North of Scotland Public Health Network (NoSPHN)

Remote, rural and island health proofing checklist

Discussion at NoSPHN meetings highlighted the benefits of developing a remote, rural and island checklist (aide memoire) to inform discussions, processes and decisions being made at for example:

- A national level eg: Shared Services Reviews; Public Health Strategy development; Public Health Review; public sector reform; national groups developments; and the Island Bill discussions
- Through regional planning and developments eg service redesign
- Locally with eg IJBs and through workforce development.

A number of tools and frameworks exist to support remote, rural and island proofing.[1,2,3,4,5,6,7] The attached offers excerpts (prompts) from these to guide thinking. They have been adapted in a public health context for two purposes:

- **Improving the health of our populations**: for generic use when considering policy and service planning developments to ensure we maximise improvements to the health of our remote, rural and island populations understanding the impacts of for example: transport links; weather; compounding issues such as remoteness and isolation; and rural deprivation.

- **The organisation and delivery of public health services / the public health workforce:** for example the effects on skills development and capacity building; models of delivery; resilience and sustainability and the need for remote and rural focussed skills.

Colleagues are encouraged to use the information in the following pages to inform work – if we can be of any support in using the checklists please do not hesitate to contact us. It is anticipated that the use of these checklists will generate revisions and comments are welcome to pip.farman@nhs.net .

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1. What is remote, rural and island proofing for health?

Remote, rural and island (RRI) proofing is a process that involves looking at policy and strategic planning and developments through a remote, rural and island lens. It recognises that one size does not fit all and asks policy makers and planners to systematically think about whether there will be any significant differentials in remote, rural and island areas and if so, assess what these might be and consider what adjustments or compensations can be adopted to accommodate RRI circumstances[1]. The aim is to ensure that RRI populations are treated fairly, have equal opportunities and access to services as their urban counterparts[1]. Key to this is ensuring that remote, rural and island communities, as recognised in legislation, are supported to inform and make decisions that directly affect them.

A number of tools and frameworks exist to support remote, rural and island proofing.[1,2,3,4,5,6,7] The following offers excerpts (prompts) from these to guide thinking. They have been adapted in a public health context for two purposes: to support improvements in the health of our populations and also the delivery of public health services. The issues are not exhaustive and it may be necessary to consider other factors that shape the RRI context that are of relevance to the issues under consideration. A framework for considering the issues is given below.

2. A framework for considering any policy, programme development

The following is adapted from National Rural Proofing Guidelines (DEFRA).[1]

A. How to remote, rural & island health proof before and during policy / programme development	
Define the issue	• What is the policy objective in terms of problem to be solved or outcome to be achieved? • What impact do you intend it to have in remote, rural and island areas? • What constitutes fair remote, rural and island outcomes in this case?
Understand the situation	• What is the current situation in remote, rural and island areas? • Do you have the necessary evidence about the position in remote, rural and island areas? • Do you have access to the views of remote, rural and island stakeholders about the likely impact of the policy / programme / development?
Develop & appraise options	• Is action needed to ensure fair remote, rural and island outcomes? • Will it cost more to deliver the policy in remote, rural and island areas? • Do the necessary delivery mechanisms exist in remote, rural and island areas? • What steps can be taken to achieve fair remote, rural and island outcomes?

B. How to remote, rural and island proof during and after implementation	
Prepare for delivery	• What action has been taken to ensure fair remote, rural and island outcomes? • Have these actions been recorded? • Have they been adequately reflected in an Impact Assessment?
Implement & monitor	• What action has been taken to monitor remote, rural and island outcomes? • What mechanisms exist for taking further action if problems arise?
Evaluate & adjust where required	• Have remote, rural and island impacts been included in the evaluation process? • How will lessons learned in relation to remote, rural and island outcomes be used to inform future policy making and delivery?

Things to think about in a Scottish public health context (with some examples of how these might be addressed) are noted below.

3. Remote, rural and island (RR&I) health proofing: ensuring policies and practice are fit for purpose and equitable for our remote, rural and island populations.

- **What is the need for services in rural settings and does this differ from urban settings?** Consider factors such as utilisation patterns, epidemiological measures and confidentiality in terms of accessing services in smaller populations.
- **Consider population characteristics that may be important?** Consider factors such as socioeconomic status (deprivation), demographic profiles (e.g. aging population and gender), population numbers and density and the impacts of change on the resilience and sustainability of local populations and services e.g. movement and migration (in and out). Consider also factors which may be specific to local populations eg isolation; and accessing services later.
- **Rural deprivation and measures.** What data is appropriate / reflective of remote and rural needs? What are the key rural indicators that should be used? Are the use of standard measures appropriate for the population under consideration (eg is SIMD[8] appropriate)? Consider whether models and data sets are appropriate in small areas e.g. the use small area based data to identify social, economic and environmental differences that need to be accounted for in the policy.
- **Are there other social and historical factors** that would have an impact on both delivery and access e.g. isolation and fragility of support services, employment and the economy?
- **Are there geographic factors that need to be considered?** Consider factors such as remoteness e.g. distance, longer travel times and cost, access to public transport and in the island context water barriers.
- **Infrastructure** e.g. housing; IT; roads and the availability of public transport need to be considered in terms of both delivery and access. Reduce the need to travel by using outreach, localised delivery or remote access. A reliance on the use of technology / infrastructure has impacts eg connectivity (mobile phone and broadband coverage) which may be limited in RRI communities. Consider more creative use of providing and accessing services and activities.
- **Weather:** consider the impact of weather (at all times of the year) on access to and the delivery of services.
- **Inequalities, morbidity and mortality –** consider how all of the above may impact on inequalities, morbidity and mortality in the populations being considered.
- **Delivery of services -** services can be more difficult and costly to provide and require different approaches / models to urban areas. Consider de minimis provision and associated costs e.g. allow for higher rural unit delivery costs in funding allocations or formulae and economies of scale e.g. island Boards are similar to larger Boards but economies of scale mean the impacts may be more dramatic – this can been seen in staffing as well as potentially health equity.
- **Remote and rural profile and branding**[4] e.g. consider the impacts of measures on how remote and rural areas are perceived and whether a different type of branding is required.
- **Workforce** e.g. models of working (these tend to be more generic in remote and rural areas), professional isolation; workload and contractual issues; education, training and professional development (in particular the need for remote access); recruitment and retention and ensuring representation ie ensure RRI colleagues are pro-actively considered in the planning of events and meetings to ensure access / representation.
- **Governance and leadership** e.g. are effective oversight systems in place locally, are performance measures specific to remote, rural and island settings, how might stakeholder engagement be improved in these settings?
- **Allow local delivery bodies flexibility to find the best local solution(s).** The issues above most usually require locally defined and delivered solutions ie subsidiarity and proportionality are key; solutions are more likely to be 'hand knitted to fit' if developed by those who live and work locally (centralisation is not always good for remote, rural and island areas). Consult equally with remote and rural stakeholders e.g. ensuring remote and rural communities and the workforce have equal opportunity to contribute to consultations.

4. **Remote, rural and island proofing for the delivery of public health: ensuring policies and plans are fit for purpose for our remote, rural and island workforce** (more detailed focus is given to these issues in Appendix 1).

- **Models of working** - these tend to be more generic in remote and rural areas, professional isolation; challenges of specialisation; workload and contractual issues all impact. There may be potential vulnerability of posts reflected in particular by funding streams eg core and ring fenced - for example individual staff funded by perhaps up to four funding streams of variable length/security.
- **Education, training and professional development** (in particular the need for remote access) and recognising the potential need for different skills set for the RR&I workforce.
- **Are there geographic factors that need to be considered?** Consider factors such distance, longer travel times and cost and availability of public transport that need to be considered in terms of both delivery and access eg to meetings and CPD.
- **Are there workforce population characteristics that may be important?**
- **Are there other social and historical factors** that would have an impact on both delivery and access e.g. isolation and fragility of services, employment and the economy?
- **The reliance on the use of technology / infrastructure impacts** eg connectivity (mobile phone and broadband coverage) – not all staff have good access to IT, but for many it is core to the delivery of work. Consider more creative use of providing and accessing services and activities.
- **Services can be more difficult and costly to provide.** Consider de minimis provision and associated costs e.g. allow for higher rural unit delivery costs in funding allocations or formulae and economies of scale e.g. island Boards are similar to larger Boards but economies of scale mean the impacts may be more dramatic – this can been seen in staffing as well as potentially health equity.
- **Recruitment and retention** and remote and rural profile and branding[4] e.g. consider the impacts of measures on how remote and rural areas are perceived and whether a different type of branding / advertising is required and how different models of working might be required. Living and working in remote, rural and island communities may have significant impacts for families of staff (eg housing and education).
- **Allow local delivery bodies flexibility to find the best local solution(s).** The issues above most usually require locally defined and delivered solutions ie subsidiarity and proportionality are key; solutions are more likely to be 'hand knitted to fit' if developed by those who live and work locally (centralisation is not always good for remote areas). Consult equally with remote and rural stakeholders e.g. the workforce have equal opportunity to contribute to consultations / and representation.

References: (all accessed 20.12.16)

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5. North West Public Health Observatory, Justin Wood. **Rural Health and Healthcare: a North West perspective**. A Public Health Information Report for the North West Public Health Observatory (January 2004). Available at: http://www.nwph.net/Publications/ruralhealth.pdf

6. Scottish Health and Inequalities Impact Assessment Network (SHIAN). Health Impact Assessment of Rural Development: a Guide (2015). Available at: http://www.scotphn.net/wp-content/uploads/2015/09/2015_05_28_SHIIAN_Final_Report.pdf

7. Strasser R, Kam SM, Regalado SM. Rural Health Care Access and Policy in Developing Countries. Annual Review of Public Health 2016;37:395-412. Available at: http://www.ncbi.nlm.nih.gov/pubmed/26735432

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The following outlines NoSPHN work to understand models of delivery in the NoS / Island Boards and assessment of risks and resilience issues.

Health Boards have statutory, guidance and governance reasons to retain Public Health services. A Health Board then needs a level of service that discharges its responsibilities, assures delivery of its Local Delivery Plan and covers key health and clinical risks.

This paper describes the essential requirements for delivery of a local public health function particularly in the context of remote rural and island population. Models of delivery vary across the island Boards as dictated by historical and local imperatives with recognised benefits and risks. A number of features of services and models are however common to each.

Workload:

- A strong Corporate component to the work of senior public health staff (DPH) – estimated to be in the region of 50% of the workload – which whilst securing benefits also reduces the capacity for Public Health duties which may be disproportionate compared to mainland Boards who have more colleagues to delegate to. Examples of corporate roles include: Executive Director, lead on planning, Child Health Commissioner, Caldicott Guardian and governance roles in addition to the chairing of a range of groups both within and out with the Health Board. All DsPH do this but when there are less Directors to share the task as on island Boards, this becomes more important.
- Working in a smaller Board offers opportunities of scale for service change, redesign and innovation not as easily afforded to larger Boards for example recent primary care IT developments or projects on Foetal Alcohol Spectrum Disorder which have subsequently been promoted or rolled out on a national level.

Workforce:

- Single handed posts (at any level) with consequent vulnerability if vacant or absent.
- Staff covering multiple roles/a number of portfolios and a move to more generic approaches within teams (ie staff carrying more generic roles) than might be evident in larger Boards.
- The potential vulnerability of posts reflected in particular by funding streams eg core and ring fenced - for example individual staff funded by perhaps up to four funding streams of variable length/security.
- Staff are often locally grown and developed which is a strength but may present challenges for example: the additional burden of delivering in-house training or the costs of accessing remote training; staff being retained on a grading from a previous role which may limit options; if colleagues are drawn from disciplines out with public health eg nursing, dietetics and they have kept up their original registration and there are gaps in these services locally they may be drawn back to their original roles thereby reducing capacity to Public Health.
- Challenges with recruitment and retention to posts – for example the unsociability for some staff of shared / off island posts given the distances involved (time and weather).
- Challenges with succession planning and flexibility eg changes in one post having significant impacts across other posts which may be more easily covered in interim periods in larger Boards.

Governance and funding:

- Public Health support being secured from elsewhere (off island) – under a range of different models and how this is coordinated and governed.
- Pressures and risks in other areas (in both health and other organisations) having an impact on service provision. The current financial imperatives of Boards are focussing attention on short term returns – there is however a significant risk of impacts in the medium to long term if core public health services are not retained for example for screening and primary prevention.
- The Boards have in place robust systems for exceptional circumstances (eg large emergencies / outbreaks) ie when needed a range of systems play in locally, regionally or nationally (for example the NoS MOU for surge capacity) but these remain vulnerable to pressures in the supporting services.

- Economies of scale – the changes affecting public health on island Boards are similar to larger Boards but economies of scale mean the impacts may be more dramatic – this can been seen in staffing as well as potentially health equity. For example the integration agenda may magnify some of the issues highlighted above.
- The changing demography of island populations - if wishing to secure island populations there is a need to continue to invest in them. This recognises too the positive impact of having staff living in local communities (compared to living off island) and the assets they bring to local communities.

Infrastructure

- The reliance on the use of technology.
- Current restrictions on travel for maintenance of knowledge and skills, networking and new learning.
- The need to maintain strong networks (regionally, nationally and internationally) to ensure levels of expertise are maintained, reduce professional isolation and support recruitment and retention recognising also the added benefits to Boards in retaining regional and national profiles and to medical colleagues attracting professional recognition (and discretionary points).