who can answer questions throughout the game and ensure that the plans are adhering to current regulations. In order to provide a more accurate planning process, the availability of a more accurate community budget would be helpful. Strong facilitation may also be required in order to ensure that groups are not being dominated by some at the expense of others. Finally, one of the key findings from this stage is that the RSF Game cannot be viewed as an engagement end point. The creation of a community plan is the *start* of the planning process that should be revisited often until such time as it may be enacted. The trust created over the course of an engagement process is fragile. As with the Figures 12 and 13 the following diagram illustrates the qualitative feedback from questionnaires completed following the game play:

Figure 14: Quantitative feedback from Stage 4



Feedback from this stage of the process indicate that Communities A, C, and D found the event particularly useful. Although scores for this indicator are particularly low in Community B, this was only the case with roughly half of the participants which brought down the median scores. Scores for ease of contribution and increasing awareness were also at their lowest in Community B, but again the scores between participants in Group 1 and Group 2 reflect a very different experience and this affected the overall scores.

Service design outcomes from the Remote Service Futures Game

This section will briefly present the results of the RSF Game for Communities B-C including the agreed community needs, the skills chosen to address those needs, and the service configuration that the participants selected within their budget. As only one community participant was present for game play in Community A and the game was used more as a discussion tool, no formal plans were recorded. Within Community D, the game was used to create a new hybrid nursing/paramedic role, therefore their end point was a set of key skills needed within the job description for the new role. The service configurations that resulted from the game can be seen in the table on the following page.

Table 9: Results of the Remote Service Futures Game

Community	Use of game	Result	Group A model	Group B model
Community B	Redesign future primary care services	Primary health care staffing model	1 full time GP, 2/3 of a district nurse, 3 part time care workers (including some intensive care hours) with some budget left for contingencies	1 full time GP ½ time health care assistant 3 carers doing 8 hours per week 2/3 of a district nurse with some money left for contingencies
Community C	Redesign future primary care services	Primary health care staffing model	1 day per week of GP cover, 1 full time Nurse Practitioner (but doing 24/7) 1 full time Health Care Assistant, 16 hours per week of an Intensive Home Carer, A volunteer scheme for informal community carers, Some budget left for contingencies	1 full time Nurse Practitioner (but doing 24/7) 5 hours per week of an Intensive Home Carer A volunteer scheme for community carers, A first responder scheme , some budget left for contingencies
Community D	Design a new local emergency/nursing hybrid role	Job description	<p>New practitioner skills:</p> <ul style="list-style-type: none"> • Able to assess a community's needs, plan and deliver services accordingly • Able to coordinate local services across all providers • Has intimate knowledge of the community • Contributes to child protection and protection of vulnerable adults, helps with accessing benefits and helps coordinate social services • Can advise patients with chronic illness • Can take medical histories, perform physical examinations, diagnose minor illness and interpret test results • Can carry out simple tests • Able to provide treatment for minor illness and injuries • Can provide care for long term conditions • Can perform a paramedic role and cover OOH • Can work with people of any age who suffer from chronic illness or disabilities 	

4.8 Evaluating the Action Research: considering validity in light of the findings

This section will consider whether the RSF process as a whole was successful in meeting the criteria for success as described in the previous chapter. It will also consider its validity as an Action Research process using the validity criteria as outlined by Herr and Anderson (2005).

Increased trust between stakeholders

Considering the feedback from communities, a change in tone can be identified, as the engagement process progressed. Feedback from first and second meetings included comments about distrust of the project aims and what service providers would do with the information generated. While a few comments indicating distrust persisted, many participants stated that their feelings of trust towards the health care managers involved increased as the process progressed. One community member (at Stage 2) noted “[I] realise the NHS cares about us and listens to our opinions”; another indicated that the most useful thing about the event was “[h]aving an actual NHS contact who seemed to have our interests at heart”.

Trust was developed among those who attended events across the process, but not as markedly so in participants who attended only one event; for example, individuals who attended only for the game at one community expressed their suspicion as to the ‘true intent’ of the engagement. It was also found that, although it was possible to build trust between stakeholders, it was easy for that trust to be broken, as occurred in Community D.

It was observed within the study that the types of language and discourse employed during the process could have a marked effect on trust creation, for example the locality manager in Stage 3 who heavily drew on management and policy discourses alienated community participants. In short, trust was more effectively created in some communities than others, and was dependent upon continuous engagement and clear communication.

Combining experiential and technical knowledge in one process

Both community members and service providers reported an increased understanding of the decision making context that the other group faced. The use of the RSF Game incorporated both narrative/experiential dimensions of health care delivery as well as quantitative service data and regulatory frameworks. Community groups in all four communities (except one group) were able to create useable primary health care service plans that they felt suited their needs and simultaneously satisfied the planning requirements of NHS Highland. During this process participants held in depth conversations about planning requirements and the majority of people were able to move past discourses of 'posts and people' to discuss needs and requirements. In this way, the methodology was successful in combining experiential and technical knowledge in community members. Among service providers, a shift was reported during the process, from thinking of community engagement as a solution to a problem, and towards thinking of it as a long term process with payoffs that may take a long time to manifest. Unfortunately, however, a change in rhetoric did not always translate to a change towards more long term partnership working as was illustrated in Community D.

Early involvement

In all four communities, engagement took place prior to anticipated service changes (although in Community C no real service change was anticipated). Communities A, B and D were all selected as a key practitioner was due to retire within the next five years. Discussions about potential service plans, therefore, occurred well in advance of any service change.

Clear timely feedback

Shortly after each group event, notes were circulated to the entire community where possible, as well as made available on the study's website. These notes were then agreed by participants as well as the wider community and further events were publicised through local channels. Although the feedback was timely, and the community review process was employed in order to ensure that the notes were a clear and accurate

representation of events, they were not always considered clear by all participants. In one case (which will be examined further in Chapter 4) a community member objected to the language used in the notes, in which a particular issue was referred to as a 'perceived' need for more of a particular service. This was due to the fact that local professionals disagreed that this need existed. Although the term 'perceived' was immediately removed following the feedback, the incident reiterated the importance of clarity of language in all communications to avoid, the appearance of bias. Hopton and Dlugolecka, in a 1995 study of Scottish patient's perception of needs, that perception of needs can differ across patients and therefore must be handled carefully when used in priority setting. It should be noted, however, that participants in this study referred to depopulation of their communities based on the perception of service efficacy, therefore it may be the case that 'perceived' need can have real impact on rural community sustainability. NHS partners within this study were uncomfortable with the idea that, during a time of economic austerity, perceived needs may have to be accounted for. However, by ensuring that perceived needs are part of a multi-agency and multi-stakeholder conversation, solutions to these needs may be found in creative and unexpected ways.

Fosters ideological debate

Both the provision of financial information and the in depth discussions held as part of the RSF Game fostered ideological debate about rights to services, community and individual responsibility, and the morality of trade-offs. By using the available data as a springboard for discussion, stakeholders were able to discuss service planning in richer, more meaningful ways, and to locate their own local health care services within a wider ideological framework. While discussions in the project did not cover the provision of services over an extended geographical area, it was apparent that the learning that took part in RSF would be useful in foregrounding such expanded dialogues.

Increased understanding and awareness of context and issues

For service managers involved with the study, even the process of travelling to the community events prompted some to indicate that they had a greater understanding of what it was like for community members in an emergency situation. In some cases, this

study constituted the first time that service managers had visited the various communities due to their remote location. Service managers also reported a better understanding of the priorities and concerns of the communities involved. An example of this occurred when a service provider manager stayed overnight in Community C following an evening engagement event. The following morning, the manager visited the (only) local store to find that there was very little fresh produce available, and that the food selection was generally focussed around pre-packaged fast food. This small piece of local knowledge had the potential to impact on local residents' self-care and the manager had not been aware of it. Similarly, following a meeting in Community D, a service provider manager expressed having a renewed understanding of the challenges an ambulance would face in trying to access the community in an emergency.

The event that community members felt increased their awareness most about local health and social care provision was the RSF Game. Feedback indicated that participants gained increased understanding of some of the complexities of resource allocation, planning and budgeting. Feedback from participants improved as the game developed, through testing and modification; early versions provided a large amount of data and information to players, but this was later streamlined. Finding out about what was happening in other communities across the project was noted as being useful in putting local circumstances into context. Researchers observed that there were many initiatives and policies afoot that affect health and social care provision to remote and rural communities, but community members are unaware of them. Thus service provider managers are trying to implement national policies, while community members may perceive that these are local 'whims'. There may be a role for working with communities on knowledge dissemination about national policies. This is a potential avenue for future research.

Improved communication between stakeholders

During events and individual interviews there were opportunities for communication between community members, service providers and other participants. Out of 112 qualitative comments on the value of the project that were fed back from evaluation, 59 stated the opportunity to communicate effectively as the most useful aspect of the

events (both to listen and to express views). As part of the engagement, communication channels between service providers and communities were established where these had not previously existed. In order to ensure meaningful communication continues, participants in most areas were given contact sheets with the names, remit, and contact information for relevant local service providers. It should be noted, however, that communication was only observed to improve during the life of the study itself as communication was observed to break down after the fourth stage in Community D.

Involving 'hard to reach' participants

As well as public meetings and several group interviews, individual unstructured interviews were held. This allowed the study to gain the views of some 'hard to reach' community members including those who were unable to leave their homes to attend group events due to poor physical or mental health (including due to conditions such as obesity and agoraphobia). The interviews also proved popular amongst community members who felt uncomfortable voicing their views in front of their fellow community members, especially if those views ran counter to those held by the majority. One interviewee also appreciated the level of detail that one-to-one communication offered them over group events. In this sense, the use of multiple methods definitely allowed people to express their views who would not have been able to or comfortable to do so otherwise.

On the other hand, the challenge associated with the interviews was how to appropriately incorporate the interview data into the wider engagement process. It was clear that it had to be included somehow but without making the contributor identifiable since the majority of interviewees wished to remain anonymous. It was found, however, that bringing views of others to a group process lacks the 'bite' of community members actually voicing those views themselves and, in a group process, where individuals are not present, their views are inevitably overlooked by the stronger voices that *are* present at the meetings. Additionally, interview participants were unable to take part in dialogue and learn from other community members' input, thus limiting the educative potential of the experience. This corroborates findings by Watt et al (2000) that, although individual

interviews provide useful participative experiences, group methods of involvement may be more effective in the generation of ideas and solutions.

Incorporating individual input in a sensitive way was made additionally complicated because, in small remote and rural communities, it was often known who had been interviewed simply due to whose home the researcher's car had been seen at, however this challenge could potentially be overcome with the introduction of additional phone interviews to ensure anonymity.

In addition to more formal group events, the methodology incorporated informal, drop-in, 'cup of tea and a biscuit' interactions between community members and service managers that diffused tension and encouraged 'normal' relations (rather than confrontation or 'issue'-based) - as well as formal meetings. Reaching the 'hard to reach', however, remains a challenge particularly in remote and rural areas where inequalities are often hidden. While spending time in the communities themselves did help to clarify where some inequalities of access may lie (for example, with those who were housebound) there may well have been other community members for inclusion who we were unable to identify.

Additionally, one of the findings from the study is that deliberative engagement methods are more effective if relationships are established and built over time. Not only are trust and relationships established in this way but this builds information, knowledge, and confidence. Individual interviewees missed out on the opportunity to learn as part of the group, and to take part in debate so some of the more educative aspects of the engagement may have been missed out. To some extent this also applies to public meetings where different individuals can attend different events, on different occasions. Such events can be unhelpful as new people need to be informed and updated with the process and this disrupts the constructive dialogue built through previous events. Nonetheless, it is clearly important to maintain an open process so as not to exclude any stakeholders. It appears therefore, that engagement involves a balancing act between inclusion and group relationship forming.

Meaningful contribution and participation

Within the feedback questionnaires, community members generally reported feeling comfortable about contributing to discussion at meetings (an overall average of 4.4 out of 5 for ease of contribution for all meetings – 5 being very easy to contribute and 1 being very difficult to contribute). On occasion participants reported feeling uncomfortable about speaking up at events; stating, for example, that they ‘felt intimidated by louder contributors’, or ‘don’t feel qualified to contribute to discussions about healthcare’, but in general, this improved over the course of the project and we made efforts to ensure that participants were given opportunities to contribute in several ways at each event, including informal one to one chats before and after events with service providers and/or researchers.

The extent to which communities embraced the process and used it as a way of achieving change varied between the communities and appeared to be related to a number of factors. Attitude to the project was one issue. One community more or less disengaged with the project at Stage 4, with only three people attending the planning game. Informal feedback from this community indicated that community members did not consider the study to carry a ‘threat’ of service change and thus the community were not concerned to participate. As Shortall (2008) points out, however *“Nonparticipation can represent a valid and legitimate choice, and often one made from a position of power”* (452). Non-participation at this stage may also have been a conscious decision to indicate a strong unwillingness to engage in any parts of the process that directly related to the possibility of actual service change, given that the community was currently happy with their service configuration.

Another issue was that different groupings or factions exist within communities that exhibit differing attitudes to participation. One community had people that wished to stay with the existing model of provision and others that considered change. The extent to which there were prominent factions within that community, and the difficult relationships this could mean for on-going community life, impacted on the capacity of the study, the community and service providers to progress plans for a different health and social care service design for the future.

The relationship between community members and service provider managers was another issue. There was evidence, from the study, that a trusting relationship could

produce the prospect of communities influencing their service model, thus encouraging their interest and co-design of services. However, some service providers could not be engaged to take ideas generated beyond the project to real service design. Their reluctance was observed by community members and directly impacted their feelings towards continuing involvement.

The creation of useable plans

Using the planning game, groups of community members from each community, together with service providers, produced *potential* health and social care plans for their community, although not all were immediately useable. These took into account their aspirations for the future, likely future demographics, needs as defined by consensus from the community participants, objective information obtained from service provider recording systems and a budget.

In general, the community groups involved in the study were interested in primary care service configurations that centred on one or two locally-based main practitioners who had a wide skills base, were flexible generalists, and were content to perform some tasks outside their current job descriptions such as public health and capacity building activities within the community. While many of the community groups were interested in the idea of exploring different service configurations to the one they currently have, they were often inhibited by the regulations that govern out of hours working.

Cost Effectiveness

In terms of cost effectiveness, the engagement process involved in this study did not require a large expenditure on overheads. The biggest outright expense (apart from staff time which it is assumed would be spent regardless of the methodology) was travel and accommodation for managers but the actual events themselves made use of local facilities, took place when convenient for the majority of community members, and required a minimum of expenses. It was estimated that, barring travel and subsistence, the process could be carried out in each community for around £250. This was considered by the NHS representatives on the project steering group to represent good value for money.

Validity of the Action Research process

Sections 4.4-4.7 addressed the findings from the individual engagement methods and considered their efficacy, as well as the efficacy of the methodology as a whole in addressing defined success criteria. This section will consider the wider Action Research framework and whether the Action Research project met the standards for validity proposed by Herr and Anderson (2005), as outlined earlier in this chapter. In many respects, indicators for successful community engagement and the indicators for validity overlap, confirming the suitability of Action Research as a framework for carrying out quality deliberative community engagement.

Outcome Validity

Outcome validity, to recapitulate, refers to the degree to which an Action Research project has resolved the original problem, and the extent to which participants have been moved towards successful action outcomes. The 'problem' that this Action Research sought to address was the need for a deliberative engagement methodology that was suitable to a remote and rural context. The iterative nature of the Action Research process allowed the original methodology to be refined and tailored to suit the four communities and one of the end results was a fit-for-purpose remote and rural planning game that addresses many of the contextual issues associated with remote and rural planning. Within the lifetime of the project, participants were moved towards successful action outcomes including the creation of plans for future service use and establishing lines of communication with which to continue engagement into the future. However, following the Action Research project, not all of these actions were taken forward which implies that the process to some extent lacks sustained outcome validity and would benefit from more robust frameworks for continuing engagement work and the support of wider policy and governance contexts to provide motivation for managers to implement engagement decisions. On the other hand, this research project *was* designed to be an anticipatory and, to some degree, hypothetical process so the expectation of service change was low. There was, nevertheless an expectation of continued engagement that was not always fulfilled, especially in the case of Community D. It would also be helpful to examine some of the contextual details around the engagement

process in more detail to further understand the effects that individual stakeholders had on this outcome. This will be addressed to some extent in Chapter 5.

Process Validity

Process validity refers to the degree to which the methodology was sound and methods were used appropriately. According to Herr and Anderson (2005), process validity can be enhanced by the use of multiple methods for triangulation. To this end the Action Research project featured multiple methods for communication (telephone, email, local media, project website, meeting notes), as well as multiple methods for engagement to capture the views of the largest amount of community members possible. This mixed methods approach proved popular and allowed participants the opportunity to engage with the project, with their managers, and with each other through a variety of means. The use of a variety of methods was particularly useful when, in Community B, turnout for the second meeting was low. At this stage efforts were made to advertise the availability of interviews for those interested in participating which was successful in recruiting additional participants. As described in the previous section, however, there were challenges with combining the data from the different methods into one decision making process, however on the whole this criterion for validity was met.

Dialogic Validity

Dialogic validity refers to the degree to which the research stands up to a stakeholder review process. Effort was made at different stages throughout the Action Research process to include both stakeholder review and more formal academic peer review. Notes from all group engagement activities were disseminated as widely as possible for participants and non-participants alike to comment on and add to. This process was also repeated with the final report, which was circulated to all stakeholders for feedback. Additionally, as part of the creation process for the RSF Game, iterative peer review was used to first assess the basic merit of the game format, and then to refine the process of play. A journal article based on the creation of the game was also submitted to a peer reviewed academic journal and was subsequently published.

Perhaps the most important use of peer review within the Action Research process was used in relation to parts of the qualitative data gathering process. When individual interviews occurred that were not recorded, where possible another researcher would be present so that two sets of interview notes. These notes were later compared for accuracy, but also to attempt to avoid interviewer bias towards topics that were of individual interest. With regard to the participant observation, key points were confirmed with other observers to ensure accuracy of reporting.

Catalytic Validity

Catalytic validity, or the extent to which the process reached its transformative potential, is interesting to consider in relation to this study. As the process was designed to be anticipatory, substantive *service* changes were not observed during the lifetime of the project, nor were they necessarily expected to be. It could be argued that the key changes that took part during the Action Research were changes to participants' perspectives and the creation of knowledge and trust. As Attree et al (2011) note, however, positive effects of engagement on participants can be undermined by a lack of continuity of participation. As was discussed earlier in the findings section of this chapter, participants reported learning from the process and expressed an increased understanding in the perspectives of other stakeholders (including community members' understanding of the viewpoints of their fellow community members). Trust was also observed to be increased during the individual engagement activities. In this sense, the Action Research project was transformative, however, the transformative nature of the project was predominantly observed within those who undertook the entire process, rather than engaging with isolated events.

Democratic Validity

In order to achieve democratic validity, or the inclusion of stakeholders' perspectives and interests, the Action Research format was designed to be as flexible as possible. Within Community D the process was substantially altered to suit the needs of the community group but stakeholders' perspectives and interests were also included in less dramatic ways throughout the process. Participant input helped to shape not only the content and focus of events, but also the style in which they were delivered.

4.9 Community engagement for co-design: a way forward

A number of conclusions about engaging with remote and rural communities for health care service design can be drawn from this Action Research project. One of the aims of this chapter was to evaluate the individual methods used and their suitability to the remote and rural planning context. While each method and its efficacy has been examined in the findings section of this chapter, wider conclusions may also be formulated. This section will consider practical recommendations for future engagement practice, based on the Action Research project described in Chapters Three and Four.

Firstly, it was found that it can be challenging to interest some stakeholders in the idea of anticipatory planning when there is no immediate crisis or action to be taken, however it was also found that incorporating small 'deliverables' can help to overcome this to some extent. Providing communities with detailed information about their local services and budget served as an early deliverable but was also invaluable to the process of genuine co-planning, both in terms of being able to create an accurate service plan but also in terms of creating a more 'informed public'. The availability of more budget information about neighbourhood level inputs/spending could help remote and rural Scottish communities to more effectively allocate money to services within a community budgeting format such as the RSF Game. In order for this to occur, more detailed local recording of activity and cost data would be required by health boards and Councils. In an investigation into participatory involvement in the NHS, Milewa et al (1999) found that one of the key reasons that managers cited for being unable to implement community decisions was that they failed to consider financial constraints. As one respondent in this study, an NHS Commissioning Manager, said "*[w]hat they still don't understand is that the amount of money we get every year is finite*" (455). The provision of detailed, transparent data to communities for engagement for planning was a significant need identified within this study as well. At the time of writing, however, significant structural changes are occurring within NHS Highland and Highland Council, during which data recording practices may be addressed.

All engagement events for this study were carried out within the communities themselves, in other words there was no requirement for significant travel for community

members. It was found, however, that it could be difficult to persuade service providers to visit the remote and rural locations due to a number of factors including travelling time and cost. This study found that there was a significant impact on trust and relationship building with the service providers who were unable to attend engagement events. If a service provider failed to attend a meeting, they lost credibility in the eyes of the attending community members and this also tended to lead to 'buck passing' by other service providers present. In other words, if someone failed to attend, there was a tendency to blame that organisation for any lapses in service that were raised at the events and may have occurred during joint working. It was felt by participants that those who did not make the effort to come out to the community would have a poorer understanding of the context of service delivery and thus would make poorer decisions about resource allocation. On the positive side, when service managers made themselves available, it was found that having representatives from several different service providers present allowed all participants to gain a '360 degree' view of the services as well as the needs of the community. Although travelling to remote and rural communities may be logistically challenging, it is essential for creating trust between stakeholders. In addition, spending time in the community during an engagement initiative (for example staying overnight and using the local amenities) is extremely important for service provider managers to gain contextual understanding. In many cases, for remote and rural areas, this may be practical anyway due to long travelling distances and provides an opportunity to undertake several forms of engagement in one trip (for example a group workshop and several individual interviews).

Another key finding from the Action Research project was that the ability of individual service provider managers to communicate effectively had a marked impact on the engagement process. Managers who employed jargon (including, but not limited to terminology from policy documents, managerial/bureaucratic terminology, and acronyms) alienated community members who felt that these terms were used to avoid direct/frank communication and thus aroused suspicions of the manager's motives. The impact of language on the process was not limited to managers, however. Within the study there was a tendency within all four communities for community members to focus on 'posts and people' rather than skill sets, which was initially frustrating for managers and other stakeholders. The use of different communication styles was observed to have

a significant effect on the engagement process. Although the RSF Game provided an opportunity to move past these discursive limitations in some ways, it may be the case that managers in particular require further training in communication and engagement, or it may be that those who are more skilled at communicating clearly should be sent in lieu of those who are not, with decision making powers being equal. A more detailed examination of the use of discourses and language in the engagement process will take place in the following chapter.

The use of the RSF game highlighted some interesting differences between community groups and service provider/service manager groups in relation to the way that they thought services should be delivered. While the different types of participant often agreed on community needs as well as the skills needed to address them, community members on the whole preferred to access services 'holistically' or continuously from one or two local practitioners with a broad or generalist skill base. This was in contrast to service managers who often preferred for skills to be delivered by different, more specialised practitioners, from multi-disciplinary teams – a practice which tends to result in some skills being delivered peripatetically (which is partly an intentional device by managers who see team provision as more sustainable and less likely to pressurise individual practitioners). Community participants appeared to value locally based (non-peripatetic) service delivery to the point that they would accept fewer skills/services in order for them to be delivered by a generalist, which aligns with the literature that indicates that locally-based remote and rural practitioners bring added value to their role (Prior et al, 2010, Farmer et al, 2003, 2005), but also that which states that health care managers may not always be aware of (or place the same value on) the additional services provided by remote and rural practitioners (West et al, 2004). It was felt by one participating NHS locality manager that the RSF Game provided a framework in which to capture this "*added value*" (Prior, 2009) that other deliberative methods had not.

The presence or absence of the local health care practitioner (for example, the local GP or district nurse) at the engagement events was also observed to have an impact on the engagement proceedings. In some cases the impact could be considered positive (for example when they encouraged others to attend or supported particular ideas which gave the ideas legitimacy in the eyes of many participants). However, the presence of a

local practitioner may also be inhibiting for other stakeholders in terms of discussing changes they might like to see within their local services, as it may be uncomfortable to discuss any dissatisfaction with aspects of the current service in front of the person or people with responsibility for providing that service.

There was found to be value to the engagement (and research) process of having spent time within the community itself, in other words to incorporating ethnographic techniques within the engagement process, both for information gathering and evaluative purposes. Although the majority of participant observation was undertaken by the researcher (myself) as part of the ethnographic type case study, these benefits were also felt by my managers who acted similarly; who made observations about the local area and used this information to reflect more widely upon the context of the engagement process. Service managers reported gaining holistic insight into the workings of the community, as well as its geography and resources. Although managers may be under time pressure and feel that time spent in communities is excessive, it may well save time at a later date if and when future co-produced plans can be implemented smoothly.

In addition to the ethnographic nature of the research, the iterative Action Research framework through which the methodology was delivered was also helpful in creating a contextually appropriate approach. Although the methods received good feedback individually, they were much more effective as part of a process (for example, those who did not engage in all parts found the final stage bewildering). The fit for purpose elements of the methodology, especially the RSF Game, allowed the method to be customised to fit the needs of the community, the service providers and the overall aims of the engagement. This may not have been possible when using a method originally created for a different context. Those involved in engagement may wish to consider the merits of creating their own method based on elements of others that suit their particular engagement context. It was also found that assisting communities to learn about initiatives being undertaken by other communities with similar challenges was particularly useful as it allowed people to consider what a service might look like in situ, rather than just in the abstract.

One of the key conclusions from this study, however, is that engagement should be viewed as a relationship, as a continuous process. Instances in the project where it was

viewed as episodic and stakeholders disengaged led to a breakdown of trust and communication between stakeholders that will only make future engagement more challenging. This corresponds to literature that suggests that lack of continuity of engagement can disincentivise participants from taking part in future engagement activities (Attree et al, 2011, Bolam et al, 2006). The incident that occurred in Community D following the completion of the project was completely counter to the values of the study and the commitment made to the community. It was clear that the manager felt that engagement 'had been done' and therefore future planning decisions could be taken without further consultation. As was found in the literature review, the viewing of engagement as episodic is a systematic problem within the NHS. Current engagement guidance encourages practitioners to view the practice as something with an end point (VOiCE) but this view can undermine trust and can lead to the future self-exclusion of participants in the decision making process who have been encouraged to take some ownership of the decision. This incident also highlights the findings from the literature review, that there is currently no statutory impetus for planners to implement the results of deliberative engagement, and adds that persistence is required by managers to work through set-backs and overcome barriers to implementing co-designed service plans. Engagement for service planning requires on-going commitment to be successful and must not be considered as episodic (Ellison, 2000). If, following a joint decision making process, additional information is introduced, it should be seen as an opportunity to go back to the stakeholders and reassess, rather than an excuse to make unilateral decisions.

It was also found within this study that there were similarities between the four remote and rural communities in terms of their preferences for primary healthcare service provision. Data gathered within the RSF project suggests that remote and rural community members value locally-based generalists and prioritised skills around general diagnostics, basic health care treatment, and emergency response skills, but they also prioritised service providers who were able to incorporate health promotion and less 'formal' skills such as in-depth knowledge of community members and being able to check up on those who were at risk but not necessarily 'ill'.

The four communities within this study contained a number of highly educated and successful individuals, however, there was little to no awareness of wider health care

policy amongst community members involved. As such, many felt that changes that had been implemented in the past were more to do with the decisions and whims of local managers, than as part of a wider national trend. It may be helpful to disseminate information about national initiatives in a more meaningful way in order to provide context for community members. If this dissemination were incorporated into regular health care manager visits to remote and rural communities it may help to provide a talking point for engagement events that is non-crisis driven which could be both educative and help to maintain an open dialogue (and consequently, maintain trust created between manager and community).

4.10 Discussion and Conclusions

Personal experience and challenges: a rural researcher's experience

By becoming a 'stranger' in the rural, by coming from elsewhere, from 'there' and not 'here', and hence by being both 'inside' and 'outside' the situations at hand, we can begin to experience that estrangement, that "uncanny displacement" (Chambers, 1994:6), which can so often characterise the experience of Otherness. In other words, we are forced to confront strange ruralities. (Murdoch and Pratt, 1997)

In the above quotation, Murdoch and Pratt describe the importance of self-reflexivity when researching within the rural context, in order to see beyond modernist/rationalist simplistic conceptions of rural communities, and uncover the intricacy and plurality of the rural. Something that is notably absent from the literature on community engagement is a commentary on how personally challenging it can be to facilitate engagement events in rural Scotland. Each of the four communities in this study started from a position of extreme scepticism if not outright adversarialism towards local NHS Highland management and those associated with them, as I was seen to be. This is particularly well illustrated by one particular incident.

As was described in Chapters 1 and 3, case study communities were initially selected by NHS Highland based on criteria for a) rurality and b) upcoming retiral or similar of a key health care practitioner. One of the four communities initially selected, which I will refer to as Community E, adhered to the aforementioned criteria but had recently been

involved in controversy regarding the removal of a previous health care practitioner. As it was anticipated that the study would be concerned with the retiral of a practitioner from a different clinical field and would not be directly dealing with this controversy, the project steering group considered Community E to be valid choice for inclusion in the project. Before the commencement of the study proper, however, it was necessary to approach the community in the same manner described in Chapter 4, through a series of meetings with local residents, along with an open public meeting, to ascertain whether there was a general will to take part in the study. This initial foray into the community was made by myself as well as my doctoral supervisor. Both of us made a series of general field notes based on our discussions with community members and interactions within the community. During this visit it became clear that there were still high levels of distrust and antagonism present within the community; towards the health board, towards the remaining local health care practitioners, and towards fellow community members. Some challenging questions had been raised at the public meeting on the subject of any connection that we may have had to recent events (none, as was the case) but community members present expressed no objection to the project going forward in their area and, on the contrary, we were welcomed into many homes over the course of our two days in the region to discuss the project further. In fact community members appeared eager to discuss their health care provision. Following our return from the community, however, it transpired that the field notes made by my doctoral supervisor had been stolen from her hotel room while we were downstairs in the hotel having dinner. These notes were subsequently photocopied and distributed within the community. Luckily, these notes were very brief and contained nothing with which to identify any of the community members we had interacted with. The theft was reported (with, it must be said, no great surprise on the part of the local police officer) and when the incident was investigated at the hotel, it further transpired that the hotel owner had retrieved and saved a discarded (and much crumpled) schedule of our visit from the waste-bin of my doctoral supervisor's hotel room that he was able to pass on to the police, indicating it appears an unusual level of interest in our movements. Due to the extreme level of suspicion present within the community that, it was now obvious, was also directed towards ourselves as researchers, it was decided by the project steering

group that the study could not continue in that particular community and another area was duly selected.

This may be viewed as an extreme example of the distrust present in remote and rural Scottish communities towards health service change, however, it could be viewed as symptomatic of a wider feeling; diluted versions of these same feelings of suspicion and distrust were present in all four of the final case study communities. Maintaining a high level of primary care service provision was, to the members of these communities, tied strongly to the very sustainability of their communities; discussions of change in service provision had come to be understood as prefaces to the withdrawal or diminishing of services. So while the level of suspicion and hostility encountered in these remote and rural communities, particularly at the beginning of the Action Research study, was understandable, it also took a personal toll on myself as a researcher. Comments of a personal and occasionally even pseudo-threatening nature were made to myself as a facilitator within the engagement process, although this most frequently occurred outside the engagement activities and from community members not closely involved in the process. Aspersions were cast upon my motives, my integrity, and my honesty, and I was, on one occasion told by a lone community member as I was about to leave the community “not to come back”. Rumours circulated about my role, the amount of power that I was able to wield, and my intentions towards the community (i.e. that I was there to provide a front for the cutting of services). This is not to say that the majority of community members in the four areas were outwardly unwelcoming by any means, but there was a frequent air of low level suspicion present. Following discussions with NHS, Local Authority and Scottish Ambulance Service managers involved in the project, I was assured that this is absolutely the status quo and that, in fact, I had been treated with far more respect as a facilitator/intermediary than are those with a clear affiliation to a service organisation. It strikes me that this is something that is little touched upon in engagement literature but forms the largest and most lasting impression of community engagement initiatives for those taking part in a professional capacity: that community engagement can be, frequently, personally difficult to cope with and requires a balance between personally disassociating whilst remaining professionally present. My personal discomfort provided some insight into the possible motivation of managers to retreat into a management discourse in challenging engagement situations rather than to try to

communicate more openly and/or not to visit communities at all. At the same time, this creates more frustration for community members who, ultimately, would like to know what is happening in clear and honest terms. Again, these challenges may be encountered in other health care engagement contexts, but it is my experience that the small and interconnected nature of the remote and rural context can act as a 'goldfish bowl' to magnify feelings of 'out of place-ness' (Gillies, 1998, Lawrance, 2001). As Slama (2004) describes it, the goldfish bowl effect is a hyperawareness of people within rural areas

"that other people are very interested in their lives and in talking to others about them. This lack of anonymity or privacy results in certain conventional behavioural expectations, as well as pressure to conform to them" (10)

This effect is specific to areas of small population in which residents are particularly visible, but also areas that are remote from other society. There was a perceptible difference, for example, in engaging with communities with differing levels of remoteness; between the experience of engaging with the remote communities which could be reached by a car journey within the day and therefore did not require an overnight stay, and those that did. Staying overnight (or occasionally for several days) in the area, while useful in ethnographic terms, did tend to feel like living under a microscope. Local people always knew where in the community you were, who you were with and what you were doing. This echoes Murdoch and Marsden's (1994) experience of being outsiders in rural England, which they summarised in the statement; *"entering a [rural] village, one becomes aware of how "public" spaces can also be "private"*. In other words, even in public spaces within the community, there is a sense of trespassing, of being present in an area where shared ownership exists but you are excluded from it. This is not to say that all of the visits were uncomfortable. Indeed the workshops appeared successful in building trust amongst participants and we were invited into many homes to discuss health care. Some participants kept in touch in between visits with friendly emails (and even a Christmas card in one case) but it would be fair to say that individual engagement activities such as interviews also yielded some of the most challenging interactions in the study.

The current guidance provided by the Scottish Government, as well as the Scottish NHS, highlights the need to be inclusive, and to seek out participants who are 'difficult to reach' (Scottish Health Council, 2012; Scottish Government, 2010). Special attention was made in the Action Research project to include participants who were unable or unwilling to participate in group activities. This strategy was, for the most part, very successful in eliciting views that would otherwise have been excluded, however, home visits and interviews could also be uncomfortable experiences when dealing with individuals with particularly strong grievances or animosity. When undertaking home visits, I was always accompanied by another researcher or, on a few occasions, representatives from the NHS. As described in Chapter 3 the reasons for this were twofold: firstly, to safeguard against interpretation bias during note taking, and secondly for safety reasons when visiting a stranger's home in a remote area. Despite being accompanied on these visits, however, there were one or two occasions on which I felt extremely uncomfortable. The majority of texts dealing with the interviewer-interviewee relationship tend to conceptualise the interviewer as being in the position of power and influence. However, being cast in the role of "stranger" (Murdoch and Marsden, 1994) can be a disempowering experience.

Although very much in the minority, there were one or two residents who expressed an interest in being included in the study and its associated engagement activities but did not appear interested in contributing positively beyond using the project as a platform to air grievances (often of a personal nature). At this point it may be worth being reflexive about how my professional conduct, research purpose, or even my language may have influenced the interaction, but however unpopular it is to acknowledge, as a *personal* experience, some people can simply be unpleasant to deal with. Interactions such as this beg the question; to what extent should unpleasant or, to call a spade a spade, mean behaviour be tolerated within an engagement process? This experience relates to Campbell's (2005) consideration of the prevalent concept of 'the good citizen'. The good citizen is, according to Campbell, one who is calm, rational and able to "*clearly articulate his or her positions on matters with the supplemental information we provide*" (696). The good citizen forms a key part of what Campbell describes as a "*rarely discussed bias [within health care engagement] concerning citizen identity*"; the concept of the good citizen forms the basis of the majority of conceptualisations of who citizens are in the

community engagement process, and those who do not fit this model (by not participating or by behaving irrationally) are problematic or, by proxy, not good citizens. This simplified ideal of participants does not fit within a postmodern understanding of engagement and is particularly unhelpful because, as Campbell asserts

“citizens can be messy, and their problems can be complicated. They can be angry, confused, demanding, and uncooperative. Even so, they are still citizens and members of our community to whom we are obligated, by the very nature of public service, to address and include.” (Campbell, 2005: 696)

This is a challenging issue because, as evidence has shown, health care is a subject that inspires passion and emotion (Litva et al, 2002), and there were undoubtedly individual participants and communities who felt they had been treated poorly in the past or have justifiable fears and anxieties about service provision in the future. But the question, as an individual researcher or practitioner is, to what extent should unpleasant behaviour, in particular aggressive and personally offensive speech, be tolerated for the purposes of inclusion? For example, one individual participant, despite disproportionate amounts of personal attention via home visits and emails, was dissatisfied with the process. The participant was keen to be involved, however was unhappy with every aspect of the engagement and expressed her displeasure in very strong and often personal terms which, towards the end of the study, bordered on abusive. At no stage, however, did it feel that the option existed to simply *not* engage with the participant.

Reflections on the process

The variation in trust and feelings towards the engagement expressed within the case study communities and described above also raises an interesting issue about consent in rural ethnographic Action Research as well as community engagement. Although some participants expressed negative feelings towards the process (for example telling me to go away and not come back), consent had been sought and obtained from the communities at several stages including at initial group events and individual interviews or focus groups. Our participation in the community was also sanctioned by local health care practitioners and presented to local community councils prior to undertaking the research. At what stage, however, could this consent be considered to be withdrawn?

Participants were, at any stage, free to disengage from the process by either not attending public meetings or by not consenting to or requesting an interview. This withdrawal from the process was clearly observed during the final stage in Community A in which only one community member attended the planning game session. Although, this too has ethical implications. If the only way that people can express displeasure with the process is to disengage, they risk not having their voice heard. As previously mentioned, for the purposes of formal ethical approval, the ethnographic Action Research study was considered by both the University and NHS Highland as falling within the category of service evaluation and development, meaning that no further ethical approval was sought, although I was still concerned that the process be considered an ethical one by participants, and that it should follow appropriate guidelines. This may be more of a problem when it comes to university led ethnographic research than for NHS managers who are legally required to carry out engagement but it does raise the question: to what extent are communities obliged to engage with the health board?

Although the engagement process described in this chapter, as well as Chapter Three, was successful in meeting many of its aims, including the creation of shared plans, is there little point in implementing such a process if the decisions made will never be implemented? This was starkly illustrated in the case of the final case study community in which the NHS manager disengaged before an agreed staffing model had been implemented. This leads to one of the key problems, which is that at present, within NHS Scotland, managers are *required* to engage with communities around service delivery design, however there is *no requirement* for the decisions made as part of these processes to be implemented. This issue was highlighted within the literature review as well but it is clear from this study that renegeing on such deliberative planning decisions can be even more damaging than failing to engage in the first instance. This is not to say that NHS managers should be forced to comply with any demands made by the community, but if there was more of an impetus to create mutually agreed service delivery plans (so long as they are safe and sustainable) and implement them, community members might be more inclined to create reciprocal engagement relationships with other stakeholders. Given the present climate of suspicion towards local health authorities observed within the case study sites (and evident within the literature as well as Scottish media), it behoves health boards to ensure that there is clarity and agreement

about *how* stakeholder input will be implemented, lest they risk causing more damage than if engagement had not taken place at all.

This chapter has concerned itself with the findings from the Action Research project described in Chapter Three, outlining the results of each stage and engagement method and considering their effectiveness within the context. This chapter has also considered the efficacy of the engagement methodology as a whole, as well as the Action Research framework that it was delivered within. It concludes by offering practical recommendations for future remote and rural engagement, and then considers the wider issues of engagement including the personal experience of carrying out engagement and which challenges still exist.

The next chapter will look more closely at some of the qualitative data produced during the unstructured interviews, and will consider the role of power and discourse within the four community case study sites by applying a post-modern analytical framework. The following chapter will examine the results of this Action Research project by considering the role that the complexities of individual participant power plays in affecting the process and outcomes of rural community engagement.

Chapter 5: Power, discourse and the rural community

5.1 Introduction: addressing research question 3

Research Question 3: To what extent was individual agency and power observed within the Action Research process and could this have affected the process?

In addressing this question several types of qualitative data gathered throughout the Action Research project (as described in Chapter 3) were used analysed with the purpose of addressing whether more complex power relations exist within the context of remote and rural engagement than the simple dichotomous model of community versus service provider that dominated the reviewed literature. This chapter features an analysis of data gathered throughout the Action Research study described in Chapters 3 and 4, in the form of both participant observation and recorded semi-structured interviews. The focus of this chapter is to examine any patterns or themes present in the data gathered that could offer suggestions as to how individual power may impact on community engagement. This chapter uses the qualitative data gathered during the Action Research study. It will also offer a further understanding of how the complexities of community power relations can affect remote and rural engagement. This is an area that has been largely ignored within the literature which is predominantly pragmatic and atheoretical, and it is hoped that by examining power at an individual level that it will lend further understanding to the complex reality of remote and rural community engagement for planning.

In order to consider the power relations at work within the communities in relation to healthcare redesign, a postmodern/poststructural approach to analysis and interpretation has been taken. Two methods have been used within this theoretical framework: a Foucauldian Discourse Analysis (Parker, 1994) of semi structured interviews, and a description of power as it was revealed during participant observation, which itself took place during the Action Research project. This chapter aims to analyse the findings of these data collection methods (semi-structured interviews and participant observation) in the light of postmodern/poststructuralist theory, specifically that of Foucault, as it relates to power and the use of discourse within the study. The analysis will also consider how the analysed texts relate to the Bases of Social Power theory advanced by French and Raven (1959) in order to further examine the types of power being created and held. By

looking at these issues through a postmodern analytical lens, it is the intention of this study to understand how power can be created in multiple ways by 'defamiliarising' and thus drawing attention to the basic unit of community engagement: language.

In short, the aims of this part of the study (discussed in this chapter) were:

1. to gain a better understanding of power relations at work within the specific case study sites; as examples of power relations in Highland rural communities
2. to analyse the qualitative data in such a way as to offer at least a partial explanation for variability in findings between case study sites
3. to add to understanding of the complexity of power relations at work within remote and rural community engagement, and their potential impact on process and outcome, and
4. to analyse the qualitative data in such a way that allows it to be situated in a larger societal context, by drawing attention to the wider discourses of power being employed by participants, using a poststructural framework of analysis

5.2 Postmodernism and Poststructuralism

This chapter will start by defining both Postmodernism and Poststructuralism, and describing how they are relevant to the study of community engagement. There is a large degree of acknowledged overlap between the two theoretical schools (Agger, 1991). Indeed, it is difficult to find an academic work that neatly separates the two traditions in such a way as to create distinct categorisations. Postmodernism and Poststructuralism are theories that stand in opposition to a modernist, and indeed a positivist tradition. Both theories reject, as Agger (1991) says, "*presuppositionless representation, arguing explicitly that such representation is both politically undesirable and philosophically impossible.*" (106) Postmodernism and poststructuralism, then, both reject the positivist assumption that there is an ultimate 'truth' that can be uncovered by social research, if only it is well designed. Both theories also emphasise the concepts of deconstruction, fragmentation, and flexibility, as well as considering study of language as key to understanding how social meaning is constructed. The work of Foucault (whose

understanding of power and discourse features heavily within this chapter) can be considered as being situated within both camps. Agger (1991) argues that Foucault's writings related to history and genealogy form some of the basic texts of the postmodern tradition, his writings on discourse fit more comfortably within that of Poststructuralism. Agger (1991) attempts to differentiate between the two schools by claiming that

“poststructuralism (characterised by philosophical ideas of Derrida and the French feminists) is a theory of knowledge and language, whereas postmodernism (characterised by philosophical ideas of Foucault, Barthes, Lyotard and Baudrillard) is a theory of society, culture, and history.” (112)

This differentiation is problematic when considering how power is both created by discourse and simultaneously situated in a wider societal context. It may be more helpful then, to consider poststructuralism as a set of analytical tools for use within a wider postmodern theoretical framework.

Postmodernism, as a movement, can signify anything from simply a rejection of the modern principles and assumptions of the ordered universe of the Enlightenment, to the works and techniques of specific theorists including Foucault, Heidegger, Baudrillard, Lyotard and others. According to Dear (1986) the postmodern takes on three different 'meanings': it is a style, an epoch, and a method (or group of methods). It is the latter form of postmodernity that is of most relevance for this study. In identifying the main features of a postmodern approach as it impacts on social research, Simonsen (1990) highlights the concepts of flexibility, fragmentation and deconstruction, the rejection of one single definitive 'truth', marginalisation, and a new emphasis on individuals and how they create meaning. Harvey (1989) explains that *“[t]he idea that all groups have a right to speak for themselves, in their own voice, and have that voice accepted as authentic and legitimate is essential to the pluralistic stance of postmodernism.”* A postmodern approach, therefore, fits neatly with the concept of community engagement and its emphasis on plurality in decision making.

Poststructuralism argues that *“in its claim to explain by unveiling an underlying structure, Structuralism is in the grip of another form of essentialism that presupposes a latent centre or core which gives rise to surface, manifest forms”* (Rice and Waugh, 1998:116). In other words, Poststructuralism rejects Structuralism for the same reasons that

Postmodernism rejects Modernism: the refutation of an ultimate knowable reality. Poststructuralism has been most strongly associated with the work of Derrida and his concept of deconstruction (Rice and Waugh, 1998, Agger, 1991). If we accept Agger's premise then, that postmodernism deals predominantly with wider social, cultural and historical themes, whereas poststructuralism focuses more on language and knowledge, both theoretical schools can be seen as two parts of the same wider tradition. Knowledge/language claims of poststructuralism (such as Derrida's theory of deconstruction) can be situated within a wider Postmodern socio-cultural landscape. When considering the concept of remote and rural community engagement for health care decision making, all of these areas of focus become important. Broadly, the techniques of analysis used in this chapter (in particular the FDA) can be seen as techniques of deconstruction, breaking down social texts in order to find underlying meaning, however they are situated within a postmodern tradition as well in order to create a link between these parsed texts and the wider social, historical, cultural and political landscape of community engagement. For the purposes of this chapter then, postmodernism will be considered as the wider theoretical tradition that the work is situated in, whereas poststructuralism is the tool that is wielded to carry out the work itself.

5.3 Community Engagement and Theories of Power

As was discussed in Chapter 2, the concept of power, and specifically the transfer of power, is key to theoretical constructions of community engagement. Since 1969 when Arnstein first proposed her Ladder of Citizen Participation, academics and practitioners have been describing community engagement, and recently the wider concept of co-production, in terms of a power shift away from powerful bureaucratic organisations (government or otherwise) and towards a previously powerless citizenry (Rifkin et al, 2000, Brodie et al, 2009). Or, to put it in Foucauldian terms, engagement exists on a virtual seesaw of capacity versus dominion: in order to maximise one you must minimise the other. In rural community engagement terms, this means that the acceptance of more power by specific communities requires that they will have to take greater responsibility, and, on the other hand, service providers may obtain more capacity but

will have to accept less control over service planning (Foucault, 1982). Criticisms have been levelled at Arnstein's dualistic 'see-saw' typology for being unsophisticated in terms of how it conceptualises the power dynamic within engagement (Tritter and McCallum, 2005; Wilcox, 1994; Burns et al, 1994; Choguill, 1996; Creighton, 2005). Tritter and McCallum (2005) point out that this dichotomization ignores the value of the process and focuses solely on degree of power shift as a means for judging the success of engagement. Such a view of the inherent 'powerlessness' of service users (unless power is *given* to them by an outside body) could be considered naïve; especially with the rise of new media such as the internet which has made it easier for service user groups including rural communities to protest about unpopular service change (Thomson et al, 2008). Arnstein's typology is also simplistic in assuming that the people within these two oppositional groups have heterogeneous power, meaning that within the groups themselves, power is equal. This aspect of Arnsteinian typology, however, remains largely unchallenged with a few notable exceptions (Tritter and McCallum, 2005; White, 1996). Studies of power in other contexts (such as Gaventa, 1982) have long been interested in the micro-dynamics of power *within* cohort groups; however accounts within the surveyed engagement literature for the most part continue to draw on Arnsteinian dichotomies. Having reviewed the literature to address research question 1, it is apparent that the majority of both academic and 'grey' literature pertaining to community engagement for health care design still maintain this simplistic oppositional model. There are a few, often notable exceptions to this trend (Doherty and Rispeil, 1995; Porter and Shortall 2009; Barnes 2009) but, in the majority of the literature surveyed, local power relations are generally mentioned in passing or as background 'colour', rather than analysed methodically for their potential impact. Failure of engagement to come to a unified decision is most frequently viewed as a methodological weakness. In terms of policy-related practical advice, the recent guidance note issued by the Scottish Community Development Centre to accompany the National Standards for Community Engagement (undated) is one of the few documents to draw attention to the potential for parochial pre-existing power relations to impact on community engagement for health. The issue remains largely downplayed within the academic literature, both in health and wider engagement literature.

Theories of Power

Drawing from the different academic disciplines, there are myriad theoretical conceptions of power dealing with how it is created, how it is wielded, and how it is transferred amongst individuals and groups. Power, as a concept, is of interest to almost every social discipline (McCall, 1978). Clegg (1989) traces the two main branches of current power theory back to the writings of Machiavelli ('The Prince') and Hobbes ('Leviathan'). Machiavelli, he argues, considers power as strategic and decentralised, in which individuals are constantly engaged in a struggle to gain total power over other individuals (33). Hobbes, on the other hand, considers power as hegemonic, as a centralised force that can exert influence over the populace for order, to subdue the inherent tendency of citizens to behave badly. Gaventa (1980) refers to this as the 'pluralist' school of power theory. According to Sadan (1997) the Hobbesian view of the power of the political community was dominant in the mid-twentieth century and was championed by theorists such as Weber (1947) who connected concepts of power with bureaucracy, and Dahl (1957) who moved the discussion of power into the boundaries of the community. Power, according to Dahl, was the production of obedience, the ability to make a person do something that they would otherwise not have done. Criticism has been levelled at Dahl's model, however, because of his assumption that community interests are "*represented by means of an open process*" (Sadan, 1997: 36). Later theories posited that while there was an overt power present in society (in the form of decision making processes, etc.), there was also covert power which was able to affect these decision making processes. (Sadan, 1997). This idea was advanced within the Elite school of power theory (Wright-Mills, 1956), in which the focus of decision making power shifted from wider government to a small group of ruling elite consisting of the politically powerful, the economically advantaged, and the well-connected (including the aristocracy). The concept of Elite Power, also drew criticism in its turn for focussing heavily on socio-economic standing and other forms of visible power but ignoring other potential dimensions of influence. In the latter part of the twentieth century Lukes (1974), and later Gaventa (1980), went a step further by postulating that not only did those with power have the ability to covertly influence decision making processes by excluding certain viewpoints or options, but that the powerful have the ability to actually influence peoples' thoughts and feelings on a particular topic.

Postmodern theories of power, also, reject the concept of a hegemonic source of power, but instead consider power to be something that is constantly being created and exercised, predominantly through the use of language and knowledge. Poststructuralism, and in particular Foucault, focuses not only on the individual that is wielding power, but also on the wider socio-historical context – the discourses – that this power is derived from and associated with. This could be considered more consistent with the Machiavellian school of thought than previous theories in the last hundred years. Michel Foucault, for example, was less interested in uncovering the individuals within a group who hold power over others, and more interested in how individuals employ different societal discourses to create, broker and transfer power. In other words,

“Foucault challenges the hierarchical view of oppressive power, arguing that power is a localised relationship of a multiplicity of forces, expressed through language and knowledge claims, particularly the knowledge-truth of scientific discourse.” (Wallerstein, 1999; p40)

Within the postmodern framework, the focus moves away from hegemonic power of the few and towards a consideration of the role individuals and factions within the community can play in decision making.

In the mid to late twentieth century, academics in the social sciences attempted to map out these power relations by identifying individuals within a community or organisation with decision making influence. Drawing on Elite Power Theory was Hunter’s (1953) concept of Community Power Structure, in which a ranked index of individual influence could be produced based on community members’ responses to a set of questions regarding decision making power. This popular technique within the social sciences emphasised the power of individuals within the community but fell out of favour following criticism for focussing more on an individual’s *reputation* for power and respondents’ interpretations of that reputation, rather than on an actor’s actual ability to influence (Wolfinger, 1960).

A more textured approach to understanding power comes in the form of the six bases of social power posited by French and Raven (1959). Rather than focussing on identifying those who hold power, French and Raven looked instead to create a typology of the

varieties of power that could be held. According to Raven, their bases of power framework:

“defined social influence as a change in the belief, attitude, or behaviour of a person (the target of influence) which results from the action, or presence of another person (the influencing agent). Social power was defined, simply, as the potential for such influence” (Raven, 1990)

According to French and Raven (1959), there are six essential ‘bases’ of power, or types of influence that can be held and exercised over others. These are summarised in the table below:

If someone in a social situation...	Has ‘authority’ stemming from societal position	Has celebrity or charisma	Has knowledge or skills that others need	Has ability to provide something others want or need	Has ability to apply negative consequences	Has facts that form the basis of a logical argument
Then they wield...	LEGITIMATE POWER	REFERENT POWER	EXPERT POWER	REWARD POWER	COERCIVE POWER	INFORMATION / PERSUASION POWER

Table 10: French and Raven's Bases of Social Power (1959, 1965)

Firstly, there is Legitimate (or Positional) Power. Legitimate Power is a form of authenticated power that a person obtains due to their station, which is often consensually agreed, for example in the case of an elected head of state, or a member of the police force, power is legitimated by consensus of the population. Legitimate/Positional Power is strongly linked to Weber’s concept of the power of the authority figure (French and Raven, 1959). Simply put, if one wields Legitimate Power, one says *"I have a right to ask you to do this and you have an obligation to comply."* (Raven, 1990) Secondly, there is Referent Power, which might also be encapsulated by the concept of celebrity. Referent Power involves the ability to attract others, to be

charismatic and to invite loyalty. This form of power is slightly more subtle as the object of power feels more implicitly compelled to comply with a request than through the use of other types of power. Thirdly, French and Raven include Expert Power; that is to be in the position of having skills or knowledge that is required by others. Fourthly, there is Reward Power, the ability to give material rewards in order to manipulate outcomes. If Reward Power is the application of positive responses, then the fifth base of power, Coercive Power, is just the opposite: the ability to apply negative responses or consequences. In short, Reward Power is the carrot and Coercive Power is the stick. Coercive Power, according to Raven and French (1959) is often associated with Legitimate Power as the subject of power will often allow themselves to be coerced by another actor because the subject accepts the 'right' of the actor to punish them. These five bases were joined later in 1965 by a sixth base of power, namely Informational or Persuasion Power. Informational Power is based on the application of information or a logical argument to persuade the object of power to a particular action, for example in the case of providing information on lung disease to persuade people to stop smoking as part of a public health initiative. French (1965), however, does qualify that Informational Power is not always the most persuasive type of power as it is often ineffective against those who hold entrenched positions on a particular subject.

Within these diverse theories of power there are attempts to classify the levels at which power is exercised, who it is exercised by, and the mechanisms through which power is wielded. All of these different dimensions of power have the potential to add depth to understanding power within the community, however, for the purposes of this chapter the focus will be on both postmodern theories of power (that is, how power is created by individuals through language) and on the social bases of power used by community members. In other words: how are individuals creating, denying or reinforcing power through language and which types of power are these actions related to?

Power and rural community engagement

Within remote and rural communities, the fragile, interconnected nature of health care services (Rosenblatt, 2004) the strong connection between health care practitioners and social capital in the community (Prior 2009, Prior et al, 2010), indicates that community

engagement for health care planning has the potential to strongly impact existing power relations by upsetting current positions of power within the community. Consequently, an examination of the impact of local power relations on community engagement processes could prove useful, not only in helping to understand variable findings for different communities within a study such as this one, but also to contribute to a better understanding of the contextual complexities of carrying out engagement for service design in remote and rural areas, and potentially even more widely.

As previously mentioned in Chapter 1, the use of the term 'community' within social sciences research is fraught with contested meaning. It is often used without explanation of the specific interpretation or theoretical basis of use and with "*minor attention to the complexity of the term*" (Liepins, 2000). It is often simply applied as a reference to either geographical communities or communities of shared interest. In a review of uses of the term community in social sciences research, Liepins (2000) argues that the term has been used, variously, to describe relatively stable entities (with observable characteristics), specific geographical localities, fixed objects that can be described through ethnographical study, and symbolic constructs created through a web of social relations. These conceptualisations can be problematic as a foundation for postmodern research as they tend to consider community as static and knowable. In addition, they do not necessarily take into account the shifting power relations that, according to Foucault, are inextricably linked to the concept of community. (Liepins, 2000; Foucault, 1982). Rather, Liepins draws on previous conceptualisations and suggests a new approach, one that "*recognises the variable terrains of power and discourse shaping the contextual ground in which the notion germinates*" (33), and that includes both the potential physical aspect of community, along with the shifting and complex social interaction that can take into account the postmodern "*polyphony of rural voices*" (33); both the cultural and the material. To that end, the 'communities' referred to in this thesis have several dimensions. In the first three chapters the term 'community' has been, for practical purposes, shorthand for four geographical localities, bounded often by either physical geography (in the case of the two island sites) or by a more complex negotiation of different boundary indicators including health care service area, postal code areas and voter registries, and local understandings of geographical community. This chapter, however, will attempt to flesh out the "*variable terrains of power and discourse*" (33)

within the four communities and, in doing so, add a layer of understanding as to the variable outcomes of engagement encountered in the Action Research project.

John Gaventa, in his 1980 book *Power and Powerlessness*, built on the earlier work of Lukes' (1974) to consider a new way to approach the analysis of community power. Gaventa expands on Lukes (1974) postulation that there are essentially three dimensions to studying power in these contexts, which relate to the wider theories of power discussed in the previous section. The one dimensional theory of power in the community is, as Dahl (1969) believed, that an individual has power if they can make another individual do something that they would not otherwise do. Within this one dimensional view of power, the emphasis is on action. Community power could be studied at this level by looking at who makes decisions locally and who gains and loses by those decisions (Gaventa, 1980:5). This assumes that decisions are made in a neutral but formal way, and that this process is equally available to everyone (the pluralist view). The two dimensional approach to power, is that "*power is exercised not just upon participants within the decision-making process but also towards the exclusion of certain participants and issues altogether.*" (Gaventa, 1980: 9). In other words, the second dimension of power in the community no longer assumes that power can be accurately analysed by looking at the results of a local decision making process; it recognises that behind the process other manoeuvrings related to power in the community could occur. At this level, community inaction and a lack of participation become interesting as indicators of power as well. While some elements of this dimension may be observable, for example if a particular group is obviously excluded from taking part in decision making, many aspects will not be observable as power relations may lie in non-participation, in essence only in non-events. The third dimension of power goes beyond these first two conceptualisations, and examines the possibility that power in the community is exerted not just to make someone do what they do not wish to do, nor simply to keep particular issues or people from influencing decision making processes, but in actually affecting the *desires* of the subject of power. In other words

"Not only might A exercise power over B by prevailing in the resolution of key issues or by preventing B from effectively raising those issues, but also through affecting B's conception of the issues altogether." (Gaventa, 1980: 12)

This third approach requires a more subtle investigation of power within the community, looking not only at its results but also at the subtle mechanisms for potential influence including the study of *“social myths, language and symbols, and how they are shaped or manipulated in power processes”* (Gavanta, 1980: 15) and therefore lends itself to the more richly contextual study of ethnographic-style research.

Within a rural community engagement and planning context, local power relations have the potential to impact on outcomes. Reed, in a 1997 study on the impact of local power relations on community-based tourism planning, noted that it is frequently assumed in engagement fore planning (or co-planning) literature that the involvement of all relevant stakeholders in planning decisions will act to overcome local power relations, in other words co-planning theory often operates under the auspices of the one-dimensional approach to power; assuming that creating a mechanism for engagement will allow for equal power distribution in decision making but, according to Reed (1997) that is not always the case. She notes that those who traditionally hold power *“may resist its redistribution, thereby hindering attempts for collaboration”* (589). In addition, she states that this resistance is not something that can simply be overcome through the use of better technique or method, but something that is endemic to co-planning, and therefore a thorough understanding of power relations is critical to understanding why some engagement succeeds and why some fails. Considering this proposition from the third dimension of power, studying the *“social myths, language and symbols, and how they are shaped or manipulated in power processes”* (Reed, 1997: 589) could help provide a richer understanding of how power in the community impacts on community engagement and planning.

5.4 Planning, Power and Discourse

The postmodern approach can be an apt fit for an examination of engagement on a local, community case study basis because:

“[p]ostmodernism with its rejection of rational objectivity and universality, legitimises a move towards an engagement with diversity and fragmentation, epitomised by the community and the local state. Postmodern thought, as it has

developed through art, architecture, and the social sciences, has come to embrace locality, localism and the political movements that have emerged from this identity” (Harvey, 1989).

The challenge, however, is that while the idea of community engagement may fit well within a postmodern framework, contemporary health care planning structures arguably do not. Current NHS service planning, it could be claimed, is rooted firmly within a modernist understanding of the world. In other words, it is based on the assumption that *“reality can be controlled and perfected and that a universal internal logic may be uncovered which can be rationally and objectively manipulated by those with the appropriate professional expertise”* (Hedgcock, Hillier and Wood, 1991:221). Health care service design and planning are based on the quantifiable; on the analysis of aggregate data and standardised assessment. A postmodern planning perspective would, according to Freedman and Combs (1996), be more concerned with finding meaning than with objective ‘facts’. It could be argued that the introduction of community engagement is forcing the NHS to try to take on a more postmodern approach to planning which creates a definite challenge: how to fit the very postmodern results of engagement (often a cacophony of local voices rather than one single ‘community decision’) into a modern planning framework. In the postmodern perspective, every individual has a view, that view is changeable and influenced by dominant societal discourses: power is fluctuating and not always readily visible. Communities, as continually changing entities, can no longer be objectively ‘mapped’, within the postmodern frame of reference. NHS guidance, however, still considers engagement as a ‘solvable problem’: a part of a positivist paradigm with a beginning, middle and end. The recommended tool for NHS engagement, at present, is VOICE, an interactive online planning tool that encourages staff to follow a basic model of Plan, Act and Assess. The previous chapter, however, illustrated just how damaging this paradigm can be to the creation of sustainable working relationships between community and health service managers (see Chapter 4 conclusions). A postmodern perspective to engagement, on the other hand, would view engagement as an on-going conversation, a constant negotiation and renegotiation, and therefore a process without end. In fact, Porter and Shortall (2009) argues that this is a significant drawback of the postmodern or, as they conceptualise it, a ‘relativist perspectivism’ view of engagement. Porter and Shortall argue that the postmodern view

of engagement, when taken to its extreme, affords all viewpoints equal priority and refuses to acknowledge one as the overarching 'truth', essentially hindering decision making and, they argue, belying hidden power relations. They argue instead for the use of 'perspectivism', whereby "*research takes account of differing perspectives in order to build up a more rounded and valid understanding of the policies and processes being researched*", under the guise of realism. Although this study was concerned with community engagement as part of a research study, not in public service decision making, similar issues apply. Porter and Shortall's main objection appeared to stem from the fact that, within their stakeholder engagement process, their opinions as academics were being 'devalued'. If community engagement is to continue to be a priority for the NHS, knowledge of which discourses are being used to which purposes can serve to further illuminate the continuing discussion, although whether these alternative discourses can be accommodated within the dominant modernist/positivist/managerial paradigm of NHS planning remains to be seen.

As was previously mentioned, power in community engagement is often viewed in terms of a binary narrative of Community vs. NHS, however, a postmodern approach can challenge the researcher or practitioner to discard this dominant narrative and accept the more complex and messy, but more contextually explanatory notion of a plurality of competing voices, and the shifting negotiation and renegotiation of power that could be said to occur throughout the process by and for all participants. In order to get to grips with this fragmented view, this complex web of power relations, it is necessary to apply a more micro-analytical form of inquiry. In short, to look more closely at how power is constructed and brokered, this chapter will examine language as the basic building block of engagement, and will examine the social texts created as part of the engagement (in the form of interview transcripts) for evidence of dominant discourses and power relations. This approach appealed to me as a researcher as, during the engagement process, I was in the position to observe individual community members and their influence over the engagement process, and was particularly interested in the different ways that community members would frame the same service or action using language and how the action of selecting different words and phrases influenced other engagement participants. From my perspective as an outsider in all four communities, it

seemed to me that the way in which issues were framed strongly impacted on the actions that were taken around these issues, and therefore I selected FDA as a methodology in order to examine the use of 'frames' in a more in depth way, linking them to wider societal discourses.

5.5 Foucauldian Discourse Analysis

"[S]ocial texts do not merely reflect or mirror objects, events and categories pre-existing in the social and natural world. Rather, they actively construct a version of those things. They do not just describe things; they do things. And being active, they have social and political implications" Potter and Wetherell (1987)

In the above quotation, Potter and Wetherell put forward a distinctly Foucauldian view of how our use of language is one of the primary ways that we, as social actors, create and broker power. Language, according to Foucault, is not a passive descriptor, it is not a neutral vehicle for communication, rather, it is a means to construct a social reality of the speaker's choosing. According to Foucault, one of the ways in which social actors create these realities is by drawing on previously existing discourses. The term discourse has a multiplicity of meanings, often dependent upon the academic discipline discussing it. For Foucault, it had a much more narrow meaning than simply conversation or discussion. For the purposes of this chapter, the term discourse will, as Foucault advocated, denote a group of words or phrases which, when used together, can form a social, political or other type of 'object' (Foucault, 1971). For example, the use of complex epidemiological terms could denote a medical discourse, which may have one meaning within an overtly medical context, such as a practitioner's conference, but may have quite another if used within a social context. Therefore, it is interesting to consider which discourse is being employed, and what meaning the discourse has when used in a particular context.

As Wooffitt (2005) explains, in a *"discourses [define] systems of meanings which reflect real power relations, a consequence of the material and economic infrastructure of society"* (Wooffitt: 146) In other words, if one were to examine the discourses employed by people in a particular context, it is possible to extrapolate from these discourses the 'real power relations' at work in that particular context, whilst simultaneously placing the fragment of examined text in a wider socio-political context. This is not to say that people

always employ one recognizable discourse at a time to consciously make a point, rather, several discourses can exist together in one short section of text in something of a heteroglossia of discourses (Bakhtin, 1935) which can be more or less consciously employed, however this does not make uncovering these discourses any less illuminating. This chapter is underpinned by postmodern understanding of discourse and power, that is to say the analysis that takes place here accepts the postmodern premise that a plurality of power exists within any given community, and that different societal discourses are used to create and broker this power by individuals. It is reasonable then, given that any community engagement initiative is, at heart, a series of conversations; that a basic 'unit' of study when analysing an engagement exercise would be conversation, language or discourse. Following on from this, it is also consistent that, if the basic unit of analysis is the language used within the context of the engagement exercise, that examining this language for both the cause and effects of power could yield illustrative results, therefore, it was decided to take a discourse analytic approach to analysing the semi-structured interview data generated in the study of community engagement. Examining the qualitative data in this way also addresses what several theorists have identified as a basic weakness of most social research (Wooffitt, 2005; Potter and Wetherall, 1987; Parker, 1992), namely the presupposition that language is "*unproblematically and simply descriptive*" (Potter and Wetherall, 1987: 6). Simply put, there is an assumption within the social sciences that what people say and the descriptions that they give can be taken at face value. A Foucauldian approach, in contrast, considers the individual discourses present in a text, how they interact and the rules that they place upon the conversation about what may and may not be said, which can allow researchers to look beyond the face value and discover how power is being constructed and by whom. A closer examination of employed discourses can help to examine why respondents choose to present information in a certain way, and what this means in terms of promoting or repressing certain people or ideas.

Discourse analysis, as a methodology, is a nebulous concept for many academics (and many non-academics too). There are, it could be argued, as many methodologies as there are researchers. According to Potter and Wetherall (1987) discourse analysis is a field in which "*it is perfectly possible to have two books on...[the same topic] with no overlap in content at all*" (6). Forms of discourse analysis and conversation analysis associated with

psychology can be highly complex linguistic investigations, in which the subtlest nuances of pauses between phrases, or where emphasis is placed on particular words, can be used to draw out meaning. (Wooffitt, 2005) Conversely, discourse analysis can also be used in a broad way to try to parse meaning from such social texts as policy documents or even advertisements (Parker, 1994). Unlike other forms of conversation analysis and discourse analysis though, discourse analysis associated with Foucauldian theory (FDA) is less focused on the subtleties of semantic and semiotic construction, and more concerned with linking the phrases and words found in everyday speech with wider socio-historical discourses to uncover how these discourses are used to create and broker power; to empower some and constrain others. In other words, FDA, like other methods derived from postmodern/poststructuralist theory, is more concerned with the *meanings* the text holds for the writer/speaker, rather than finding an objective truth or reality within the text.

While it may seem slightly esoteric for such a pragmatic and outcomes-focused subject as health care service planning, Foucauldian discourse analysis has been used within a sociology of health research context. FDA has been employed for range of research purposes including the analysis of societal influences on women's experience of involuntary childlessness (Kantor, 2006), an examination of the extent to which dominant discourses are reflected in patients' talk about health and illness (Mackey, 2007), gaining a better understanding of nursing documentation and practice (Heartfield, 1996), and an examination of the discourses of informal care and how they help to construct the identity of carers (Heaton, 1999), to name a few. According to Cheek (2004) FDA can help researchers to understand the potential constraining effect of a particular discourse in health care, and thus can make it "*possible for a new space to be opened up for other discourses or ways of thinking*" (1143). FDA also draws attention to the ways in which certain discourses are used to condone or limit certain ways of framing health care issues which can have consequences. For example, Graham (2005) cites the discourses used to describe attention deficit hyperactivity disorder (ADHD) and how the medical establishment's use of a variety of terms including 'deficit' help to define it as something lacking, most specifically control. By using this particular discourse around the illness, it frames it as something potentially *within* the patient's control, which can have implications for how ADHD is treated and how an ADHD patient feels about themselves if

they are unable to self-manage the illness. In other words, discourse analysis can be described as an act of both deconstruction and what Victor Schklovsky (1998) refers to as 'defamiliarisation' (similarly to Derrida's concept of 'différance'): it makes explicit the implicitly held assumptions that underpin everyday language and, by so doing, allows people to rethink their assumptions about the objective nature of truth and knowledge construction.

According to Graham (2005)

"[T]ext work through discourse analysis drawing on Foucault aspires to dissect, disrupt, and render the familiar strange by interrogating, as Foucault (1980a: 237) describes, "the discourses of true and false...the correlative formation of domains and objects...the verifiable, falsifiable discourses that bear on them, and...the effects of the real to which they are linked" (4).

By thus examining the qualitative data produced as part of the Action Research project, it is the aim of this chapter to uncover the dominant discourses being employed by community members as part of the RSF engagement process (specifically during unstructured interviews) and thus help to understand how meaning can be constructed about health care and their community. FDA can also facilitate better understanding of which discourses and people are marginalised by the dominant discourses and how this could be complicating community engagement activities.

The advantages of using FDA within this context are therefore primarily that it allows the researcher to:

- identify and describe discourses and thereby power relations within the text,
- examine the data contextually, while at the same time allowing it to be historicised within a wider set of public discourses, and
- examine the data in such a way that does not consider it to be unproblematically representative.

FDA as a methodology is not without challenges. Criticism has been levelled at FDA for being, overly complex, overly interpretive, and overly subjective to the point of invalidity. As the current climate of social research continues to privilege a positivist paradigm (Graham, 2005) it can be challenging to defend a methodology in which analysis is

considered to be more an *“interpretive art”* (Edwards and Nicholl, 2001) than scientific scrutiny, however, as previously mentioned, the postmodern/poststructural perspective emphasises that all social research is an act of interpretation and it is only through making bias explicit that real meaning can be found. When addressing challenges to research validity within a positivist paradigm, triangulation of data is often used to strengthen a weak methodology. Triangulation, however, assumes the existence of an ultimate reality that may be uncovered by examining the data from different angles. Since the postmodern/poststructural paradigm eschews the notion of a knowable truth, Miller (1997) instead posits *“using several methodological strategies to link aspects of different sociological perspectives, not to discover indisputable facts about a single social reality.”* Instead of triangulation that focuses down on one particular reality, Miller (1997) instead uses the metaphor of a bridge to explain that the use of several methods may help to link social texts to wider societal discourses and, therefore, shed more light on how these texts are used to create meaning. To this end, it is anticipated that the use of Participant Observation in addition to the FDA within this chapter will help to further illustrate the meaning behind the discourses and themes found within the texts by ‘bridging’ a better contextual understanding between the discourse analysis and the researcher’s actual experience of being in the community.

The examination of power relations within the texts was a twofold process. While the FDA was used to examine discourses employed and thus more implicit creation of power through the speech itself, the analysis also examines the actual statements and descriptions of power relations within the communities that respondents gave. To put it another way, within the FDA process, the aim was to examine both implicit and explicit references to power within the community.

5.6 Methodology

Selection of Texts

As previously mentioned, the Action Research project described in Chapter 3 generated a large amount of qualitative data, including individual semi-structured interviews. A more detailed description of these interviews, both in terms of methodology and findings, can

be found in Chapter 3. While 39 interviews were undertaken in all, the first round of interviews in each community were conducted in an informal manner (i.e. as unstructured and often unrecorded conversations), to obtain background information to help shape engagement activities as well as functioning as an engagement activity themselves, and therefore were not recorded. On subsequent return visits to the four communities, respondents were asked if they would mind being recorded, however, several declined. Even among those who were willing to be recorded, respondents sought reassurance that there was no way that other community members would have access to the recording. This led me, as the interviewer, to assume that one of the chief sources of discomfort for respondents was the perceived potential for other community members to hear and disapprove of their expressed views. It may also indicate a degree of distrust with myself as a researcher and 'an outsider' to the community. There was, therefore, a limited pool of transcribed interviews to draw from: in one community there were actually no recorded interviews, and in another only one. Where there were several recorded interviews within a community, transcripts were selected to obtain a variety of views from respondents from a variety of self-described backgrounds and positions within the community. These transcripts were categorically *not* selected to be representative of the wider views of the community, but rather to serve as examples of the way in which individual community members use discourse within a one-to-one engagement context. Therefore the selection of interview transcripts includes:

From Community A: Respondent 1A, 2A, 3A

From Community B: Respondent 1B, 2B, 3B

From Community C: Respondent 1C

These respondents included:

- One community council member who was also a local business owner (C1), one locally-based health care professional (B2),
- one middle aged single individual (B3),
- two older, retired individuals (A1, B1),

- one young parent active in the community (A3), and
- one local business owner/entrepreneur (A2).

Due to the dearth of transcribed interviews from two areas, the FDA therefore is predominantly focused on two of the four communities. While this is disappointing, it does allow for a more in depth analysis of these two communities than would normally have occurred, given the in depth and time consuming nature of FDA. Participant observation, on the other hand, was taken from all four community sites. Only verbatim transcripts of interviews were included for analysis. It was decided to exclude hand transcribed interviewer notes as an object of analysis for several reasons. First of all, when more than one interviewer was present, there was a variation in what was recorded by hand by the different interviewers]. Also, a shorthand method of distilling meaning from phrases (i.e. notes) was used, meaning the direct wording and complexity of phrasing was lost. According to Potter and Wetherell (1987)

“verbatim transcripts are very different both from our intuitions about speech and from our later recollections of conversations. Part of the reason for this is probably the difficulty of escaping from our literary conventions for representing speech in written form” (13).

In other words, when conversation is noted by a researcher, the very act of taking notes during an interview is an act of translation, an act in which the researcher decides in that moment what is important about what is being said and jettisons the rest. Therefore, only fully transcribed interviews were analysed for this study in order to create a comprehensive basis for discourse analysis, and to preserve discourses which may be lost through the interpretive process of note-taking.

Texts for analysis were selected in the following manner: firstly, all transcribed interviews were initially analysed using NVivo software, looking for either implicit or explicit references to power. Transcripts that made specific reference to power structures (such as local community council or other organisations) or power positions (such as local business owners, local doctor or local lairds) within the community were selected for analysis, (predominantly in order to ensure that it was possible to look at how these ‘traditional’ power holders could be framed by different discourses, in addition to how

interviewees framed themselves and their fellow community members) with three transcripts being selected on this basis from each of two sites and one transcript from the third, as it was the only transcript available from this location. Seven transcripts were selected to get a flavour of the complexity of discourse and power present. To reiterate, these transcripts were *not* selected to be in any way representative of the views of the communities involved, but rather to paint a picture of the discourses of power present within a small selection of individual engagement interviews, as an illustration of the way that language can be used to create and broker power within a remote and rural engagement context. As Parker (1994) argues,

“rather than fetishize ‘consistency’, researchers into language should focus on variation, that variety of what [is] called ‘interpretive repertoires’ constructed a sense of what was going on for members, and that language understood in this way functioned in the world rather than simply represented it” (94).

The findings from these texts were compared, for, as Bondarouk and Ruel (2004) point out, texts lose relevance when considered individually. Discursive activity does not “*occur in a vacuum*” (5) and therefore the texts should be considered within the wider contexts in which they occur.

Because the focus of research question three is on the power relations present within the communities, only respondents who lived within the areas initially delineated as the ‘communities’ were included. This decision was made in order to focus more clearly on power relations within each area but this is not to say that there were not power struggles between NHS management and the community group, as classically defined within the literature. The purpose here, however, is to expand on that traditional binary construct and ‘flesh out’ the picture with local power relations that could affect engagement. Reference is made to some of the most striking incidences of management versus community power struggles in the previous chapter. The selection of texts in which power positions were mentioned, as well as the selection of only recorded and transcribed interviews (which may have eliminated those without strong convictions either way) may well have produced a biased sample towards those with more extreme views, however, to reiterate, the aim of discourse analysis was not to provide a comprehensive and representative set of community views, but rather to examine the ways in which discourse can be used by *any* community member in order to influence

discourse. The use of participant observation data later in this chapter was used to link discourses to observed actions.

Analysis

Selecting the methodology for the analysis was perhaps the most challenging aspect of carrying out FDA. While other forms of discourse analysis may follow strictly prescribed stages, the challenge with FDA is that a prescriptive methodology is at odds with the very basis of the Foucauldian postmodernist perspective. The postmodern/poststructural approach, as previously mentioned, eschews claims of objectivity or knowable truth (Graham, 2005). The challenge is, therefore, *“how can one remain open to poststructural “undecideability”...without being accused of unsystematised speculation?”* (Graham, 2005: 4) As previously mentioned, criticism has been levelled at FDA as a methodology for being too *“broad”*, and for a *“general lack of explicit techniques”* (Morgan, 2010). As Morgan (2010) points out, *“[a]s with all critical theories, discourse analysis is not a hard science, since it is a deconstructive reading and critical interpretation or construction, and there are no strict guidelines for analysts to follow”* (5). There are a number of researchers who do employ a highly prescribed methodology for conducting FDA (including Parker (1994) who outlines no less than 20 defined steps for carrying out the analysis), however it is difficult to reconcile this highly prescriptive methodology with the principles of postmodern/poststructural analysis. At their most basic, FDA methodologies (if that term can be used) generally follow the same simple framework: to identify wider societal discourses within a text, to identify objects within the texts, and finally to consider how the discourses relate to the objects and what implications this has for either empowering or constraining the object. Although this is a great simplification of the work of some analysts, at its heart these steps appear to form the basis of discourse analysis based on the work of Foucault.

As the scope of this analysis was to give context and understanding to data collection that had already occurred, rather than to be the focus of an entirely new research undertaking, a methodology that tended towards the complex end of the analysis spectrum was outside the time and capacity of the study. After deliberation it was decided that a pared-down, simplified approach to FDA would be an appropriate way to

proceed. Given that the background to this research is neither strictly rooted in psychology nor in linguistics – where most of the complexity from other methodologies lie, the decision was made to use FDA in the most straightforward way possible and to maximise its usefulness within the research context whilst minimising the potential for error in straying too far into a discipline in which the researcher has no background. This pared down approach to FDA has been used with some success in previously cited health care related studies and appeared to be a pragmatic approach to analysing the data. Based on the example provided by Graham (2005), analytical guidelines were created, rather than a detailed, set methodology. These guidelines were:

1. Conduct a close reading of interview transcripts, identifying overt references to power in the community (positions and structures).
2. Follow with a second close reading, identifying the use of particular discourses (a group of words or phrases which, when used together, can form a social, political or other type of 'object')
3. Conduct a more detailed analysis of discourses employed, looking specifically for how the discourses were used, trends in discourse use between respondents, which discourses were dominant, and how discourses were used to either empower or censure *objects* within the text (to understand how the use of certain discourses in relation to objects/people can dictate their behaviour and whether that behaviour is to be considered acceptable or not.)
4. Group discourses into themes and consider how the use of these discourses is related to particular dimensions of power and how they may have impacted the engagement process.

5.7 Reflexivity

As previously mentioned, one of the predominant criticisms levelled at postmodern/poststructuralist analysis, and at FDA in particular, is that it is heavily dependent on the interpretation of the researcher for its findings and therefore runs the risk of being so heavily biased as to be considered invalid. While the heavily interpretive

nature of FDA cannot be denied, proponents of postmodern social research argue (Potter and Wetherall 1987) that *all* forms of social research contain researcher bias, including positivist or quantitative research, but that these forms of research do not go far enough to make that bias explicit. The act of analysis – even the analysis of statistical data - is, by its nature, an act of interpretation or translation. The difference, however, is that postmodern researchers believe that there is no overarching narrative, no one knowable scientific ‘truth’ to be arrived at and therefore any interpretation of the data is as valid as another *as long as the perspective of that interpretation is made clear*. In other words, all research is inherently biased and therefore the researcher must make that bias explicit in order to allow others to understand the *meaning* of the findings. This is especially important in community based social research because, as Wallerstein (1999) explains it, the “*exposure of one’s own stance and the deconstructing of one’s own ideology establishes the researcher as only one player in the telling and interpretation of stories and disrupts the researcher/community imbalance of power*”(43).

To this end, I would like to offer an explanation of my own positionality within the study and make explicit any potential sources of bias that I may bring to the collection and interpretation of the data. In addition, as the analysis I have undertaken is directly related to power relations that occurred during an engagement process, it is also appropriate to acknowledge the power that I held as part of that process, as I and other participants may have perceived it. In this section I will describe my positionality as I believe it relates to the interviews that were conducted. Later, in section 5, I expand on this to describe my positionality as it relates to the participant observation portion of the study.

Firstly, I approached the study from an academic perspective, rather than that of a health service manager, practitioner or even from a community development perspective. As an academic researcher, I acknowledge that I may have been perceived by the community as having particular bias towards gaining academic knowledge at the expense of practical application of findings, although this was not my intention within the knowledge exchange project. Coming from an academic background I acknowledge that I possessed a potentially alienating tendency, particularly at the start of the engagement, to use academic language in a way that may have distanced me from respondents. I believe this tendency was mediated by my status as a young woman who had grown up in a rural

environment and therefore was not necessarily perceived as being totally without understanding of the challenges of rural living. As a non-Highlander, and indeed a non-Scot, it is possible that to some respondents my status as an outsider within the four communities may have been compounded. On the other hand my Canadian nationality and 'strange accent' often served as the starting point for conversations and acted as an ice-breaker in potentially challenging social situations during the engagement, since many of the respondents in the four Highland communities had some link to Canada in the form of emigrated relatives. For the most part I did not feel like my female gender strongly influenced how I was received by community members, however there were a few isolated occasions, particularly with men in positions of traditional authority (local government, medical personnel, etc.) in which I felt that my perceived power was diminished by my gender and, also potentially, my relative youth. This impression was usually triggered by the use by respondents of dismissive monikers when addressing me, such as referring to me as a 'young girl', despite the fact that I was present in a professional capacity.

As the Action Research portion of this thesis was undertaken as part of a UK Government Scheme – as a Knowledge Transfer Partnership Project between the university and the NHS, there was commitment on my part to help provide some practical and applicable guidance for NHS managers with regards effectively engaging with remote and rural community members. This necessitated a close working relationship and often involved travelling to communities with NHS managers. This fed suspicion among some (although not all) community members, particularly in Communities A and B, that I was not the independent mediator that I purported to be. Although I attempted to clarify my position on several occasions (that I was employed by the university and was there to mediate engagement, not to champion a particular 'side'), both publicly and privately with individual community members, pre-existing suspicion of and ill-will towards NHS Highland based on previous dealings was so high in all four communities and there was an aspect of my being 'tainted by association'. Also, as the project went on, a difficult economic climate began to affect state-funded public services in earnest and, on occasion, there was some confusion about where the funding for the project originated. It was not a frequently expressed concern but in one of the communities there were comments from an individual participant about whether money had been diverted from

core health care budgets to fund research projects such as this that were, by implication, a frivolous use of money; a view that could definitely have influenced that participants' view of the engagement process.

In terms of potential sources of ideological bias, I approached this study with a background in management and cultural research (having both an MBA and a Masters in literature and cultural studies) and a strong ideological belief in the empowerment and strengthening of rural communities. Although part of the remit of the project was to help communities explore potential new models for service delivery, my personal bias may have been towards maintaining strong rural communities and away from anything that would be perceived as a reduction in quality or a cost cutting exercise. This is partly due to the fact that, as a university employee I had no direct or indirect responsibility for reducing a budget or facilitating the implementation of cost-savings and was therefore primarily beholden to my own ideological and ethical beliefs, as well as the core project aims. Also, as a researcher I approached the study with the theoretical understanding that health professionals contribute more to rural communities than just their clinical role; a view that was influenced by the literature review undertaken as part of this project, and also by previous academic work published by my thesis supervisor. At times during the Action Research project I found it very frustrating when community members challenged my position, occasionally implying that I was either being less than truthful about my role in the engagement or that I was being used as a "puppet" by the NHS, especially as this ran so contrary to my personal beliefs about why I was conducting the study.

In terms of my perceived power within the community, my association with the university may have given me a degree of what French and Raven (1959) refer to as Expert Power. The (erroneous) belief amongst some community members that I was more closely associated with the NHS than I was may have led them to infer that I also held a combination of Legitimate and, by extension, Coercive power, in that they may have believed I could influence their present and future service delivery, and this was most frequently perceived in a negative light. In addition, I was responsible for facilitating the engagement events within the community which put me in a position of quasi-Legitimate Power for the duration of the engagement. The only form of power that I consciously

employed was that of Informational Power, as I was in a position to find specific information (for example service data and cost information) from the NHS for the community, although this was not used to further any particular end other than moving the engagement process forward in an informed way.

In addition to my ideological position potentially influencing the way in which I interpreted the data, community perceptions of my position may have also affected the way in which community members interacted with me as a researcher, and therefore may have affected the way in which they interacted with me during data collection. The interviews examined here were all conducted by myself, but were occasionally also attended by another researcher who had accompanied me to the community in order to provide facilitation support for the group events, often the Principal Investigator of the Knowledge Transfer Partnership project or a colleague from the Centre for Rural Health. It should of course be noted that the discourses employed in these interviews may or may well have differed given a different audience, such as if the respondent were speaking to their fellow community members with no outsider present.

5.8 Findings

Findings from the FDA are described below, starting with a section on overt references to power found in the transcripts and followed by thematic groupings of the discourses found. Remember, transcripts were not selected to be *representative* of the views of the overall communities, rather they are illustrative of the complexity of power relations within the case study areas and how certain discourses can be used by engagement participants to further particular agendas. As such, the focus in the analysis was on power relations that exist *within* the case study sites. Nor are the findings below intended to be an exhaustive list of all discourses employed by respondents or all power relations referenced. The findings below are based on common themes among discourses employed by all respondents and reflect the dominant discourses found within the texts.

Overt References to Power

As previously mentioned, the first thing that the interview transcripts were examined for was overt references to power within the community. Within the interview transcripts, respondents recognised and made explicit reference to a number of existing power relationships based within their communities. Most of these references were to, what French and Raven (1959) would consider Legitimate Power positions including local development companies, local medical services (doctors or nurses), individual community leaders and members, and local community councils. In some cases, these references served to reinforce the power of these people or organisations, in others it undermined it. Sometimes so-called 'legitimate' power was considered to be wielded either inappropriately or ineffectually, however, Legitimate Power sources were recognised as playing a semi-formalised role within the community that, in theory, lent them a certain amount of power.

Local 'Legitimate' Bodies

Community Councils and organised committees that were cited as being based within the community and having influence within the community would fall within French and Raven's definition of holding Legitimate Power. Community councils, according to the Scottish Government, are *"the most local tier of statutory representation in Scotland. They bridge the gap between local authorities and communities, and help to make public bodies aware of the opinions and needs of the communities they represent"* (Scottish Government 2012). These organisations are not unproblematically representative. One respondent, when describing local power structures said: *"I withdrew from all the committees and all the processes and now I live out in the world."* (A1) There is a strong indication here that local 'committees' and other local governance structures are not part of the wider world of influence, and therefore lack legitimacy and power. When the respondent was asked if this made it difficult to participate in local decision making the respondent replied: *"No, not at all. I go direct to the Scottish Government now. And to the appropriate MP"* (A1). In this further statement the respondent reinforces the authority of the Scottish Government and its MPs as a higher power than existing local governance structures and thus disempowers the local structures by the comparison. Community

councils were also frequently cited as problematic vehicles for local power and were characterised by respondents as being “*very ineffective*”(A1) or focussed on “*personal agendas*”(A1). This, however, was not a universally held view as another respondent cited their local community council as helping to facilitate engagement with the NHS. In a different interview, a local community development company was also cited as being ineffectual: “*it’s failure, failure, failure, failure, just endless, the number of failures, no successes.*” (A1). Conversely, reference was made to a local action committee which, although informal, appeared to have gained Legitimate Power within the community and which was able, when needed, to “*shake the local authorities’ tail feathers.*”(A3) In short, references to local ‘legitimate’ organisations of power within the community illustrated varying levels of perceived influence within the different communities, and some organisations that would not necessarily be viewed from outside the community as an organisation of Legitimate Power were considered so by community members. Views on which local groups or organisations were considered powerful or legitimate varied by the respondent. In other words, the same ‘legitimate’ organisation might be considered powerful by some members and not by others.

Individuals in Positions of Power

Within the transcripts, overt references to individuals with power tended to be to those inhabiting positions of ‘legitimate’ power. While the most frequent reference to individuals in legitimate positions of power was in relation to a local health care practitioner – usually either a GP or a District Nurse (which will be examined in more detail in the next section). Two respondents also made specific reference to a lack of strong individual leadership in their communities. One respondent summarised the struggle for local power, thus:

“They’re all vying for position, and I keep seeing, I’ve got this mental image of this little pond, full of big fish. And there just isn’t enough water. So it’ll sort out, you know, some of the fish will get cooked and eaten.” [A1]

In this analogy, the jockeying for local power occurred within a group of potential leaders from within the local community. They characterise power relations as being in a state of flux and the community as suffering from an overabundance of potential leadership

positions. The reverse problem was evident in another community in which one respondent expressed the belief that, rather than a 'leader', what the community had was *"the same old people, the community council, the whole committee and development company are the same people moving around with different hats on."* (B3) This respondent pointed to a dearth of local leadership and also indicated that positions of power were, at present, being taken up by incomers to the community, which should rightfully go to someone local. This theme of local/incomer was a prominent one and will be explored further in the following section. Reference was also made in one community to the local 'Laird', which was the only reference to feudal or inherited power positions. Although the respondents in this community referred to the position held by the Laird as historically being powerful, they did not consider the Laird himself to possess a great deal of Legitimate Power in the community (although this view was not shared by others, as is discussed in the participant observation section of this chapter).

Respondent's References to Their Own Power

Within the transcripts, respondents made few references to whether they themselves feel powerful or powerless within the context of their community, although several respondents referenced their position or role within the community. Two respondents were former members of local community councils and one a former member of a community development company. One was a local business owner, and another made reference to their membership of a local committee and action group. One respondent, as previously mentioned, referenced their direct relationship with the Scottish Government, and another was a local GP. In the case of the doctor reference was made to their own power in the community (in the form of their ability to help the community obtain future services) but their descriptions of relations with the community suggested that they may have lacked either the legitimate or Expert Power that would be expected in such a professional position. In this instance, it may be that the respondent highlighted their ability to use reward or coercive power (to either help or not help the community obtain services) in order to compensate for a lack of power in other areas.

Power was also referenced in specific relation to views held by the respondents. In the case of one respondent who considered themselves to be espousing a controversial viewpoint, the phrase *"I could be hung for saying this"* (A1) was used. While the

respondent was no doubt employing hyperbole, the statement does paint the respondent as being victimised by other community members who are implied to hold a different viewpoint. By using the metaphor of being 'lynched' by the community for expressing an alternative point of view, the respondent highlights the relative powerlessness of community members with dissenting views in relation to the rest of the community. On the other hand, another respondent who also claims to hold views that run counter to that of the community majority, characterises themselves as both an "*antagonistic bastard*" (A2) and "*notorious*".(A2) While these self-labels would not perhaps be considered to be positive, they are not necessarily disempowering. While the first respondent feels alienated and potentially victimised due to their alternative views, the second turns the condemnation around and appropriates the negative response of the wider community as a strength. Their alternative viewpoint makes them 'notorious': someone to be feared, rather than a potential victim.

While these overt references to positions of power within the community give a flavour for some of the complexity of power relations beyond the obvious structures, the next few sections will review the discursive themes uncovered by the FDA as well as how discourses have been used to both enhance and temper the power of some of these figures of authority.

Discourses relating to local health care practitioners

As would be expected from interviews on the topic of health care in the community, frequent mention was made in all seven transcripts to local health care related practitioners and services. During the course of all seven interviews, while speaking about health care practitioners and their role in the community, respondents employed discursive frames to delineate the boundaries of what is and is not acceptable behaviour for local health care professionals (both doctors and nurses). A number of different discourses were employed by respondents to create these discursive limitations for local health care professionals, several of which will be examined more closely below. While respondents used different discourses in order to place limits on acceptable behaviour for health care professionals, several also used discourse to create sanctions that reinforced the boundaries of their discursive frames and helped to illustrate the perceived severity

of transgressing these borders. This was most frequently achieved by employing a legal discourse or discourse of legality or tradition/history.

One of the forms of discourse used by respondents to describe and [constrain] local health care practitioners was, perhaps unsurprisingly, a medical discourse. According to Arney and Bergen (1984), medical discourse:

“is more than just a set of facts known by physicians and embodied in a professional, specialized, inaccessible language. The medical discourse is a set of rules that enables facts to become facts for both physicians and patients. It is a set of rules that covers not only what is important to doctors but also what patients can speak about as important. Knowledge is power precisely because the knowledge embedded in the medical discourse supplies rules by which patients ascertain when they are speaking true about the self and when they are speaking about things which are imaginary. Knowledge tells the person what is important and not fanciful about his or her experience of illness and patienthood” (P5).

Medical discourse, therefore, can be used not only to define the limits of personal health and wellness, it is, according to Cheek and Rudge (1994) a privileged discourse that holds prominence over others and, over time, has achieved ‘truth’ status. That is, medical discourse, along with certain other discourses including scientific discourse and (arguably) legal discourse, has reached a dominant status that has the power to override other discourses when employed within modern Western society, and its use can legitimise the power and authority of those who employ it (Cheek, 2004). As discussed in Chapter 2, this can be problematic when it comes to community engagement as health care managers, local practitioners and community members are not always able to employ a medical discourse equally and, therefore, there is the potential that those with the most mastery over such a privileged discourse may dominate engagement. Obviously it would be overly simplistic to state that medical practitioners and health care managers are the only groups able to successfully employ a medical discourse, however one can instinctively assume the privileging of this particular discourse, even when used by community members, could lead to the subjugation of other discourses such as those of community empowerment or development. Interestingly, respondents utilised medical discourse in order to effectively limit the power of local health care practitioners. One respondent states:

“to be elderly is not a National Health Service Issue. It is not an illness, it’s not a disease, it doesn’t need curing” (A1).

The respondent here employs a medical discourse by using the terms “illness”, “disease”, “curing”, but dampens their power by limiting their relevance to “aging”, implying that the NHS erroneously views aging as medically problematic. The implication through this refutation is that the NHS is involving itself in matters outside its rightful domain, which the respondent establishes in a previous sentence as being *“mending people physically, as well as mentally”*(A1). Through the use of discourse the respondent effectively redraws the barriers around what is appropriate for NHS employees to undertake and what is inappropriate. This is further qualified by a definition of what is appropriate for communities to undertake themselves, which is defined as: *“community activities, meeting together socially, all the things that are desirable from a healthy community point of view should be left to the community”* (A1). Although the term “healthy” is employed which could be considered as part of the medical discourse, it is defined by the respondent as being within the remit of the community and therefore is removed from remit of the NHS. In this initial selection of text, it appears that the object of this discursive frame is the NHS as a wider organisation, but in a following statement, it is made clear that the local nurse is also an object relating to this frame as the respondent uses the example of her running of the local lunch club as an example of a transgression of NHS boundaries relating to aging.

Later, the respondent employs what could be described as a legal discourse when they define the consequences of transgressing these discursive boundaries, in other words, what can happen if the local health care practitioner goes beyond what has already been discursively established as their sphere of activity. The respondent refers to an elderly man who suffered an injury was put under NHS care and *“it took the National Health Service twelve months to kill him”* (A1). The term “kill” provides a jarring contrast to what the respondent has already defined as the terms of an appropriate NHS remit, that is *“mending people, physically as well as mentally”*(A1). Although the respondent has already framed the “mending” of broken bones as within the NHS’s purview to treat, the implication is that in this case a patient was over-treated simply because they were elderly, and therefore there are dire consequences. While the expression can illustrate genuine concern on the part of the respondent, the use of the term “kill” as an emotive

and hyperbolic juxtaposition to the previous discourse of healing, allows them to emphasise the importance of the established discursive frame. The use of a legal discourse here (the unlawful and purposeful taking of life) also serves to highlight the formality and severity of a transgression by NHS staff, and carries the implication that the proper sphere of treatment may be sanctioned by legal methods.

Just as the previous respondent used discourse to metaphorically draw the boundaries around local as well as NHS practitioners and what it is within their remit to treat, several respondents similarly delineated the appropriateness of local medical personnel's personal relationships and how 'close' they could be to the rest of the community and still be considered professional. One respondent said "*if you are friendly with the doctor, you get a better service*"(A2), attributing variance in levels of primary care to the 'friendliness' of the doctor. Although 'friendliness' in another context would denote a positive personal characteristic, the implication here is that it is unprofessional for the doctor to engage in personal relationships with community members, and this unprofessionalism leads to variance in the standard of care. This respondent, like the previous respondent, makes reference to the over-treating of patients and the implication is that local medical staff must beware of overstepping boundaries of professional care:

"And what I mean is people who are not really needing attention, and they're flocking around them like bees round a honey pot to clock up their hours. And I'll take it a stage further. When most of the elderly people [in this community] sadly died out, and there was quite a lot of work, and they were doing round them doing this and that, and now that the people have died out and they're not there, we wonder who the next victim is going to be, is going to be pestered to allow them to fill their timesheets" (A2).

The respondent offers no further explanation as to specifically *how* these metaphorical boundaries are overstepped other than that *too much* personal care is given leading to overtreatment, and therefore it could be inferred from the text that the primary transgression that has occurred is in fact in a blurring of the line between the role of professional and that of friend/neighbour, since no further discourse is applied to the object. Interestingly, the respondent characterises this inappropriate behaviour as being related to "*fill[ing] their timesheets*", the implication being that they may be financially

motivated. This is counter to characterisations by other respondents (including B1 and C1) that providing additional care is being a feature of *appropriate* remote and rural health care delivery. As before, this respondent evokes a legal discourse with the term “victim”, the implication of which is that transgressing these boundaries, and in this case providing *too much* care, leads to nothing short of death for patients: the respondent states that “*we wonder who the next victim is going to be*”(A2). By using the inclusive plural ‘we’, the respondent widens the scope of their sanctions from one community member’s opinion, encapsulate that of the entire community or at least a wider segment thereof, deepening the impact of the disapproval. Another form of boundary reinforcement placed on local medical practitioners by this respondent is the use of a belittling/mocking discourse. When describing the sight of nursing staff travelling to see one of these “*inappropriately*” over-attended patients (or “*friends*” as he refers to them in an earlier sentence) the respondent refers to the staff as going by in their “*little blue tops or little white tops*”, effectively depersonalising and belittling the nurses, but simultaneously stripping from them any professional status that their uniforms may have previously afforded them. This concept of transgressing the boundaries of care is further illustrated by the same respondent in the following excerpt:

A2. Well so far as I’m aware we have a doctor, permanent doctor, a waft of nurses, various nursing, I don’t know what they all do, and from the point of view of the provisions supplied by the health service, they’re all there, but it’s how they are administered locally that I feel is majorly wrong, and basically if you are so and so, without naming any names, you get a better standard of care than so and so, and one small example is [name of family member], has very many aches and pains, she will never get a visit from the doctor. Other people, who don’t have a lot wrong with them, the doctor literally, and the nurse literally stay, have bed and breakfast with them.

I. So why is that then, in your opinion?

A2. It’s due to the festering community. It depends who you are, what you are, if you’re friendly with the doctor or friendly with the nurse, that’s how they...

I. And is that different to what it might have been like with previous...?

A2. Oh, there’s no question it’s different. There’s absolutely no question it’s different. And, em, got to be careful how I say here, but... the medical profession [in this community] no longer command the status they once did. Insofar as once upon a time they were basically once removed from the community.

As with the earlier respondent, Respondent A2 considers it inappropriate for elderly people to receive too much treatment as it 'victimises' them, and yet he resents his mother not receiving informal visits. He appears to consider personal attention inappropriate but also seems to want it for his family. Another interesting implication in this statement is that the respondent feels that he knows the level of care needed by others in the community well enough to overrule the judgement of the medical staff. This may in some way indicate that the discourse of 'rurality', of history and tradition overrules the medical discourse. That these elements of localness form a type of legitimate or Expert Power that overrules that held by the medical staff. The community, according to the respondent, is "*festering*", it is rotting, in a natural state of decay. Part of that rot is the medical profession which has transgressed professional boundaries by forming personal relationships and now the respondent is unable to judge whether care is administered due to need or for more personal reasons. They feel marginalised by the medical profession. The ideal is for health professionals to be "*removed from the community*" and to have mixed has caused their "*status*" to fall, their authority to wane. There is an implication that their Expert Power was in some way based on their very otherness. And as this otherness wanes so does their legitimate position. In a sense this discourse may reflect a confused and postmodern way in which remote and rural people regard their health care workers, and also reflects how such doctors and nurses are portrayed in the media (Thomson et al, 2008): on the one hand doctors and nurses are heroic and their position needs to be 'saved' from possible service cuts, on the other hand they are abusive and bureaucratic and no longer fit the selfless 'vocational' model of rural care. In any case, this liminal position appears to be very much a rural phenomenon, or at least very much heightened in remote and rural communities.

The blurring of the lines between professional and personal life is an acknowledged difficulty for practitioners who both live and work in remote and rural communities (Farmer et al, 2010; West et al, 2004; Slama, 2004). This issue is highlighted by another respondent who instead creates a boundary around appropriate *community* behaviour and the contribution of community members to creating this blurring. When discussing the local health care practitioners, one respondent states:

“We’re very lucky, we take it for granted. We use and abuse them, we do. I mean, it’s so irritating to walk in the shop and see somebody say “Oh [GP’s name] can I just tell you...[District Nurses’ name] can I just tell you...”, and you think for goodness sake, leave them alone, they’re not at work. You know, and this is what you can’t train people for. It’s either in them or it’s not. You know, I mean I dread to think how many time [District Nurse’s name] has put her life on the back burner for the community. We really are not in a good position when [District Nurse’s name] has decided her time is up” (A3).

In this extract the initial assertion that the community is lucky is soon qualified with the phrases *“we take them for granted...[w]e use them and abuse them, we do”* (A3). The implication being that the community mistreats its local health care practitioners in an abnormal way. To ‘use’ in current colloquial usage can mean that a liberty has been taken, the community has gone beyond what is expected of them in terms of their side of the health care delivery contract/relationship. The term abuse takes this point further. The word ‘abuse’ has connotations of neglect or mistreatment, particularly as applied to a person in a position of authority with regards to someone in their care who is in a more vulnerable position such as a child, elderly person or patient. The term abuse belongs primarily to a legal discourse, in which someone in a position of authority or a position of trust violates this trust in an inappropriate way. For the community members, who are the patients in this scenario, to abuse the health care professional says something interesting about the balance of power in the rural health care practitioner/community member relationship. Whereas one might assume that the practitioner would hold Expert Power over the community member, this is problematized by the idea that the community are the ones in a position to ‘use and abuse’ the medical staff.

The respondent goes on to describe the problematic nature of interacting with the rural community for health care practitioners with the statement *“this is what you can’t train people for”* (A3) The respondent alludes to an innate quality that remote and rural practitioners possess, to subjugate their own lives and needs for the sake of the community, a community who ‘uses and abuses’ them. In this statement, the respondent indicates pity for the practitioners, saying that she *“dread[s]”* to think of the District Nurse putting her own life on hold. On the one hand, this can be read as a discursive framing of appropriate community behaviour in relation to health care professionals. To expect health care provision outside of the time when professionals are “I” is unreasonable to

the point of “*abuse*”. Following this logic, the reason that community members are “*lucky*” is that service providers put up with being ‘taken for granted’, ‘used and abused.’ However, this discursive boundary is somewhat problematized by the statement “*it’s either in them or it’s not*” This phrasing introduces the concept that there is something natural or inherently present in rural health care practitioners that allows them to transcend the ‘normal’ reactions to being ‘taken for granted’ or ‘used and abused’, it is ‘what you can’t train people for’. In a further extract, the same respondent is further questioned about what it is that is ‘in them or...not’:

A3. No, I think it’s in the person. Certainly, I mean, I went into nursing when I left school. And I sit and listen now to people going into nursing and it’s not what it used to be. It used to be a vocation, it used to be a vocation, it was a way of life. It’s not now, it’s just a job. And to do that, you can’t just treat it, to do the job, certainly that’s required [in this place], and I think for nurses everywhere, not just [in this place], I think to do the job properly, it’s either in you or it isn’t.

I. So do you think it is a bad thing now that people consider nursing as a job rather than a vocation?

A3. Yes. Yes. Yeah. People can’t be treated as a job. They’re not just an item, because no two items are the same. And everybody needs to be treated as an individual, and if you treat it as a job, you cannot treat that person as an individual.

In this excerpt the respondent talks about how it is an inherent, natural quality to approach nursing as a vocation, however, complexly this is no longer the case. If it is natural, then by implication today’s nurses are *unnatural*. This ‘inherent’ quality is no longer present in the “people going into nursing” (A3) so there is degradation in the profession as a whole, there used to be a nursing golden age, again reflecting a postmodern confusion about the role of health care workers. Interestingly, the respondent is critical of this though no longer practicing nursing herself, but gives no further explanation of this. Unlike previous respondents, she does not make a distinction between remote and rural nurses and the profession as a whole. In this statement, all nurses must treat it as a vocation. When asked if treating nursing as a job rather than a vocation (“*a way of life*”) the respondent is emphatic: “*Yes. Yes. Yeah.*” The strong implication is that to treat nursing as a job with on and off hours, is to not “*do the job properly*”, and to treat people as “*an item*”, not as “*an individual*”, it is to be derelict in

what is approaching a sacred duty. It is interesting to contrast this section with the same respondent's earlier statement in which she described the way in which community members did not treat health care practitioners as individuals by failing to respect their home/work division. Within these two short excerpts from one respondent it is possible to see how the discursive frameworks placed around local practitioners and how they should behave could be very problematic to negotiate.

The local health care practitioners are expected to be inviolate in their professionalism and, therefore do not fit comfortably within the boundaries of 'community': they are censured for becoming too close (with accusations of unfairness, preferential treatment) but also for being too distant, as illustrated by the local health care practitioner who reported feeling alienated from the community and feeling unsupported. The local health care practitioner role was further problematized as several respondents characterised them as requiring specific skills to work appropriately within a remote and rural community.

The discursive boundaries of what a practitioner must do to be an appropriate fit for the local community was defined through the discourse as being something inherent, not something that could be taught. As Respondent A3 stated: "*it's either in them or it's not*". Another respondent, when asked what would make a local nurse suitable, replied "[t]hat they could live our way of life" (A1), implying that there is *one* 'way of living' within the community.

This discourse of nature and inherent ability can be characterised as a discourse of tradition/history but would also fit within a nature discourse. Several respondents characterised the historical role of either rural GP or rural District Nurse as being in decline. Respondent A3, referring to district nursing said "*it used to be a vocation, it was a way of life. It's not now, it's just a job*". The contrast between "vocation" and "job" has moral undertones and implies a loss of caring and dedication on the part of modern nurses. Another respondent said, of the perceived decline in nursing their community as it moved from a locally based to a peripatetic service "*For years they've been sent off on courses, community nurses, then some other kind of nursing, then some other kind of course*" (C1). The strong implication from this statement is that the historical role of district nurse was an appropriate fit and that change in the role is not viewed as progress

but rather decline. This discourse of tradition places limitations on remote and rural health care staff as it casts career change or progression in a negative light. There could be an implication in this statement that nurses are no longer in their 'rightful place' within the community: they are learning more but doing less. Nurses, within this discursive frame, belong *within* the remote and rural community. The respondent also described how previously the community had felt "secure" because they had "very very good district nurses" (C1). By referring to the past nurses (the object of this statement) as being "very very good" (C1), it invariably draws a comparison with the current nurses in the community who, by extension, are not "very very good". In a similar vein, the respondent describes the NHS's reaction to their request to reinstate a resident nurse: "they'll say oh, old-style district nurses and blah blah blah blah blah" (C1). By minimalizing and infantilising the management argument that uses a discourse of modernisation and progress, the respondent effectively nullifies any arguments about the need for the modernization of the profession.

Similarly, the role of doctors is perceived as having changed. One respondent, using what can be considered a discourse of tradition, says "Twenty years ago you'd call your doctor, doctor whatever, now, they're not held in the same regard" (C1) and later "if the doctor said this you did it and, or , they were kind of somebody to be admired and looked up to" (C1). This historical ideal is held up in contrast to the present when "they've been given a lot more money to do a lot less". Again, this statement draws from the same discourse of tradition that contrasts "vocation" with "job".

Studies have shown that rural health care practitioners tend to perform 'extra' work in addition to their actual job description and often feel pressure from the community to carry out additional work (West et al, 2004), and it isn't always clear even to the professionals in this study whether the additional work (in the form of checking in on the elderly, etc.) was part of their defined clinical role or part of being a good neighbour who happened to have healing skills. By using the discursive frame of tradition/history and characterising the historical rural health care worker as someone willing to work outside of their job description (because it is a vocation, not just a job), someone who is resident in the community, and who is associated with caring and moral behaviour, in contrast to a modern health care worker who is characterised as work-shy, non-local, bureaucratic and

concerned with money over people, respondents were able to effectively create a discursive frame that encourages health care workers to work to 'the community's' standards. By discursively associating certain characteristics (such as working 24/7 and living within the community) with being caring and in some way inherently moral, it makes it difficult for practitioners to refuse this behaviour, for example by opting out of working out of hours, or taking time off.

The role of health care practitioners in remote and rural communities is problematized by the discursive power of community members. On the one hand, they are expected by their line managers and the wider NHS employment structure to adhere to strict boundaries about what is and is not part of their health/clinical scope of practice. Similarly, it is sometimes considered inappropriate for community members to contact them when they are "not at work" with work problems. Practitioners are expected to keep strict professional boundaries and not to become inappropriately close with any community members as it is tied to their "status" to be removed and aloof. Yet on the other hand again, there is a discourse present in several transcripts that marries a discourse of history and tradition to one of the natural rural and the very elemental nature of the all-encompassing vocation, in which the practitioner willingly and selflessly gives up their personal life to be at the beck and call of the community. Not only are these discursive boundaries strongly policed within the community members' discourse (to transgress them is at best unprofessional and at worst criminal), they are also contradictory and this creates a troubling liminal space for local health care practitioners in which to exist.

Interestingly, although the rural doctor is considered to be a high status occupation, both the expert and Legitimate Power afforded by this position can be superseded by a discourse of history/tradition and legality in order to dictate their behaviour; similarly, this power of history/tradition can supersede Expert Power and Legitimate Power to place sanctions on behaviour. This may have implications for health care planning engagement if the discourse of history/tradition is perceived by community members to supersede that of medical or evidence-based expertise.

Discourse of nature and organic growth/decay

Within the analysed transcripts, discourses of nature and of organic growth or decay were often employed by community members. In areas where respondents felt that their community was in decline, terms such as “*festering*” (A2) were employed, as was seen in a previous excerpt. On the other hand, respondents with a more positive view of their community used phrases such “*young,*” “*vibrant,*” and “*grow,*” (A3) all phrases to do with organic health and flourishing. The use of natural imagery to describe the remote and rural is not a new concept and it fits neatly in with Bell et al’s (2010) model of the Idealist Second Rural.

According to Bell et al (2010), there are two principal ways in which the idea of the ‘rural’ is constructed: a materialist construction and an idealist construction, and these have different impacts on rural power. Within the materialist construction of rural (what Bell terms ‘first rural’) are the ideas related to physical geography, demography, population density, agriculture and economy: those demographic or ‘factual’ characteristics that define what is rural. Bell argues that this first conceptualisation of rural is predominantly represented as “vulnerable, disadvantaged, under threat and disappearing” (209), what he refers to as the notion of the Death of the Rural. Within the idealist construction of rural on the other hand (or what Bell terms ‘second rural’), is what Mingay (1989) and Bell (2006) and Cloke and Little (1997) refer to as the rural idyll or the ‘other countryside,’ rural is conceptualised as idealistic, natural, organic, clean, wholesome, productive and moral. While the idealist conception of the rural appears to be a positive characterisation of rural areas, it, like the first rural, is a passive, disempowering conceptualisation: change is something that happens *to* rural communities, they are not agents of their own destiny.

One respondent, when referring to the perceived decline of their community, likened it to natural seasonal processes. Having already described summer as a time of hard work and useful industry in the community, they go on to say:

“When I first came here I was told, watch out for the winter, that’s when the knives are out because they haven’t enough to do. But it happens all year round now” (B2).

This decline of the community, when the respondent first arrived, was akin natural process of seasonal decay and renewal, in summer the community would renew itself and pull together through industrious labour, and in the winter the community-spirit would decline and people would become less supportive of each other, however, in recent years something has changed, and has thrown the natural cycle out of balance causing, by implication, a terminal rot to set in. The community is no longer connected to a natural change process. When the respondent was asked what has changed in the community, the respondent attributed the change to the “*number of incomers*” (B2). While the discourse of Incomer/Local will be examined more closely in the next section, it should be noted here that the incomers have acted as a catalyst in the change process. The presence of the incomers has changed the natural seasonal model of community decay and renewal by injecting an unnatural element to the community. Secondly, the use of a natural discourse is also used in conjunction with the incomer/local discourse to reinforce the natural ‘belongingness’ of the local within the community, as opposed to the artificial influence of the incomer.

The use of a discourse of organic decay creates a sense of inevitability, of unstoppable decline that occurs as part of a natural process and, by extension those who attempt to halt the process are either foolish for attempting to prevent the inevitable, or are undertaking something of an unnatural act. At the same time, characterising events within the community as part of a natural decay, or inevitable decline also serves to take the onus from respondents who felt that they did not fit in with the community by casting the community as mouldering, it is not they that fail to flourish. With regards to planning and engagement, this is a challenging discourse because the idea of a community in inevitable decline does not sit comfortably with the current policy discourses of co-production and community development that underpin the concept of involvement. If the discourse of decay were to become dominant it could encourage apathy to the planning process, which was certainly displayed within at least two of the communities in this study.

Othering Discourses

The most frequently employed discourses found within the seven transcripts were discourses that allowed respondents to create a constitutive Other. The Other, originally a Hegelian concept often advanced by studies in postcolonialism and gender, is a sociological construct (also referred to as the Constitutive Other - source) in which the speaker highlights the 'otherness' of another individual or group: that which makes them strange or, in some basic way, not 'us'. This process of highlighting the differences present in a person or group in order to distance oneself from them is also known by the verb 'othering'. Edward Said (1978), in his book *Orientalism*, described how portrayals of the orient in western writings effectively created an oriental Other; they highlighted the unfamiliar and created thematic tropes that were often reproduced by those within occidental culture in order to maintain distance from the oriental Other at a time when, following the breakup of the British Empire, western culture felt itself to be vulnerable.

Othering is a popular technique used to strengthen group or individual identity since identity is often constructed in terms of what it is not. While othering can be useful in helping to create a self or community identity in reference to others and can lead to in-group bonding, there is the danger that that which is othered is also dehumanized and that the act of creating metaphorical barriers around identity leaves others feeling isolated. Johnson et al (2004) succinctly describe othering as *"a process that identifies those that are thought to be different from oneself or the mainstream, and it can reinforce and reproduce positions of domination and subordination"* (253). In terms of othering in relation to health care, research has shown that othering has been associated with such negative health outcomes as depression and stress (Littleford & Wright O'Dougherty, 1998; Noh et al, 1999), and is associated with creating barriers to access within health care services (Johnson et al, 2004). Within the interview transcripts a number of types of othering occurred and so it is worth examining them separately.

Local Health Care Practitioner and the Other

As has already been touched upon, the discourses used by respondents tended to place local health care practitioners in a liminal space. To take this one stage further, it could be argued that by highlighting their difference in relation to the community effectively 'others' practitioners. However, othering was also undertaken *by* the local health practitioner in their transcripts, in relation to the NHS. By creating space between themselves and NHS Highland management and not self-identifying as a part of the organisation, the practitioner creates a large amorphous Other, which they term 'the powers that be', that allows them to distance themselves from unpopular centralised decisions whilst placing themselves in a 'local' context. Since the respondent also describes how they feel distanced from the community, disassociating themselves from the wider NHS in the context of health care planning allows the respondent to reframe their position in relation to the community and to place themselves *within* the category of community away from the 'the powers that be'. At one stage the respondent describes themselves as being essentially all that stands between the community and potential cuts to the NHS service, reframing the liminality of their position as almost heroic. It is possible that, in the light of their reduced status in the eyes of the community, they feel that they lack the Legitimate Power that their position would normally afford, as well as the Referent Power that comes from being well liked, therefore they are attempting to highlight their potential reward power within the community, or indeed coercive power if they decide not to intervene at all.

Incomer and Native/Local

The duality of incomer and native is a type of othering discourse that has gained a privileged status throughout the Highlands and Islands (Crow and Allan 1995, Jedrej and Nuttall, 1996; Burnett, 1998; Macdonald, 1997). The dichotomy between locals (those who belong) and incomers (those who intrude) is produced and reproduced again and again in everything from media, popular local mythology (including the infamous Highland publication from the 1970s, 'Settler Watch'), and even academic papers. Burnett (1998) states that these categorisations are both "*fuzzy and contestable, and yet widely reproduced as an academic as well as a commonsensical distinction.*" (205) In other

words, despite the fact that the distinct concepts of 'native' and incomer have little bearing on the actual social relations of rural people (Burnett, 1998, Macdonald, 1997) they maintain a privileged 'truth' status as a discourse about belonging in rural Scotland.

According to Jedrej and Nuttall (1996), the current incomer/local dichotomy began in the Scottish Highlands in the 1970s with the counterstream migration that saw the declining population of the rural Highlands start to increase again due to a number of socio-economic factors. In-migrants to these areas tended to include large numbers of people from the Scottish cities, as well as further afield from England however "*[c]ounterstream migration not only amplifies the experience of depopulation, it is commonly held that it erodes a certain special quality of social life associated with a small community.*" (180) Since this time, a large number of people have taken up residence in remote and rural areas of Scotland, and in some areas the population consists almost primarily of those born outside of the 'local' area. Rather, however, than diminishing with the new blended rural communities, the incomer/local dichotomy appears to flourish. It is worth exploring, then, the layers of meaning that this discourse brings with it.

As Jedrej and Nuttall (1996) point out, "*the claims of those describing themselves as 'locals' are premised on the notion of the natural, yet ancestral, and enduring rights of an indigenous population.*" Therefore the term local carries with it the weight of the authentic, that which belongs. It also carries with it the impression the moral high ground that has become associated with indigenous peoples on the verge of displacement in a postcolonial world. By associating current 'local' Scottish rural peoples with other colonised and displaced peoples through the use of this rhetoric (First Nations people in North America are a common source of comparison) the discourse carries with it the full horror of previous bloody and genocidal colonisations in a way that heightens the drama of what is essentially migration within the same governed nation. This rhetorical trope is carried on through the use of terms for incomers such as "white settler". The category of local/native, therefore becomes associated with all things natural, historical, authentic, and 'real' about the rural, whereas the 'incomer' becomes associated with things impure, unnatural, inauthentic and imposed. Common sense would tell us that these are stark categorisations indeed, and that it is unlikely that people living in the community would fit so neatly into these boxes, and yet the hegemony endures. Employing an

incomer/native discourse has become legitimized; an accepted way of denoting who is representative of the community and who is not, who is an authentic community member and who is not.

To be cast as an incomer is to exist in a problematic liminal space, being both necessary to the survival of shrinking rural communities, while at the same time unwelcome; to be accused of trying to change rural communities while at the same time being accused of not contributing enough to the local civic space. In some ways it is similar to the problematic relationship that local health practitioners face. In other words,

“Incomers, as a well-entrenched ‘non-local’ construction, must contend with a paradoxical position of being excluded from the ‘local’ frame of reference by virtue of their label and yet incomers are both invited and expected to accommodate and engage with ‘things local’”. (Burnett, 1998:206)

Burnett also states that “the incomer is overwhelmingly constructed as a negative influence, a ‘threat’, and there is a moral tone to the discourse which argues that the incomer is “identified as a source of unintended generalized harm”(2086). The type of ‘threat’ posed by incomers often fall into one of two main stereotyped categories (Burnett, 1998):

1. The non-contributing incomer ‘taking up space’ in the community, that could otherwise be filled by a local person. This categorisation is often reinforced with the concept of incomers ‘artificially’ driving up house prices above where they should ‘naturally’ be, or taking up local housing that would otherwise go to a local family. This type of incomer is passively dangerous to the survival of the community.
2. The overreaching incomer who tries to change the community from its authentic natural self by imposing outside ideas. This type of incomer is often characterised as loud, bossy and actively dangerous to the survival of the community.

Within the analysed transcripts, six out of the seven respondents made heavy use of the incomer/local discourse. Of the six, only one respondent was actually born in the community and yet none of the respondents *self-identified* as an incomer. This is unsurprising considering the negative connotations associated with the label. Some made reference to the fact that other community members may consider them to be incomers,

but this was always qualified in such a way as to nullify this qualm. For example, Respondent A3 states: *“I moved to X with somebody who was from X, so maybe I have a different outlook on it than other incomers”*. Although the respondent places themselves in the discursive category of being an incomer, they also effectively distance themselves from the other incomers and make their claim for local status as being partners with someone that other locals would accept as one of their own. The one respondent who was born within the area of their community, describes their status thusly: [I was] *“born here, among the rocks and the heather. One of only five natives left”* (A2). The respondent both self-identifies as a ‘native’, but also uses evocative natural imagery to illustrate how their authentic claim to native-ness is based on a connection with the land, with the natural. The intersection of the incomer/local discourse and the natural/historical/tradition discourses can be seen in the following passage:

When asked how many actual A-ites there were in community A one respondent stated that there were only five out of the entire population. When asked to elaborate the respondent continued:

We’re a bit unbalanced in terms of population because we’ve had a tremendous influx of people from elsewhere. I come from about 70 miles away, [name of town], we’ve been here for hundreds of years in this area and my family’s from all the other areas around us. So there’s this sort of cultural thing about people that come from this area, the west coast of Scotland and the islands, and it’s unspoken, much of it, it’s there. And we can talk like that. I can see someone on a train or a boat that’s from out here and we’ll have a conversation right away, we know, you know, it’s just an immediate thing. And so for someone that’s not from [here] it takes them quite some time, possibly another generation before they can sort of get into the ways, the unwritten ways. (A1)

Despite the fact that the respondent *“comes from 70 miles away”* and is a retiree to the community, they are still able to make claims to non-incomer status because they are from a wider area. The respondent makes claims of belonging based on heritage, and innate natural qualities *“it’s unspoken, much of it, it’s there”*. Localness is a form of tacit knowledge but nonetheless real for that – even when outside of their ‘natural’ environment, it is still possible to see it. In this extract ‘localness’ shares some elements of nobility, like the fairy tale Princess and the Pea it can be detected by those who possess

the right qualities. This extract does, however contain hope that that in a long time, incomers could adapt.

When discussing the incomers in the community who had retired to the area, one respondent said *“most of them are entirely inappropriate”* (B3) which implies that there is a standard of appropriateness reached by some of the local residents. By linking the discourse of the incomer/local to the discourse of the natural, the right, this respondent create a discursive frame that *cannot be transcended* through appropriate behaviour. This is further illustrated by a respondent who discusses incomers who have taken up a local crofting lifestyle: *“they’ve come here with plenty money, bought a bit of land, and keep a few sheep and call themselves farmers”* (A2). Even when incomers attempt to engage appropriately in ‘local’ rural behaviours or actions, they are still perceived as inauthentic, reinforcing the notion that incomer and local are inviolate categories.

All seven respondents whose transcripts were analysed made explicit reference to how incomers had impacted their communities and, with only one exception these impacts were considered to be negative. In the exceptional transcript, the respondent cited both negative and positive impacts of incomers, but this was the exception:

“the community is growing, very definitely growing. We’ve got ridiculous amounts of children, right now. Considering when I moved to A the population was very definitely older, it’s a very young community which in turn means it’s vibrant”. (A3)

This statement refers to the in-migration of a number of families with young children to the community and clearly highlights positive effects of in-migration on the area. Interestingly, however, the respondent does not refer directly to adult in-migrants as the object of this discourse, rather they refer to the *effects* of the in-migration (more children, a young community, vibrancy). Also, the respondent does not directly correlate these positive effects with in-migration. Reading this excerpt without knowing the wider socio-demographic situation in the community could lead a reader to conclude that those already resident in the area were simply having more children than usual. The respondent goes on to say:

“there seems to be an influx of people who have moved to A and want to change it. And that’s not to say A shouldn’t change and shouldn’t progress, it should...My way of thinking was move to A to be a part of A, I didn’t come to A and expect A to be a part of me. And I think it’s changed to that a little. And I don’t think that’s always necessarily for the best.”(A3)

In this way the respondent distances themselves from the negative characteristics of the Incomer. Using their intent to live as *part* of the community rather than try to change the community, the respondent frames herself, if not as a local, then as a non-incomer. Categorisations of Incomers by respondents did tend to fall into one of the two above categories as was suggested outlined by Burnett. Incomers who were categorised as being retired or wealthy were similarly considered to offer little to the community:

“There’s a lot more people who have come into the community late on, come to the island rather than the community, to retire, they don’t particularly want to get involved, they don’t contribute very much to the community” (B1)

and

“it’s brought new people on to the island but they’re probably people with money, who don’t want to work, don’t have to work, and it’s, they don’t necessarily contribute anything to the community” (B1)

These are interesting discursive statements as, in earlier parts of the text, *both* respondents referenced jobs in their communities as being low paid and mentioned how the local residents have to work hard to earn a living. Presumably, the addition of residents who would not compete for local jobs but would contribute to the economy might be a positive thing. This statement also assumes that if incomers do not work, they will not contribute in other ways, although as retired people these residents would be well placed for activities in the community such as volunteering. Another respondent goes on to say *“they don’t bring an awful lot to the place, in the way of skills that this place needs” (B3)*. Attached to this concept is the notion of wealthy incomers ‘artificially’ driving up local house prices. A respondent says: *“when houses come on the market they tend to sell for what could be called slightly silly prices...for people who work on the mainland they don’t look too bad” (B1)* giving the impression that there is a ‘natural’ or ‘sensible’ level for house prices, rather than one that is always dependent on economic

forces. Again, the presence of incomers has had an 'unnatural' effect on the community. House prices have been made "silly", or other than they should be 'naturally'.

The second categorisation, of Incomers as being 'bossy' or disruptive, was also evident. The examples most frequently cited within this discourse were related to incomers attempting to take up positions of power or authority within the community. For example, a respondent recounts a past incident in which a newcomer to the community attempted to start up a small local volunteering scheme. The respondent refers to the incident as "*a huge stromash*" (B2) (interestingly, the respondent, who is English in origin, uses a local Scots term to describe the disturbance made by (an)other incomer) and says the new resident "*has only been here five minutes, has decided to be in charge and is extremely bossy*" (B2) and therefore local residents were not willing to take part. Similarly, a respondent identifies the local leaders in their community as being "*very vocal but are not local*" (B2)(although they do live full time in the community) and are identified as the first point of contact for the community ("*the ones that people phone up*" – B2) but they are "*not very community spirited in the traditional sense of that word*" (B2). The respondent goes on to describe the difference between leading in a community spirited way and not as a dichotomy between "*actually hands on doing*" (B2) and someone who is "*quite 'aren't I the cleverest'*" (B2). The respondent identifies two 'local' (native) residents who they feel would be the natural leaders but due to the fact that they are not "*trusted enough by everybody*" (B2) (the implication being they are not trusted by the incomers) they cannot lead. There is a strong indication that the natural or rightful leaders of the community have been usurped by those who are "*vocal but are not local*". The categorisation of rightful leaders as being local, hands on, and not particularly vocal (the quiet, hard-working country resident) is placed in opposition to incomer leaders who are categorised as bossy, loud disruptive, and 'showing off' rather than helping in any real way. In this categorisation the incomer is cast as someone who wants to change the rural to suit themselves. The use of these two discursive frames within the incomer category (the weak, older, wealthy and unhelpful incomer and the bossy disruptive and interfering incomer) neatly boxes anyone who is cast as an incomer as they must constantly negotiate a fine line between engaging too much or too little with the community.

The Incomer/Local discourse was the most dominant discourse uncovered by the FDA. Like all othering discourses, that of the Incomer/Local disempowers the othered. It privileges that which is considered local as authentic, natural and representative. This has implications for not only power relations within the community, but also for the practice of community engagement. As was discussed in Chapter 2, current community engagement best practice still advocates representativeness. If only that which is designated local is considered representative, it encourages participants to downgrade the importance to the inauthentic contribution to engagement, that of the incomer. And not to forget, as Burnett (1998) points out, Incomer/Local is a distinction that often does not reflect the social reality of living in rural areas. Indeed, of the six respondents who utilised the discourse heavily, only one was born locally. The Incomer/Local discourse therefore creates false categorisations that may be unhelpful when it comes to planning. The Incomer/Local discourse is inextricably linked to the concept of suitability/‘unsuitability’ which implies that only certain people ‘belong’ in rural areas. Not only that but, within the discursive frames created by respondents, the Incomer/Local discourse was linked to a discourse of nature and tradition which means that, unlike the discursive frames placed around the behaviour of health care practitioners, even though appropriate behaviour an incomer is unlikely to transcend their discursive category.

By examining these texts through the lens of FDA it is clear that remote and rural community members can and do use language within an engagement process to both empower and constrain. By employing particular discourses, community members were able to legitimise the contributions of some and delegitimise the contributions of others, to place discursive frames around the behaviour of both local health care practitioners and their fellow community members that delineate appropriate behaviours and place sanctions on inappropriate behaviours.

With health care practitioners, discourses of history, legality, tradition and othering were used to outline appropriate behaviour and with local community members, discourses of history, nature and othering were used to legitimise the contributions of those who were considered ‘representative’ community members, true locals, and to delegitimise those

who were left on the outside of this rather flexible discursive frame – a claim perhaps to Legitimate Power or Expert Power through localness.

Interestingly, discourses that are often considered dominant (such as medical discourses), were often trumped by discourses of rurality and tradition and those tied to these discourses such as that of incomer/local. The medical judgements of local practitioners were secondary within these excerpts to discourses outlining the historical role that they should play. The incomer/local discourse was particularly dominant and was tied in to notions of representativeness, nature and legitimacy.

5.9 Participant Observation

Background and methodology to the participant observation is described in the previous chapter. Since it would be impossible to scrutinize in depth every incident relating to power that occurred in all four communities throughout the year that the Action Research project ran, this section will instead focus on the most significant incidents according to my (the researcher's) perception. While many small actions may have impacted the course of the engagement, the people and events recounted here emerge as the most salient and, when looking back at the research some months after, remained in my mind as having the most impact on how I viewed the process. Again, the purpose here is not to create a detailed 'map' of community power, but rather to give a flavour of the roles and behaviours that were observed to influence engagement. To structure my observations, I will first deal with observed positions of power within the community that may have impacted engagement, and then move on to the power brokering behaviours displayed by individual community members.

5.10 Findings

Legitimate Power Positions

During the course of engagement with the four communities, a number of positions of Legitimate Power (French and Raven, 1959) were observed, in other words, instances in which community members held positions as part of an organisation or government body

that, through elected means or otherwise, would normally afford them 'legitimate' and representative decision making power. Positions that fell within this category in the four communities included members of the local community councils, directors or members of local community interest companies (such as community development companies), land owners (including feudal landowners such as lairds) and local health care professionals such as doctors and nurses.

In addition to their status as Legitimate Power holders, there was often observed to be crossover between those holding positions of Legitimate Power and those who had membership in other groups often associated with power and their status as 'experts', including high socio-economic status or high knowledge. Individuals who held Legitimate Power positions within the community could theoretically be said to wield not only Legitimate/Positional Power, but if they also held high socio-economic/knowledge status as well, they had the potential to wield Reward/Coercive power and in some cases referent or Expert Power as well. Members of one community interest company, for example, were mostly comprised of community members with both high socio-economic status and incomers with a degree of pre-existing business knowledge. It could be argued that in these cases, the pre-existence of socio-economic power or additional knowledge helped to bolster the power of those in Legitimate Power positions by adding a dimension of potential reward power and/or Expert Power. Additionally, it was observed that some community members holding Legitimate Power positions also, as in the case of local doctors and nurses, held Expert Power, or, on occasion Referent Power, if the practitioner was well liked. Conversely, however, some community members who held power positions that would outwardly be perceived as legitimate (for example by NHS managers during the engagement process) were not necessarily accepted as 'legitimate' by their communities and were considered unrepresentative. This was most frequently observed in relation to community members who sat on local community councils which are sometimes unelected, but also occurred in one instance where the local doctor was not well liked and held a relatively low degree of legitimate/Expert Power in the eyes of many community members. Since many of the guidance documents and advice notes for engagement consider those in Legitimate Power positions to be unproblematically representative (Scottish Health Council, 2012) it is worth teasing out a few examples of

observed instances when Legitimate Power positions were problematized within the case study communities.

Locals versus incomers:

In the section 4.2c the problematic categorisation of 'incomer' was explored. This characterisation was dominant within the discourse analysis but it was also observed as part of the participant observation in relation to community members holding Legitimate Power positions. A number of community members holding Legitimate Power positions, particularly in two of the four communities, were considered by their fellow community members to be 'incomers', which had the effect in some cases of dampening their Legitimate Power by questioning their implied representativeness in decision making. On the other hand, new residents who held positions in one community's local interest company were not universally castigated as incomers but rather the business skills they had brought with them were considered an asset. The difference between the two situations may be due to the perception of what the Legitimate Power role requires in order to be 'legitimate' in the eyes of the community. In the case of the community interest company (a business that aims to make a profit), the skills of the incomers are potentially more important in fulfilling their role successfully. Within the community council, however (a local governing body), 'representativeness' may be more important in establishing the legitimacy of the power position. Since people who hold Legitimate Power only do so as long as their position is considered legitimate by those they have power over, the label of incomer did occasionally dampen claims to Legitimate Power within the case study sites. However, it is also possible that placing the label of incomer on someone in a position of Legitimate Power is one way for their detractors to attempt to mediate their power. In other words: is the incomer in a position of power considered less legitimate because of the fact of their 'otherness' or is their 'otherness' played upon in order to downplay their legitimacy.

Another example of the incomer/local dichotomy used in relation to a position of power occurred with reference to a local Laird, who was characterised by community members as being 'frequently absent' or, not really a part of the community. He was also frequently cited, due to being a majority landowner, as having significant power over the community

and as having the ability to inhibit local activity if he saw fit. In this context, highlighting the Laird's 'otherness' and casting him in an incomer role may have been used as a means to try to mitigate his claim to Legitimate Power.

The Position of Local Doctors and Nurses

The concept of local healthcare personnel, especially doctors, as community leaders has been well documented within remote and rural health care literature (Farmer et al, 2008). In some of the case study communities the Legitimate Power of the local GP was easily observable, in which case community members often linked them to other positive happenings in the community, for example people being attracted to the area. In places where the local doctor or nurse held a strong position of power, they were often deferred to within the engagement process as having the 'final say' in what was appropriate for their local area, which suggested not only a high degree of Legitimate Power, but also a high degree of Expert Power on the topic of local health care services. For example, in one community a particular voluntary scheme was being discussed by the community as a possibility. A presentation on the scheme had been made by professionals from the relevant organisational body and discussion had ranged back and forth between community members with no real sense of momentum or decision, however, once the local GP made their favourable opinion known, the idea was considered to have merit and the discussion around the topic changed to one of decided action.

In other communities, however, the Legitimate Power of the local health care practitioner was not as certain. In this community the local health care practitioner was not well regarded either professionally or personally which appeared to limit their power to influence the community in a positive way, through Legitimate Power or, indeed, Referent Power. In other words, the practitioner found it challenging to initiate new or innovative practices within the community: to inspire the community to progress. Interestingly, the practitioner *was* successful in using coercive means to influence the community, by mediating between the community and the NHS Highland and highlighting potential negative impacts of a particular course of action, which ultimately eroded the relationships being built between the community and the local NHS Highland managers and undermined future engagement activities that occurred following the project. This

indicates that, although the Legitimate Power of the practitioner was low, they were still valued within the community as an expert in the workings of the NHS. In this way, the practitioner was able to use other bases of power to partially compensate for a lack in another.

Observed behaviours relating to power

A number of behaviours and actions were noted as part of the participant observation that can be interpreted as either brokering or creating power for the actor. These activities have been separated into two categories: gatekeeping activities (in which an actor tries to mediate another actor's involvement in the engagement) and withholding activities (in which an actor mediates their own involvement in engagement). Interestingly, most observed behaviours relating power were associated with language and the control of how language was used within the engagement process. Examples of these behaviours are outlined below:

Gatekeeping Activities

One of the most frequently observed behaviours relating to power in the community was that of gatekeeping. Gatekeeping, in its simplest form, is the control by one individual of another individual or group's access to information (Saunders et al, 2007). Gatekeeping behaviours can be strongly linked to power brokering, in a postmodern theoretical perspective, because controlling another person's access to certain dialogues or discourses limits their potential to harness the power of these discourses and, in turn, influence decision making processes. Gatekeeping can take the form either of an act of limitation (in which an individual denies another individual access to information) or an act of translation (in which an individual attempts to mediate what another individual has said by putting it 'in their own words'). While minor gatekeeping activities occurred frequently throughout the process ('I think what she means to say is...') a number of gatekeeping behaviours were observed during the course of the engagement that could be seen to have impacted significantly on the outcomes of engagement, some of the most noteworthy to the researcher are outlined below.

Gatekeeping Activity 1

Prior to the first visit to one of the communities, a community member who could be described as holding a legitimate position of authority sent a general email to a community mailing list (encompassing most adult community members). This email cautioned the community against participating in the Action Research project, and counselled potential participants that, should they take part they should not be tempted to say anything about the local medical services that could be construed as negative or these services would be withdrawn by NHS Highland. Based on an erroneous understanding of the aims of the project, as well as suspicion of the wider NHS and their motives for wanting to engage, this community member acted as gatekeeper for the adult population of the community. Following a private interview with this community member in which the aims of the project were explained, they voluntarily retracted their earlier statements at the first public engagement event and endorsed the project, however, this very likely had a lingering impact on the community and their feelings of trust towards both the project and the NHS. Following this initial visit, the community member followed up with a subsequent email to myself summarising 'how the community feels now' which constitutes a further gatekeeping act, this time of translation, between community and researcher. In this case, the acts of gatekeeping served not only to strengthen the community member's Legitimate Power by placing themselves as 'spokesperson' for the community, they also allowed them to act in a protective capacity towards the community and their services against a perceived threat. These acts of gatekeeping, however, also served to disempower the wider community by attempting to mediate their right to express their own opinions about their services, and indeed to monitor their access to the engagement and the planning process in the first instance.

Gatekeeping Activity 2

As part of the information dissemination and communications strategy for the project, it had been agreed by the project team that all public engagement activities would be advertised using a variety of methods, including through local media channels. These channels often took the form of local newspapers, newsletters or websites. In the case of one community, the community member charged with maintaining the local website had

become frustrated with the engagement process following an incident involving the notes from one of the first meetings. Part of the community member's input to the meeting had been a statement that there was a lack of available nursing hours according to the needs of the community. The local nurse, who was responsible for assessing the clinical needs of the community, disagreed. In order to reach a compromise, it was written in the notes that there was a "*perceived lack of nursing hours*" in the community. The community member complained that this language minimised the impact of their view and it was summarily changed. While I, as well as the appropriate NHS managers dedicated considerable time to reassuring the community member their views were taken seriously, they remained unconvinced as to the merit of the process. The community member's frustration took on the form of gatekeeping when, prior to a public engagement activity in the community, an advertisement for the event was placed on the local website. The advertisement was placed alongside editorial comment from the community member discouraging people from attending and implying that their views would not be taken seriously. While it is difficult to ascertain the degree of impact this gatekeeping had on the community, the community member's 'translation' of the intent of the event, as well as their attempt to discourage other community members from participating, may have influenced the degree of trust some community members subsequently felt in the project. In addition, this example highlights the potential of those able to negotiate internet and new social media to influence. This type of gatekeeping utilises a type of power that does not readily fit within one of French and Raven's (1959) six bases. While the community member does use informational power in one sense (in that they mediate the information available to influence others), the use of a global media (the internet) but with the claim of 'local' legitimacy, may also give the community member access to a very specialist type of Legitimate/Expert Power.

Gatekeeping Activity 3

The third noteworthy incidence of gatekeeping occurred during one of the public engagement events, following a presentation from a member of a formalised volunteering organisation. During the discussion that followed the presentation, a comment was made by a community member of high socio-economic standing that such a scheme would not be suitable for the community because they were close-knit and

could adequately take care of each other without formalizing care roles. Following this statement, a member of the community who had previously remained quiet at earlier events, stood up and contradicted the first community member, indicating that, as a non-member of a high-status clique, they did not feel taken care of, and saw potential benefit from the scheme. This was an interesting occurrence for two reasons. First of all, the first community member's assertion that 'the community does not want or need this scheme' was, in fact, a gatekeeping activity. In attempting to speak for the entire community, those who did not share this view were disempowered and their view essentially nullified. Secondly, it is interesting to note that, in this instance a community member with an opposing view *refused* the claims of the gatekeeping activity and asserted a different view point, however, the incident only appeared significant and provoked discussion afterwards because the gatekeeping act was challenged. As the first speaker was a community member with high socio-economic standing, who was closely connected to others in the community with Legitimate Power positions, it was *unusual* that someone drew attention to the gatekeeping behaviour and challenged it. This event served to both draw attention to the impact that gatekeeping acts can have when undertaken by someone who is perceived to have power (in that it was so unusual for such an act to be challenged) but simultaneously it illustrated that gatekeeping activities are not always successful and that by taking control of the discourse around the volunteering scheme, the second community member was able to reframe the discussion and 'seize' power within the context of the engagement.

Peripheral Gatekeeping Activities

In addition to the classical gatekeeping activities listed above, other behaviours occurred within the engagement process that could be referred to as peripheral gatekeeping activities, that is, activities which attempt to influence other community members' perception of the engagement but do not actively limit or translate the input of a particular individual or group. On one visit to a community, the first interview of the visit occurred with a community member who could be considered to hold a Legitimate Power position within the community (a member of the local community company). During this interview, the information arose that a staff member of the Scottish Ambulance Service (SAS) would be attending the next engagement event in the community (at the request of

several community members, to provide information on a voluntary scheme). It was made clear during this interview what the purpose of the SAS employee's visit was (to provide requested information). By the time the engagement activity took place some hours later, a rumour had spread to almost all participants that the SAS would be removing the air ambulance service from the island. The use of rumour in this case highlighted a lack of trust within the community towards the purpose of the engagement, however, it also illustrated the use of rumour as a powerful peripheral gatekeeping tool. The rumour, although baseless and openly discussed at the community engagement event, may have coloured the way that other community members interpreted the input of the SAS employee, and in essence, mediated their input into the engagement process. It also resulted in an unusually high turn-out at the meeting which illustrates the potential for gatekeeping activities to affect such a central aspect of community engagement as attendance at group events. Although this was by no means the only rumour that circulated within the four case study communities with relation to the Action Research, it is interesting to consider how powerful a tool rumour can be to influence power relations within a small community.

Withholding Activities

Another type of power-brokering activity observed took the form of withholding activities, that is, activities in which individuals mediated their own involvement in the engagement process, with varying effects on the outcomes of engagements. These behaviours are outlined below:

Opting Out

During the course of the Action Research project, a number of community members withdrew from the process entirely. While this could be considered a passive act (due, perhaps to a lack of interest or simply lack of time), withdrawal from engagement can also be used as an active expression of power (such as in the second degree of power as described by Gavanta (1980), also noted by Shortall, 2008). Withdrawal from the engagement process can signal a lack of belief in the process or a feeling that one's contribution is not making an impact, but it can also be used to make an active statement

of protest about the direction the engagement is taking. I believe that both of these reasons contributed to withdrawal from the Action Research project described in Chapter 4. In one particular community, there was a significant lack of trust between previous representatives of NHS Highland and the community when the project commenced due to historical difficulties. As the process continued, trust was built and the community participants came to believe that the NHS managers involved were not involved in a cost-cutting exercise, however, with the decrease in fear came an increase in apathy: it is possible that community members were no longer motivated to attend events purely out of concern that services would be withdrawn. In this community the final engagement event was poorly attended. In this area, however, community members had also expressed a particularly high level of satisfaction with their current service. Poor attendance at the final event (which featured a 'planning for the future' element) could also then be interpreted to mean that community members did not wish to engage in a dialogue that involved considering an alternative service model, using non-attendance could have been used as a form of mild protest. Interestingly, this is how the NHS manager involved interpreted the non-attendance of the community.

Over the course of the Action Research project, community members were not the only participants who were able to withdraw from the engagement. In one community, a productive dialogue about future planning had been established during the course of the Action Research project and a continuing communication plan was established to carry actions and discussions forward after the end of the project itself. Following the end of the project, however, the NHS managers involved disengaged from discussions with the community and did not follow the agreed plan. Within a year of the end of the Action Research project, the working relationship which had developed between NHS Highland and the community had disintegrated. It is unclear as to why NHS employees withdrew from the process but it has severely impacted on the potential for future engagement and planning within that area.

Participating without participating

On a number of occasions, participants in the community engagement events attended an event physically, but were unwilling to fully engage in the discussion at hand. Often

this took the form of a participant who came prepared with a particular statement on the topic of health care (for example, 'we can't do without our nurse/doctor') and would repeat the statement, often verbatim during the event regardless of the particular activity or topic of discussion. This is thought-provoking when considered in the light of Foucault's theories of discourse and power as it could be viewed as a tacit acknowledgement of the power of discourse. To use even slightly different phrasing to express a point appeared to be uncomfortable for some participants. The refusal to employ certain discourses around the topic of health care could imply that even the very act of speaking differently about services is a dangerous act. This was further illustrated by another incident in which participants in an engagement event attended but refused to fully engage with the activity:

In the final planning game stage of the Action Research project, participants from one community were split into two groups: the first group whose members had been involved for the duration of the Action Research project, and the second, whose members had not. Those who had not previously taken part in the engagement activities were suspicious of the motives of the project and, in particular, in the purpose of the planning game. Having come to the event late and missed the explanatory portion of the event, this suspicion was compounded. The members of the second team had come, not only 'armed' with specific views and statements on the topic of healthcare, but unwilling to enter into any dialogue on the topic, which led to a curious result. When playing the game, participants from the second team considered it to be so 'dangerous' to engage with the dialogue at hand, and to employ any alternative discourses, that the plan created as part of their game play exactly recreated the health care services in their community *as they were*. What is significant about this is that members of this community had overwhelmingly expressed that nursing services in the area were insufficient. Although in agreement with this assessment, the second team chose to use the planning tool to recreate their local services *including* the nursing service that they considered inadequate. This indicates that their 'non-participation' in the process contains an element of unwillingness to entertain any alternative discourses, even to their own detriment. This incident illustrated that, while the act of non-participation can be used as a form of protest (and therefore, potential source of empowerment), on occasion the result can be disempowering as it

withdraws actors from the engagement and planning process and can even prevent them from fully expressing desired change.

5.11 Discussion and Conclusion

This chapter has considered power in relation to community engagement, in terms of both the level of influence and type of influence an individual or group can hold over the other *within* the remote and rural community context by looking at power both as its effects are observed and as it is created through acts of speech. It has examined power in relation to the postmodern and how Foucault's theories of discourse and power can be used in an engagement context to more closely scrutinise the existing power relations at work. This chapter has also taken a postmodern/poststructural approach to the topic of power in remote and rural community engagement, (as befits a topic that highlights the importance of the local, and deals with the fragmented 'polyphony' of community voices) and has postulated that community engagement is postmodern concept that may be ill at ease within a modernist planning paradigm at present. In order to further examine power in this context, two methods were used: Foucauldian Discourse Analysis and Participant Observation.

Limitations of the Foucauldian Discourse Analysis described in this chapter may include the fact that the texts considered were not representative of wider community views, and that the analysis was heavily dependent upon my interpretation. Attempts were made to overcome these limitations by also including participant observation (to give context to the discourse fragments) and by checking my analysis against another participant who was present at the interviews, namely my thesis supervisor, in order to ensure that my interpretations were reasonable within the context.

Within the majority of community engagement literature, as well as engagement guidance for practitioners, the dominant narrative is that service providers and government hold the power in community engagement with the community as the passive recipients (or not) of transferred power. Engagement is, for the most part, still conceptualised as a transfer of power from a powerful government/service provider to a powerless citizenry. Little attention is paid to individual agency within the engagement

process. This dichotomous view is a logical way to conceptualise engagement that emphasises the empowerment of communities as a key goal and it fits well within a Hobbesian view of power relations. This study, however, has illustrated that not only do communities have the power to affect engagement, but individuals within remote and rural communities can and do exercise power in such a way that it can impact the process and outcomes of a community engagement for health care planning engagement initiative. This power to control discourse can influence other forms of power, for example it can dictate the boundaries of Expert Power, or it can delineate who is and who is not deserving of Legitimate Power, however it does not itself sit comfortably within French and Raven's (1959) typology. Study findings show that, in a remote and rural context, communities can also use *discursive* power to impact on the process in a way that both augments and transcends French and Raven's typology. This chapter will suggest that Discursive Power, or the ability to wield discourses to create and broker power, is in itself a form of power that can exist alongside but can also transcend the bases of social power (French and Raven, 1959).

A number of local figures occupying outwardly 'legitimate' positions of power were described within the FDA and were also observed within the participant observation, however, they were intermittently presented as contested figures. The legitimacy of Legitimate Power figures appeared to vary by each respondent, which is interesting to consider since local decision making bodies such as the community council are often the first point of call for managers seeking to engage with an unknown community.

Local health care practitioners also act as very powerful figures with the potential to influence engagement which they can and do, however community members also exercise power over local health care professionals by placing discursive boundaries on their behaviour, and limiting their potential to exert Expert Power. Health care practitioners were placed in a liminal space by the analysed discourses, walking a fine line between their professional role and their role as a community member, often negotiating contradictory expectations. Discourses included narratives of 'suitability for community life', which implied that, while local medical and nursing personnel do often hold a strong degree of legitimate and Expert Power within the community, they are constrained by discourses about suitability for the rural, as well as the incomer/local dichotomy, and

must maintain a level of 'separateness' from the community in order to maintain their Legitimate Power. Discourses of 'tradition' were also employed that effectively constrained remote and rural health care practitioner behaviour and encouraged them to work 'above and beyond' their job description. Within the participant observation [notes], local health care practitioners were seen to be aware of the high expectations of the community and felt pressured to conform to a role that was potentially very stressful and unrealistic. In an informal conversation, one local district nurse gave an example of this pressure by explaining that she never felt like she was 'off the clock.' She could never sit down in an evening and have a glass of wine or two because she was permanently on call and could be needed by the community at any moment. She felt denied of these small freedoms.

Community members also exerted intra-community power in the form of gatekeeping activities, as well as using discursive categories such as incomer/local that excluded certain community members' contributions by deeming them unrepresentative. By emphasising the dominant narrative of incomer/local, community members also played in to the idea that there is an ideal participant, a truly representative community member, which plays in to the concept of representativeness. In other words, within the traditional 'narrative' of community engagement, NHS Highland has looked for representative community members, and respondents in this chapter have positioned themselves to fill that role. Community members appear to understand the power of this discourse, however, it is also an excluding discourse; it disempowers as it empowers and those who are defined in opposition to the 'local' and 'natural' are effectively othered and their contribution lessened.

Discourses relating to the natural and organic decay were also found in several transcripts, used to describe the entire community either in full bloom or in the process of mouldering. These discourses were linked to the concept of the rural idyll, but were also linked to the incomer/local discourse when the presence of incomers was seen to affect the natural order (either by causing the community to 'bloom' again, or acting as a catalyst for its decay). The discourse of the natural and of organic decay is significant because, if this discourse is dominant within a community a process of decay can be seen

as inevitable, natural, and therefore cause a loss of momentum in an engagement process.

It is the contention of this thesis that, based on the characteristics of remote and rural communities identified by the literature review in Chapter 2 (including, but not limited to the role of the practitioner as both resident and professional, and the ‘fishbowl’ effect of rural society), that the complex power relations observed and their effects were specific to the remote and rural context. That is not to say that individual power does not affect engagement in other contexts, merely that the discourses employed (rurality, history, incomer/local) are imbued with a special meaning in the remote and rural context that makes them more powerful, in particular in relation to outside service managers. As evidence, I offer a personal anecdote. At a recent meeting of the Cross Party Rural Policy Group at the Scottish Parliament (October, 2012) I observed service providers and policy makers employing these same discourses, in particular that of incomer/local, when discussing the future of Scotland’s rural communities. The discourse used a normative and powerful way when discussing rural peoples’ attitudes towards new developments and it was very much the case that those identified as incomers by the group were dismissed as holding unrepresentative opinions. I posit then, that if the incomer/local dichotomy is recognised at a *policymaker* level as a dominant ‘truth’ discourse, then it is a powerful tool that remote and rural residents are able to use within the arena of civic engagement and decision making.

To summarise, throughout both forms of analysis, complex power relations were observed, although it was sometimes the case that, due to the power-brokering behaviours of other community members, power was not always held where and by whom it would be expected by an outsider. In several cases organisations and individuals who would outwardly be considered legitimate non-community members, were considered ineffective and illegitimate by community members, whereas other individuals or informal groups (such as action groups) may have held power but would not be immediately known to the NHS in an engagement process. In short this chapter has shown a number of complex power interactions and acts of power creation that took place during the engagement process described in Chapter 3. A summary of the effects or assumed effects of this are illustrated in the table below:

Table 11: Summary of potential effects of individual power on community engagement (individual level effects)

Individual Effects
To cause some participants to withdraw from engagement entirely or not engage in the first instance
To cause some participants to dominate discussions and others to be subordinated
To cause some participants who took part to refuse to engage with other discourses (both community members and managers)
To delegitimise the contribution of some participants and to valorise others
To place discursive limits on the behaviour of some individuals, affecting not only their behaviour but how it is perceived by others

Table 12: Summary of potential effects of individual power on community engagement (community level effects)

Effects on the community
To influence which ideas were considered viable and which were not
To influence which ideas were taken forward successfully and which were abandoned
To influence how the contribution of certain individuals or groups was perceived by the community: as representative or not
To influence how the community views itself and its potential to be empowered/resilient and to take part in engagement

To summarise, it is my belief that the observed and uncovered power relations had the potential to influence the outcomes of the engagement initiative. Observing the individual creation and brokering of power first-hand emphasised that power is not a static concept but something that is constantly being created and recreated, and therefore not something that can be easily mapped or inferred with reference to specific local governance structures. Community members can and do exercise power over local health care practitioners, NHS managers, and their fellow community members through the use of both discourse and gatekeeping activities.

The use of a postmodern theoretical perspective was key to uncovering the complexity of the local power context and helped to provide understanding of the practical difficulties entailed in 'shoehorning' a postmodern concept like community engagement in to a

modern planning process. The use of French and Raven's (1959) typology was helpful in considering the types of power that were being created, promoted or limited by discourse or action, however it was also found that discursive power itself can both affect other bases of social power but also act as a base of power itself, distinct from expert, informational or other types of power.

This chapter emphasises the danger in approaching engagement as a finite project, it is instead a conversation, an on-going negotiation of power, discourse and knowledge. While considering the Action Research data in this light does not offer to solve any of the difficulties that arose during the engagement process, it does shed light on some of the *meaning* created, which can help to create a more informed conversation for the future.

Chapter 6. Conclusion

6.1 Return to the original problem

At the core of this study is the issue of engaging with remote and rural Scottish communities for the purpose of anticipatory health care service design. This is a complex, contextual issue that is predicated on certain assumptions: firstly, that demographics and disease profiles in Scotland's rural areas are changing (Scottish Government, 2012; Skerrett et al, 2012). Secondly, that new employment structures for health care workers (The NHS Staff Council, 2004; European Parliament, 2003) and requirements for cost savings (MacRae, 2009) have led to a change in how primary care services are delivered (Scottish Government, 2008). At the same time, community engagement and mutual co-design have become statutory requirements for public service planning (Scottish Government, 2004), but evidence from academic papers, as well as the Scottish media, suggests that it is not always done well (Carnegie, 2009; Milewa, 1997; Pollock, 2008, Cramb, 2007), especially in rural areas. Within the reviewed literature, few studies were found to examine the effectiveness of using an engagement approach for resource allocation (NICE, 2008) and at the time of writing, none were found that considered community-level health care planning within the remote and rural Scottish context.

The majority of academic and 'grey' literature (including practical guidance and policy) on the topic of community engagement portrays engagement as a basic process of transferring decision making power from one (largely homogeneous) group to another with a few notable exceptions (Doherty and Rispell, 1995; Porter and Shortall, 2009; Barnes, 2009). Furthermore, the majority of studies of power in community engagement settings were found to focus on systematic or organisational power (with the same aforementioned notable exceptions), rather than considering the power that non-elite participants within a process may yield (Perrucci and Pilisuk, 1970; Hunter, 1953). In addition, few studies have considered barriers or promoters of effective engagement (NICE, 2008) including those that may come from individual power and influence.

The aims of this thesis were threefold:

1. To consider remote and rural community engagement for healthcare design in a Scottish Highland context, understanding the roots of current practice, the policy environment, and key contextual issues.

2. To review an iterative process for engaging remote and rural areas of Scotland for the purpose of designing their future health care services that was undertaken from 2008-2010 in the Scottish Highlands, considering the real challenges of engagement within this context.

3. To investigate how power could be constructed, deconstructed and brokered by the community-based stakeholders during this process, using participant observation and a poststructuralist discourse analysis, and consider whether individual power/agency could affect the engagement process.

In order to meet these aims, three core research questions were addressed:

Research Question 1: What is the context and evidence base for engaging remote and rural Scottish communities for health care service design?

Research Question 2: How successful was the Action Research process described in the thesis (RSF) at achieving its aims and; what wider learning can be extrapolated from these results about the reality of engaging with remote and rural Scottish communities for health care design?

Research Question 3: To what extent was individual agency and power observed within the Action Research process and could this have affected the process?

The following section will reiterate how these research questions were addressed by this thesis. This chapter will then go on to consider what the original contribution to knowledge of this study is, and what is recommended in terms of further research.

6.2 Addressing the original research questions

Addressing Research Question 1

Chapter Two endeavoured to address the first research question, namely, what is the context and evidence base for engaging remote and rural Scottish communities for health care service design? In order to address this question, a systematic review of the current

literature dealing with the contexts of engagement, remote and rural Scotland, and health care was undertaken.

Chapter Two considered the roots of current engagement practice and found them to have emerged from various, not always compatible traditions including community development (Rifkin et al, 2000), empowerment (Butterfoss, 2006), neoliberal politics of state withdrawal from public services (Barnes, 2009), participative democracy (Pelletier et al, 1999), and Action Research. It was found that there is a heavy Scottish policy emphasis on engagement and co-production, including at the local (community) level. However, it was also found that this policy context was not always compatible with wider European policy around working times (European Parliament, 2003), not to mention rigid NHS governance (The NHS Staff Council, 2004) and planning structures. The literature review also found that an emphasis on engagement aligned with contemporary discourse around new rural governance (Little, 2001; Shucksmith, 2009) and the new rural paradigm (OECD, 2006) but questions were raised within this academic debate around the role of community engagement in new rural governance structures as a potential tool for disempowerment as well as empowerment (Mackinnon, 2002).

The literature review found that the majority of literature pertaining to engagement for planning was most often grounded in a physical or environmental planning context, and within a health care context it was most frequently undertaken by health care managers seeking to involve public experience at different 'levels', or on a patient to clinician basis for planning individual health care plans, but least frequently in instances of genuine community level co-planning. There was also evidence, that healthcare engagement was not always effective and was on occasion being used to legitimise pre-decided outcomes, or that input from community members was not being used to make substantive changes. This was highlighted as a translational problem by Healey (2009) who considered that managers and community members may value different types of knowledge in the decision making process but lack the means to effectively communicate. It was also considered that, despite legislation and guidance on community engagement, the modernistic planning structures of the NHS are not easily compatible with the postmodern plurality of voices supported by community engagement, at least theoretically.

A number of features of the remote and rural healthcare context were also highlighted as differentiating it from other engagement contexts, including features of remote health care delivery (Douglas, 2005; West et al, 2004, and Farmer, 2010) as well as features of the remote and rural communities themselves.

In terms of methods used, the literature review uncovered a number of deliberative engagement methods for planning including citizen juries (Leneghan, 1999), planning for real (Democracy Network, 1998), discrete choice experiments (Ryan et al, 2008) and charettes (Sanhoff, 1999) but found that there was insufficient evidence for their effectiveness in bringing about quality joint decisions, and additionally that they may be ill-suited to the specifics of remote and rural planning contexts. The review yielded no examples of anticipatory health care co-design in a remote and rural Scottish context at the time of writing.

Addressing Research Question Two

Chapters Three and Four described an Action Research project that aimed to engage four remote and rural Scottish communities in anticipatory health care service design. The second research question described in this thesis is: how successful was the Action Research process described at achieving its aims and what do these results mean about the reality of engaging with remote and rural Scottish communities for health care design?

Chapter Three described the Action Research methodology of the RSF Project, which was loosely based on a public decision making model popularised by Renn et al (1993), and featured a range of methods including community meetings, community conferences, community workshops, information road shows, interviews, and a new participatory planning game called the RSF Game, which aimed to marry experiential knowledge with the NHS planning system. The Action Research methodology allowed each of the methods to be planned, implemented, evaluated and re-implemented within four remote and rural Highland communities, and therefore to be iteratively refined for contextual suitability.

Chapter Four described the findings from the RSF project, and in doing so addressed the second research question. Each stage of the project was evaluated using a combination of participant observation and simple mixed method feedback questionnaires. These data

were then compared to the evaluation criteria used within the project, which was based on an evaluation framework posited by Boutillier et al (2001). On the whole it was found that participants valued the chance to hear other viewpoints in the community and to learn more about their services (especially cost information). It was also found that some participants were frustrated by the anticipatory (and indeed the research-based) nature of the process as they were keen to see immediate changes. In terms of the Action Research methodology as a whole, the iterative nature was useful in altering individual methods to local needs. It was also found that participants were able to use the process to build trust with their service managers, however, it was also observed that this trust was easily broken when managers failed to remain engaged. The RSF Game was found to be a useful planning tool that allowed participants to create potentially useable health care plans, but with some limitations. These included challenges found in collecting necessary data for meaningful play, and a need to engage with a wider process of learning and engagement to make it meaningful for participants. Attendance at engagement events was variable. This chapter also described the personal challenges faced by the engagement facilitator, something that has been widely overlooked (or glossed over) within, as Porter and Shortall (2009) refer to it, the “almost universally sanguine literature concerning stakeholder involvement” (271). The chapter concluded by making practical recommendations for future engagement within the context.

Addressing research question 3

Chapter 5 addressed the final research question: To what extent was individual agency and power observed within the Action Research process and could this have affected the process? This question was addressed by means of a poststructural Foucauldian Discourse Analysis of existing interview data from the RSF project, combined with participant observation gathered throughout the Action Research project. This analysis was *not* intended to provide a representative picture of attitudes or feelings within the four Highland communities, but instead aimed to analyse the potential for individuals to create, broker or hinder power through their own actions or use of discourse. Findings were related to French and Raven’s (1959) bases of social power theory in order to consider which types of power could potentially be affected. It was found that respondents were able to (consciously or unconsciously) employ discourses that had the

potential to constrain the power of fellow community members and enhance their own within the engagement process, and to influence whether their community was perceived as empowered, resilient, or declining. It was also found that respondents were also able to create complex discursive boundaries for local health care professionals who were shown to operate within a liminal space (neither fully community member nor fully other).

6.3 Contribution to Knowledge

In terms of a contribution to knowledge, this thesis makes three key contributions. Firstly, it contributes further contextual knowledge about the challenges of engaging with remote and rural Scottish communities for local health care service design; a topic about which very little has been written. Secondly, it contributes a novel method for anticipatory health care budgeting aimed at a remote and rural Scottish context, namely the RSF Game. Thirdly, it contributes to the debate around individual power and agency within remote and rural community engagement for healthcare, which few studies have examined. These contributions will be further explored in the following sections.

6.4 Remote and rural healthcare in Scotland: a context for anticipatory engagement

Remote and rural barriers to engagement

While a number of potential barriers to community engagement in remote and rural areas were uncovered by the systematic literature review, including challenges of distance, geographies and demographics, this study uncovered other barriers, previously unaddressed. There is often an assumption within the literature, that any existing barriers to engagement are reinforced by the body of authority (in this case the health board), or by power elites who seek to maintain the status quo, however little consideration is given to the ways in which these boundaries can be created by 'ordinary' individuals within a rural community in a health care engagement context. In fact, guidance written for the Scottish Government on health care engagement suggests that "[m]embers of the

community or users of a particular service are likely to have more knowledge of where people are who have a stake in what is being considered" (Scottish Executive, 2002). In other words, it is implicitly assumed that community members are best placed to identify those who are appropriate for inclusion in the health care engagement process. Within the poststructural analysis, this thesis did aim to not, as Murdoch and Pratt (1994: 85) would have it, reveal the ways of the powerful in order to "influence their decisions", but rather, as Cloke and Little (1997) expressed, *"to allow particular people in particular places to speak for themselves about the power relations in which they are located"* through their use of discourse (5). During the course of the discourse analysis described in Chapter Five, it was found that individual participants themselves drew on symbolic constructions of representativeness (authentic rural Highland-ness) in such a way that could be potentially affect the 'empowerment' of other individual community members. Despite the emphasis on inclusion rather than representativeness taken within the Action Research study, the concept was reintroduced by engagement participants who, through the use of discourse, positioned themselves and others as being either representative of an authentic community viewpoint, or as not, often through the use of an incomer/local discourse and discourse of nature/rurality. These are particularly powerful discourses with relation to the concepts of representativeness and legitimacy in remote and rural areas as *"[t]he claims of those describing themselves as 'locals' are premised on the notion of the natural, yet ancestral, and enduring rights of an indigenous population"* (Jedrej and Nuttall, 1996: 16). As MacKinnon points out,

"much of the appeal of community rests on a sense of loss in terms of nostalgia for earlier forms of social organisation supposedly characterised by close interactions and intimate face-to-face relations (Levitas, 2000). This serves to focus attention on rural areas as contemporary repositories of these (imagined) virtues" (MacKinnon, 2002:310).

The continued emphasis on representativeness by service managers (observed within comments about the diversity and representativeness of the participants present during the RSF project) was not lost on community members, who were able to discursively position themselves within the category of 'representative' and others without. It appears from the discourse analysis that individual participants in the engagement process found purchase with these notions of rural representativeness and employed notions of an ideal

rural representative to augment their power in an engagement setting, invoking the incomer/local discourse frequently, and occasionally by drawing on symbolic imageries of rural Scotland. Cloke and Little (1997), in their book *Contested Countryside Cultures* describe the powerful potential of such discourses of locality:

“The discursive power by which mythological commonalities of rural culture will often represent an exclusionary device, serving to marginalise individuals and groups of people from a sense of belonging to, and in, the rural, on the grounds of their gender, age, class, sexuality, disability, and so on. As rurality is increasingly understood as a phenomenon which is socially and culturally constructed, so the exclusionary qualities within these constructions need to be highlighted” (4).

Discourses such as the local/incomer discourse, and those dealing with tradition, history and nature are particularly powerful within the Scottish remote and rural context. As Jedrej and Nuttall (1996) assert:

“[n]owadays there is little material difference between rural society and urban society except the feeling that there is something different about rural life. This feeling arises, firstly, from what might be called the amplification of systemic features of social structure, features which are muted in the urban setting and, secondly, because in the construction of national identities the rural landscape and its inhabitants are resorted to as a treasury of images” (14).

By drawing on this rich “treasury of images” (that includes, according to Burnett and Danson [2003], hegemonic images of wilderness, nature and a ‘pre-modern peasantry’ with ancient and historical ties to the land) individuals in rural areas are able to tap into dominant tropes that have become culturally privileged. By framing some community members in a colonial role, their outsider status is highlighted, but so too is the potential for damage to the community caused by their presence. Doel (1994) refers to this familiar process of othering as *“The Other of the Same”*. Doel, building on the Foucault’s concept of ‘The Same’, argues that as academics, we impose and reaffirm the same hegemonic modes of thought, even when dealing in postmodern modalities. Philo (1992) considers the incomer/local diode as a key hegemony that is used by academics as a *“familiar and conceptual mooring”* (24) and by the process of reproducing these same tropes, there is the potential for other “rurals” to become marginalised. (25) As the local/incomer dichotomy is a modernistic framing of the rural, Halfacree (1993) asks whether drawing attention to these formations of identity perpetuate these very processes. In other words, does an academic reiteration of these “othering” tropes reinforce a false

categorisation that is unhelpful in uncovering the multiplicity of rurals present in a postmodern rural Scotland? This thesis does not seek merely to reiterate these categorisations, but rather is concerned with how individuals within a remote and rural community are able to harness such 'metanarratives' for their own purposes. These modernistic tropes, although imbued with the illusion of (truth and stability) are in fact shown to have shifting boundaries and to have postmodern applications within the everyday, individual creation of power and identity.

It is worth considering whether these discourses would be similarly employed if the speaker had been within a wider community group setting at the time of recording. Framing oneself as legitimate or representative mouthpiece for the community to an outsider (myself) also occurred with quasi-legitimate authority figures within the community, for example unelected community council members who acted as gatekeepers for the rest of their community. If, as it appears to be, the notion of representativeness is embedded as a dominant discourse in its own right, it may prove challenging for rural health care managers to move beyond this rhetoric.

A number of practical conclusions and recommendations for future engagement practice were made in Chapter Four based on the results of the RSF project, however Chapter 4 also recognised key contextual challenges which included the need for continuity of contact between stakeholders and a processual rather than an episodic approach to community engagement, but it also identified the specific challenges faced by those who undertake engagement. It is a truth widely unacknowledged within the engagement literature (but very much anecdotally acknowledged by health care managers) that engaging with remote and rural communities can be a personally demanding task. The personal toll that is taken by standing in front of a hostile room and receiving, often very personal, abuse should not be underestimated as a barrier to further engagement in this context. The complex role of the remote and rural health care practitioner was also highlighted within this study as having the potential to act either as a barrier to engagement or a promoter to a meaningful and productive design processes.

6.5 A new method for engaging remote and rural communities for health care service design

The RSF Game was initially conceived to address a perceived gap in the available methods for remote and rural health care planning including a need for a method to address the contextual/evidence-based “*language barrier*” (Healey, 2009) between community members and health care managers, that was context appropriate (including relevant roles, skills and costs), could result in a useable health care plan, and built on an existing engagement process. In many ways the RSF Game was successful in addressing these aims, but with some caveats. Due to the iterative development process trialling the game in four different remote and rural areas, the game became increasingly contextually appropriate as it evolved. Trialling the game with managers from a variety of health and social care organisations (including the NHS, Local Authority, Scottish Ambulance Service and more) also ensured that the resulting information was useable within a variety of planning structures.

The RSF Game combined experiential knowledge and preferences of local participants with NHS costs and planning criteria. The game was found to have a variety of applications including training and education (participants reported learning a great deal about the planning process), the creation of job descriptions, the identification of joint priorities, and full service planning. However, there were also found to be a number of limitations to the game’s effectiveness. Firstly, it proved difficult to meaningfully include the contributions of participants who were not present. Additionally, it was found that game play had to be strongly facilitated, both to ensure that groups were not dominated by any one voice, but also to ensure that groups had equity of access to knowledgeable stakeholders in the room such as local managers from various service organisations. It was also game was most effective when played as part of a wider engagement process.

One of the key difficulties with the RSF Game, however, was that it proved challenging to obtain accurate budgets at a community level, especially from service providers dealing with mainland communities without such discrete boundaries, so there was, by nature, a high level of estimation involved in creating a budget summary for each area. Not only did service providers (NHS Highland, Scottish Ambulance Service, and Local Authority) often

appear unwilling to divulge budgets, but there was a lack of uniformity across localities in the way that data was collected and reported that made it difficult to compare across communities. It also proved difficult to obtain disaggregate data for mainland communities which proved to be a particular challenge in areas where there were claims of service inequity. This situation, however, may be in the process of changing at present as NHS Highland and the Highland Council are in the process of merging and reconfiguring health and social care service delivery.

Although this thesis makes no claims that the RSF Game is a panacea for all remote and rural health care planning challenges, it does constitute a unique contribution to the field. Since its creation the game has been incorporated into the Scottish Health Council's Participation Toolkit (2012) and is currently in the process of being trialled in rural Australia (Farmer, private correspondence). The game has also been used as part of planning simulations in order to teach engagement practitioners such as service managers about the complexity of engagement for planning. Over the course of the study, two well-subscribed workshops were held in which service managers from a variety of organisational backgrounds operating within remote and rural Scotland (including NHS, Local Authority, Scottish Ambulance service, charities and police) were given 'roles' to help them consider the engagement process from another perspective.

6.6 Power, Discourse, and Rural Community Engagement for Healthcare

Traditional conceptualisations of community engagement postulate a basic power struggle between engager and engaged (Arnstein, 1956; Rifkin et al, 2000). In fact, the Ladder of Citizen Participation, a typology created by Arnstein (1956) that operates on this basic assumption, still underpins most practical engagement guidance today. There is little information, however, about the power struggles that exist *within* these stakeholder groups, for example, within the community itself. In addition, academic studies that do deal with power relations within rural areas tend to focus on 'static' power structures such as local government and economic loci of power, or else on the 'power elite' within communities (such as Perrucci and Pilsuk, 1970; Gaventa, 1980; Reed, 1997). There is

little information, however, on how power is created, reinforced or undermined by *all* individuals within a rural engagement process.

Philo's (1992) paper 'Neglected rural geographies: a review' identifies what Murdoch and Pratt (1993) describe as an "*unwarranted focus upon, and concern with the interests and activities of powerful groups*" (53) in the field of rural research. Murdoch and Pratt, while agreeing in principle that greater engagement with postmodern conceptualisations of plurality is needed, express concern that, in dealing with the interests and activities of *all* rural peoples, that aspects of the postmodern should not merely be tacked on to modernist frameworks. In other words, what is called for is a more self-reflexive postmodern framework for analysis: a framework that allows researchers to examine the rural *as it is constructed*.

It is the contention of this thesis that within a small, remote and rural community, there is potential for individuals to exert even more influence over an engagement process than in a larger, more metropolitan setting with more potential 'players' (Slama 2004), and therefore a closer look at the complexity of power relations within such a process could be illuminating for future engagement practice. For this purpose, this thesis has employed Foucault's theories of power and discourse to examine how individual community members continuously use language to broker power and how this affects this community engagement process in practice.

One of the primary goals of engagement in healthcare, as outlined by Rifkin et al (2000) is empowerment of participants. Conceptualisations of this power transfer, however, remain simplistic. According to Rifkin et al (2000) the result of participation is that

"community people, essentially the poor, gaining information, access to resources and eventually control over their own lives rather being dominated by the authorities by whom they have been exploited"(14).

At the same time, De Vos et al (2009) point out that "*[w]ithout due analysis of power relations and interests, it is impossible to work on empowerment*" and Carr (2007) contends that "*[d]ifficulties with power relations...underlie the majority of identified problems with effective user-led change*" (267). It has been one of the central aims of this thesis to address this gap of understanding in "*power relations and interests*" in order to further understand the complexity of power relations present in the remote and rural

Scottish healthcare engagement context and better understand these relations that may underlie problems with user-led service change.

Extending the bases of social power in a remote and rural engagement context

Jedrej and Nuttall (1996) assert that most studies of rural communities do not “*go beyond the rhetoric*” of remote and rural communities and show “*how community is produced and deployed by actors themselves.*” A majority of previous studies dealing with rural community have focused on modernist conceptualisations and categorisations of power via an exploration of power elites. Studies of power within rural communities have tended to focus on either systematic power, resistance to systematic power (Gaventa, 1980) or the presence of power wielding elites such as land owners . A few studies focussed on individual power in engagement that took place in an organisational setting (Carr, 2007; Hodge, 2005) and none were found at the time of writing that examined individual power within a Scottish rural community-based engagement context. What this thesis considers is how all community participants (and indeed all participants) within an engagement process employ discourse (whether consciously or unconsciously) as a form of power with the ability affect the engagement process.

It was discussed in Chapter 5 that not only do the many forms of social power impact on the remote and rural engagement process, but also that the very language used within the process itself can be used to create, reinforce or undermine power. It is the contention of this thesis that, within a remote and rural community engagement context, discourse can not only affect the other bases of power, but it can function as a new type of power in and of itself and it can have very real consequences with regards to engagement outcomes. The use of a particular discourse, whether conscious or not, has the potential to affect people’s perceptions and behaviours – in other words, it acts to subtly influence choices. According to French and Raven, their categorisation does not focus on the *motivation* of one yielding power, but rather on how other actors are influenced *by* the power holder.

Discourse analysis has been used by previous studies to examine power relations within engagement initiatives, however, these studies examined the use of systematic power within formalised engagement proceedings, for example patient involvement groups

(Hodge, 2005). They have not been community based, nor have they examined the way that ‘ordinary’ individuals may yield power of their own within the process.

If someone in a social situation...	Has ‘authority’ stemming from societal position	Has celebrity or charisma	Has knowledge or skills that others need	Has ability to provide something others want or need	Has ability to apply negative consequences	Has facts that form the basis of a logical argument
Then they wield...	LEGITIMATE POWER	REFERENT POWER	EXPERT POWER	REWARD POWER	COERCIVE POWER	INFORMATION / PERSUASION POWER

Table 13: French and Raven's (1959) Bases of Social Power

Discursive power differentiates itself from the other bases of social power in French and Raven’s framework in that its influence does not stem from traditional authority or societal position (Legitimate Power), it does not rely on charisma or ‘celebrity’ (Referent Power), and it does not provide something that others want or need (Reward Power). The use of discourse was seen in this study to affect Expert Power by discursively positioning particular objects as either local or non-local, and therefore uniquely placed to provide knowledge about the local area. It was also seen to have coercive effects by placing discursive boundaries around the behaviour of local health care practitioners as well as other community members, and to ‘delegitimise’ Legitimate Power. The use of discourse, however, does more than simply augment or limit the other bases of power for either the speaker or the object of speech. By drawing on wider societal discourses, respondents tap into existing ‘conversations’ and tropes that create meaning. The act of *affecting* power through the use of these discourses is in itself powerful. The ability to create meaning and reframe a subject in such a way that in can affect peoples’ behaviour differs from use of French and Raven’s informational or persuasion power, in which the speaker uses facts to form the basis of a logical argument that in turn persuades the listener. It is also more than simple manipulation of the listener as discourses can be employed without full consciousness of their effect. Rather, the use of discourse both affects the existing bases

of power within a rural engagement initiative and operates independently of them, as its own source of power. An individual may consciously or unconsciously use what I will call discursive power to reframe a subject and create their own discursive reality. The following diagram (Figure 15) outlines how individual discursive power fits within French and Raven's (1959) bases of social power, in that it can act both as a base of power itself and as an influence on the other bases (excluding Informational Power which is often omitted due to weakness of potential to influence). This relationship is illustrated on the right hand side of the diagram, whereas the left hand side shows a continuum of group decision making power. This is to illustrate that individual influence on the engagement process *does not* negate the fact that overall, one group is still likely to control allocative and decision making power and that different types of engagement methodology or approach may well facilitate a transfer of this power to some degree, as Arnstein pointed out in 1969. This study has shown, however, that individual forms of power have the potential to impact on the success of an engagement initiative at any point along the continuum of power.

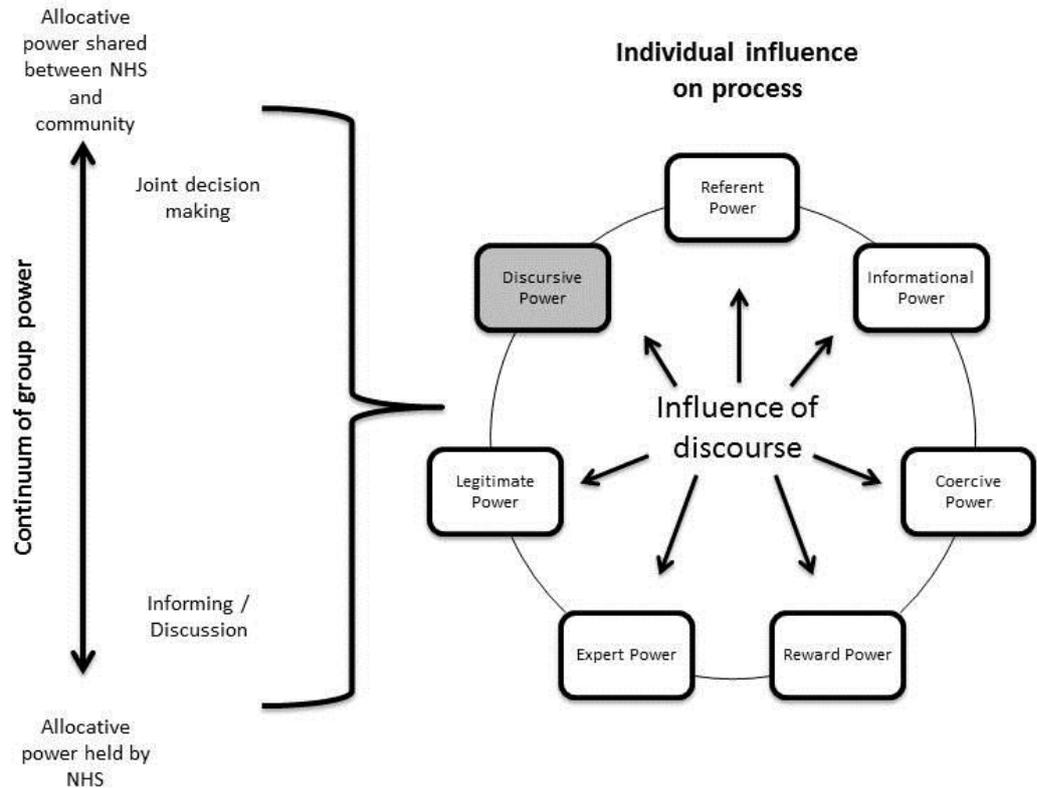


Figure 15: Conceptual diagram illustrating the influence of discursive power within the engagement process

Through the use of discursive power a community member can be framed as an outsider, the conduct of a GP as unprofessional or exemplary, certain behaviours become either acceptable or unacceptable, and an engagement process becomes either legitimate or bogus. When these discourses become part of the 'shared narrative of an imagined community' they can have very real effects regarding who is invited to the table, what the conversation consists of, which can in turn affect engagement at all points on the continuum, from informing/discussions through to joint decision making.

So what application, if any, does this have for engagement practice? Although community members were observed to have the power to influence the *process* of engagement, in many cases ultimate decision making power still lies with the NHS. In one case, an unwanted decision was countered by a remote and rural community who, via the media,

effectively employed a discourse of victimhood and discourses of tradition and rurality to leverage changes to unpopular decisions, however having to go to these extremes to feel 'heard' does not foster a positive collaborative environment for future engagement. Rather, it creates an adversarial atmosphere, amplified by the media (Thomson et al 2008) that makes both managers and communities reluctant to 'return to the table'.

An awareness of discursive power and how it can be used to create, reinforce or undermine other forms of power could be helpful to further engagement processes. That the type of discourses that are employed by the wider NHS, as well as NHS representatives could potentially help set the tone for interactions between stakeholders is acknowledged within the reviewed literature (Hui and Stickley, 2007; Martin, 2008) It is well known that the use of policy discourses and management jargon can be very alienating to community members and can influence how a manager is perceived within the community (Babidge et al, 2007) Similarly, an understanding of how community members can act as gatekeepers, often through their use of language or by controlling other peoples' access to an engagement dialogue, could be useful in empowering individuals to have their voices heard. At very least, using a post-structural method such as Foucauldian Discourse Analysis can help to defamiliarise familiar ways of creating meaning, and can draw attention to the potential effects that the use of discourses can have on the speaker and those around them. It can also highlight the use of discourses that are

"preferenced, reified, and legitimised, serve to mobilise meaning and maintain dominant ideology, while the exclusion of certain discourses allows for the silencing and marginalizing of others, assuring continuity of the prevailing power structures" (Kantor, 2006; 26-27).

There is, however, a danger in privileging Foucault's theories of discourse power in that, as Stein and Harper (2003) point out, of privileging the discourse of power can get to the point where it becomes reductionist and no longer helpful within a planning process. In other words, viewing all relationships and interactions within an engagement process in terms of power can distort the theory and practice of planning. As Stein and Harper explain

“One of the most crucial aspects of effective real-world planning is to distinguish things clearly between what should be done (the right, fair, just thing to do) and what is actually being done (the distortions due to power) and to effectively counter the effects of power...a view that sees everything as power cannot make this distinction” (137).

Therefore, a postmodern analytical lens can be helpful in drawing attention to these “*distortions due to power*” as well as instances of resistance, and can help to give a more nuanced understanding of the ‘rural community’ and how categories such as Others and Sames are enforced, shifted and manipulated. In the case of this study examining qualitative data to look for discourses that might further understanding of observed inequalities, it is also helpful to draw the eye back to the pragmatic in order to be able to make planning decisions at all.

Considering the postmodern issues of power, difference and otherness, Mol and Law (1994) posit that three ways of ‘seeing’ rural areas exist within rural academia. Firstly, there are is the *regional* conceptualisation of the rural which incorporates traditional modernist land-based discourses including the trope of the rural idyll, and is arguably the most common way in which the rural has been traditionally represented. Regional conceptions of the rural focus on “*purified representations of rural space*” (Murdoch and Pratt, 1993; 66) and are invariably modernist/positivist in their creation of categories and metanarratives. The second way of ‘seeing’ the rural, is from a *network* perspective. The network perspective, unsurprisingly, is concerned with the networks of power within and surrounding rural areas are held by local elites. While the network approach does go beyond the regional framework for rural analysis, it still “*tells us nothing about those who lie outside the (power) networks*” (Murdoch and Pratt, 1993; 62). This leads us to Mol and Law’s (1994) third approach to conceptualising the rural, the *fluid* approach. Fluidity, based on postcolonial notion of the ‘third space (Murdoch and Pratt, 1993) is an interstitial, malleable, and ambiguous space in which postmodern understandings of rural communities can find purchase. The fluid rural is one in which boundaries and categorisations are not constant but rather are drawn and redrawn by rural actors. This thesis locates itself firmly within the fluid approach to rural studies. Although it draws on regional (rural idyll) and even network discourses of the rural (incomer/local), it also examines how individual rural community members have the ability to recognise metanarratives such as those belonging to region and network discourses, and employ

them to negotiate power by the creation of temporary and constantly shifting boundaries that, nevertheless, can have an effect on the behaviour of other community members, particularly when these metanarratives are still 'bought into' by planners with conceptualisations of representation. Within this study it was found that participants were able to choose how they self-identify and how they identify others (with a little 'o'), but equally they were able to create discursive boundaries around behaviour that, if adopted as dominant discourses, could affect the power and behaviour of locals, authority figures, and local health care practitioners. This thesis draws attention to the fact that, in spite of functioning within an engagement 'system' that continues to be weighted in favour service provider managers in terms of deciding engagement *outcomes*, individual rural actors are able to employ powerful discourses that allows them to 'play' with power within their communities and affect the *process* of rural community engagement for healthcare. More study is needed, however, to consider how this knowledge can be used to create a more beneficial engagement process for all participants.

When taken as a whole there is a contrast to be seen between the rhetoric of community engagement put forward in Scottish policy, guidance documents, and within academic literature. Engagement is predominantly portrayed somewhat romantically as benign and normative but little attention is paid to the very real challenges that impact on the outcomes of engagement. Within a remote and rural Scottish health care design context, these challenges may arise from

- approaching community engagement episodically and a failure to maintain communication in the long term,
- The contrast between trying to adhere to the rhetoric of policy and guidance with relation to community engagement within a reality of planning constraints that rarely take into account the remote and rural context,
- lack of understanding of the role that individuals can play in influencing engagement outcomes (based on the dominant and simplistic representation of binary 'us versus them' power relations within community engagement),
- lack of understanding about the aspects of remote and rural communities that make them different from other engagement contexts,

- dearth of commitment to following through with potentially novel solutions that may require additional bureaucratic manoeuvring on the part of managers
- failure to accommodate the complex, sensitive and often contradictory role that health care providers such as doctors and district nurses are asked to play within the engagement context, and finally
- lack of acknowledgement of how uncomfortable and personally challenging engagement can be: something that likely has the most significant impact on health care managers' perception of community engagement but is rarely mentioned within the literature.

Remote and rural community engagement can be messy and challenging. Acknowledging this, as well as the plural and often contradictory representations of rural identity that arise from the engagement process can help to reflect the tensions and ambiguities of the changing remote and rural health care context. As Renedo and Marston (2011) point out, there are inherently inequalities in any engagement process, in terms of who has access to information, to resources, and to positions of status, however by considering remote and rural engagement in a more nuanced way it is possible to consider the reality, rather than just the rhetoric.

6.7 Recommendations for further research

While this chapter has outlined the contributions to knowledge made by this thesis, the research described here has also led to a number of recommendations for further study. This thesis has described a new participatory planning game for remote and rural healthcare; the RSF Game. The game was effective in facilitating the creation of local health care plans, however there were limitations in terms of its effectiveness in including the viewpoints of non-attending community members. Further study is required to consider how this data could be usefully synergized during game play. Additionally, it is not known whether the game would be effective in other contexts, such as accessible rural, urban, or non-Scottish contexts. At present, the RSF Game is being trialled in remote Australia (facilitated by thesis supervisor Professor Jane Farmer) but it may have wider applications in other geographical areas. More study is needed to ascertain whether the game would be effective in these contexts.

Although the RSF process described in Chapters 3 and 4 was designed to ‘pump prime’ sustained engagement within the four communities, there was evidence that at least one NHS manager had abandoned the process once it was no longer being facilitated by the researcher (myself). More study is needed into effective ways to marry the breadth of community engagement undertaken within the RSF process (engaging as widely as possible with all available community members), with the depth of engagement that was achieved within individual methods, in a sustained and meaningful way.

This study has raised wider questions about just how community members would *like* to be involved in health care planning and the extent to which involvement in public planning is a requirement of citizenship. As previously mentioned, engagement in health care service design is a statutory requirement for the Scottish NHS, and it is represented as a normative and ethical practice to undertake. However, there are additional questions raised about the ethics of imposing engagement on communities in which ‘no change’ is not an option. Additionally there is work to be done around considering the degree to which there is an impetus for co-created community design plans to actually be implemented, or if not, to be redesigned in conjunction with community members. In other words, one of the largest gaps between rhetoric and reality in engagement for service design is that policy rhetoric *implies* that a mutual service design process will lead to the implementation of mutually designed services, however the reality is that the trouble or bureaucracy involved with actually implementing these solutions may stop them from becoming a reality. Whether or not health boards should be required to implement co-designed plans, and the weight that community input should be given in relation to other factors is a significant issue for remote and rural community engagement for health care service design. The lack of impetus on the part of the health board to enact the results of engagement continues to impact on the extent to which community members trust in the design process, but it has yet to be resolved.

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Appendix 1: Feedback Questionnaire

Designing Health Care Services for Rural Areas, *with* Rural Areas Workshop

FEEDBACK FORM

Thank you for attending this workshop. Please take a moment to fill in this form and return it to the session leader before leaving. Your feedback allows us to help shape future workshops so that they are of most benefit for everyone involved.

1. On a scale from 1 to 5, how useful did you find today's workshop? (1 being the least useful, 5 being the most) Please circle one.

1 2 3 4 5

2. What did you find **most useful** about today's workshop?

3. What did you find **least useful** about today's workshop?

4. On a scale from 1 to 5, how likely is it that today's workshop will inform your future practice? (1 being very difficult and 5 being very easy) Please circle one.

1 2 3 4 5

5. On a scale from 1 to 5, how much did you feel that today's workshop increased your awareness of the issues around community engagement for health care design? (1 being did not increase awareness, 5 being awareness was greatly increased)

1 2 3 4 5

6. Would you recommend this workshop to colleagues?

7. If the content from this workshop was more detailed and was offered as a professional development qualification, would you be interested in taking such a course?

8. I think that this workshop could be improved by...

Thank you for taking the time to complete this questionnaire.

**Appendix 2: Individual Community Design Outcomes (results of the
RSF Game in full)**

Results of the Remote Service Futures Game in Full

Community B

Community needs (identified prior to Stage 4):

- Medical and social care for the substantial elderly population
- Emergency response (for a very remote area)
- Continuity of care
- Health professional(s) suitable to the island/community circumstances
- High blood pressure
- Conditions associated with smoking
- Depression
- Asthma
- Coronary Heart Disease
- Obesity

Additional community needs identified during game play:

- Conditions associated with drinking/drugs (which, at the time, were not captured in QOF data)
- Potential degenerative conditions such as Alzheimer's
- Preventative health care
- Screening
- Maternity and child care

Priority skills required to meet these needs:

- Can prescribe medicines (chosen by **1** group)
- Can perform examinations (chosen by **1** group)
- Can diagnose illnesses (chosen by **2** groups)
- Able to work out of hours as a separate budget exists to pay this worker if they do (chosen by **2** groups)
- Can support self-care, helping people stay in their homes (chosen by **2** groups)
- Able to work in the home to give care to elderly or disabled community members (chosen by **2** groups)
- Able to provide basic aid, perform emergency life support and comfort patients until further help arrives (chosen by **2** groups)
- Can visit people in their homes or in care homes, providing medical care for patients and supporting family members (chosen by **1** group)
- Able to provide treatment for minor illnesses and injuries and help patients to manage long term conditions (chosen by **1** group)
- Able to carry out more specialised care tasks within the home such as help with
 - Oral hygiene
 - Catheter care
 - Tube (peg) feeding
 - Stoma care
 - Moving and handling

- Use of hoists
- Nebulisers
- Renal assistance (chosen by **1** group)
- Able to carry out health screening (chosen by **1** group)
- Able to work effectively with elderly patients, recently discharged patients, physically disabled patients, or the terminally ill (chosen by **1** group)
- Able to dispense medicines and immunise (chosen by **1** group)
- Able to carry out some technical duties such as taking a patient's temperature and pulse rate, performing simple tests, applying simple dressings and demonstrating equipment (chosen by **1** group)
- Able to carry out non-medical care tasks such as dressing, toileting, washing, preparing and assisting with meals and some practical household requirements such as shopping, minimal domestic work and medicine prompting (chosen by **1** group)

Who or what could provide these skills?

Approximated community budget for community health and social care services (i.e. NHS plus council) is £200,000. Currently this budget pays for GP, nursing and social care services provided in the community plus cover for holidays and sickness and unforeseen health and care needs of community members; for example, someone requiring a hip replacement or to go into residential care.

Group A's chosen service configuration:

1 full time GP at a cost of £120,000

2/3 of a district nurse at a cost of £20,000

3 part time care workers (including some intensive care hours) at a cost of £40,000

Contingency money £20,000

Total £200,000

Group B's chosen service configuration:

1 full time GP at a cost of £120,000

½ time health care assistant at £11,500

3 carers doing 8 hours per week £14,000

2/3 of a district nurse £20,000

Contingency money £20,000

Total: £185,500

It was clear that a full time residential GP was key for both groups. Information from the 'skills' was subsequently used by the health board in drafting a new job description upon retirement of GP.

Community C

Community needs (identified prior to stage 4)

- Need for optimal emergency response (including a local response backed up by something more effective than single manned ambulances)
- Need for responding professionals to be able to more easily find specific houses within the community
- Need for patient transport
- Need for a health care professional whose role is holistic and flexible
- Need for continuity of care
- Need for social care for the elderly
- Need for informal visits to elderly residents to check up on them (not necessarily medical or social care)
- High blood pressure
- Conditions associated with smoking
- Obesity and side effects
- Coronary Heart Disease
- Asthma
- Cancer
- Alcohol abuse
-

Additional needs identified during game play included:

- Long term chronic disease management
- Need for urgent local assessment
- Midwifery care
- Carer support and intermediate care
- Mental health issues
- Drugs
- Social care for the young
- Evening services

Priority skills required to meet these needs

- Able to work effectively with elderly patients, recently discharged patients, physically disabled patients or the terminally ill (chosen by **1** group)
- Able to work out of hours as a separate budget exists to pay this worker if they do (chosen by **2** groups)
- Has intimate knowledge of the community and therefore can tell if something is amiss with an individual community member and can inform the health care provider (chosen by **2** groups)
- Able to provide treatment for minor illnesses and injuries and help patients to manage long term conditions (chosen by **2** groups)
- Able to carry out more specialised care tasks within the home such as help with
 - Oral hygiene
 - Special diets
 - Catheter care
 - Tube (peg) feeding
 - Stoma care

- Double moving and handling
- Use of hoists
- Nebulisers
- Renal assistance (chosen by **2** groups)
- Can carry out some technical duties, such as taking patient's temperature and pulse rate, performing simple tests, applying simple dressings and demonstrating equipment (chosen by **2** groups)
- Can assess risk to support anticipatory care (illness prevention) (chosen by **2** groups)
- Able to provide basic aid, perform emergency life support, and comfort patients until further help arrives (chosen by **1** group)
- Can work with mothers and young babies on areas such as feeding, safety, physical and emotional development (chosen by **1** group)
- Able to dispense medicines and immunise (chosen by **1** group)
- Able to recognise and respond to emergency maternity situations (chosen by **1** group)
- Can work independently but also part of a larger group under the supervision of a senior group member (the senior group member could be physically in another location though) (chosen by **1** groups)
- Can visit people in their homes or care homes, providing medical care for patients and supporting family members (chosen by **1** group)

Who or what could provide these skills?

Roughly approximated community budget for 'community health and social care services' (i.e. NHS plus council) is £138,200. Currently this budget pays for GP, nursing and social care services provided in the community plus cover for holidays and sickness and unforeseen health and care needs of community members; for example, if someone has to go into residential care.

Group A's chosen service configuration:

1 day per week of GP cover £24,200

1 full time Nurse Practitioner £40,000 (but doing 24/7)

1 full time Health Care Assistant £23,040

16 hours per week of an Intensive Home Carer £16,000

A volunteer scheme for informal community carers: free except for volunteer time

With approximately £34,000 left in budget for emergencies

Group B's chosen service configuration:

1 full time Nurse Practitioner £40,000 (but doing 24/7)

5 hours per week of an Intensive Home Carer at £3,500

A volunteer scheme for community carers: free except for volunteer time

A first responder scheme

Note: this group was not able to finish their detailed budget within the allotted time

There were serious challenges with community expectations from both groups who wanted a nurse practitioner to operate in the community 24/7 (as this was the service provided 'unofficially' by their previous District Nurse. However, even with a privately contracted nurse it was discussed that this was illegal under the European Working Time Directive and at least 4-5 nurses would need to be employed in order to give 24 hour cover. Currently, GPs are the only profession not bound by the European Working Time Directive. However, one group indicated that this could be overcome by having a first responder scheme in place to support the Nurse Practitioner. Also raised was the concern that a Nurse Practitioner is a highly skilled position and it would be challenging for such a practitioner to maintain their specialist nursing skills in a small remote community.

Community D

Community needs were identified as:

- Ageing population that requires care (both medical and social)
- Young families with specific needs
- Need for robust emergency response (very remote)
- Need for a professional who is able to do health promotion activities
- High incidence of high blood pressure
- High incidence of conditions associated with smoking
- High incidence of obesity

As the participants in Community D had slightly different planning needs than in Communities A-C, they used the game, in conjunction with their locality NHS manager, to identify skills needed within the community and then classified them as whether they were skills that were already available within the current local service team, skills that could be delivered or by someone outside the healthcare field, and skills that they required their new practitioner to have.

Skills already provided within the local health care provision team:

- Able to carry out care tasks such as dressing, toileting, washing, preparing, and assisting with meals and some practical household requirements such as shopping, minimal domestic work and medicine prompting
- Able to dispense medicines and immunise
- Can help in-home patients with eating
- Can prescribe and dispense medicines
- Able to carry out specialised care tasks within the home such as help with
 - Oral hygiene
 - Special diets
 - Catheter care

- Tube (peg) feeding
- Stoma care
- Double moving and handling
- Use of hoists
- Nebulisers
- Renal assistance

Skills that could be delivered peripatetically or by a non-health care worker:

- able to provide basic help to community members who are elderly or housebound such as lifts to a friend's house, help with shopping or other household tasks, or even just stopping in for a cup of tea to avoid social isolation
- Has specific skills to give advice during and after pregnancy and to deliver babies
- Following the assessment of needs by a qualified health care professional, this person can help patients to meet identified health and personal care needs, e.g. simple wound dressing, bathing/showering
- Gives advice about how to live healthily and prevent illness
- Works with community to identify and build activities for community development such as increased employment, affordable housing, attracting young families, and community transport
- Someone who works with the community to create activities to improve and maintain health e.g. exercise classes, healthy eating advice, walking groups
- Able to provide basic aid, perform emergency life support and comfort patients until further help arrives

Skills that participants would like their new practitioner to have:

- Able to assess a community's needs, plan and deliver services accordingly
- Able to coordinate local services across all providers to give an integrated service to individuals
- Has intimate knowledge of the community and therefore can tell when something is amiss with an individual community member and can inform the health care provider
- Contributes to child protection and protection of vulnerable adults, helps with accessing benefits and helps coordinate social services
- Can advise patients and relatives on how to care for long term chronic illness
- Can take medical histories, perform physical examinations, diagnose minor illness and interpret test results
- Can carry out some technical duties such as taking patients temperature and pulse rate, performing simple tests, applying simple dressings and demonstrating equipment
- Able to provide treatment for minor illness and injuries
- Can provide care for long term conditions, helping people stay in their homes

- Can perform a paramedic-type (i.e. emergency nurse practitioner) role and cover OOH
- Can work with people of any age who suffer from chronic illness or disability, helping them to overcome difficulties

The final set of skills was to form the basis of a job description for a joint health/emergency worker, the details of which would be considered between SAS and NHS managers who had both taken part in the engagement workshops. Subsequent meetings between the NHS locality manager and the community group to take forward the development of this new role were planned prior to the end of the event.

Appendix 3: Health and Place Article