Public Health England

Protecting and improving the nation's health

Enclosure PHE/17/08

PHE Board Paper

Title of meeting	PHE Board
Date	Wednesday 22 February 2017
Sponsors	Richard Parish and Rashmi Shukla
Presenter	Rashmi Shukla
Title of paper	**Overview of PHE's work on Rural Health**

1 Purpose of the paper

The purpose of the paper is to provide the PHE Board with an update on actions to support partners working in rural areas and to respond to the board watch list on rural health as generated by the external panel members in January 2015.

2 Recommendations

2.1 The PHE Board is asked to

a) **COMMENT** on the progress made to date by PHE to support rural areas in their efforts to identify areas of need and take action to improving health and

b) **AGREE** that PHE continues to have a focus on rural health, working in partnership with Local government, NHS and others to deliver improved outcomes for rural populations.

3 Background

3.1 A Panel Discussion on Rural Health was held at the January 2015 Board Meeting, the purpose of which was to discuss how best PHE can support rural areas to secure improvements in health, based on discussion and debate with Board members and a panel of experts. The board panel discussion had been initiated in response to request for support to the Chief Executive and to the Director for Midlands and East Region from Directors of Public Health working in largely rural local authorities.

3.2 The expert panel included Directors of Public Health, the chair of the Rural Services Network and the (then) NHS England Clinical Director for Rural and Remote Care. There was a wide ranging discussion which resulted in a number of observations and suggestions as to how best Public Health England may support local areas to secure improvements in health. These are listed in appendix 1 and an update is included against each element.

3.3 Further discussions with Professor Richard Parrish and Professor Sian Griffiths (as the two non-executive director links for this work) assisted in further clarifying

PHE's role. The approach we have taken is to focus on a small number of specific areas: primarily on ways of identifying needs, either directly or by proxy through analysis of disadvantage, and highlighting areas of innovative local practice for sharing more widely. This approach complements the generic support and actions that PHE undertakes, and where relevant rural aspects are considered, including in the development of PHE tools and resources.

3.4 A PHE Rural Health working group has been established and is chaired by the Director for Midlands and East Region and comprises of PHE (representation from Centres and Regions, Health & Wellbeing and Knowledge & Intelligence directorates), Local Authority Directors of Public Health (DPH) including the Association of Directors of Public Health rural health lead, and academic partners (University of East Anglia and Small Area Health Statistics Unit, Imperial College, London). This group primarily exists to collate and coordinate as appropriate PHE's work on rural heath.

3.5 This paper provides a summary update of work undertaken by PHE, and in collaboration with partners. This update is not intended to be an exhaustive analysis of everything we do to support rural areas, for example local bespoke support by PHE Centres covering rural communities are not included, nor is the health protection support being given by our teams to rural areas, such as managing the human consequences of outbreaks of avian influenza.

4. Update on rural health

Health in Rural Areas – PHE/ Local Government Association (LGA) publication

4.1 PHE and the LGA are preparing a significant joint publication on 'Health in Rural Areas' report, aimed primarily at local authority members. The report makes the case for why a focus on rural areas is important; that despite overall health outcomes being much better in rural areas, rural communities can differ substantially with wide ranging needs; describes the challenges of providing services for an increasingly older population with co morbidities; the potential impact of the relatively poor transport infrastructure on access to care facilities; digital exclusion and other risks.

4.2 The publication will share where certain social determinants may have a greater impact in the rural areas and how local authorities and their public health teams are developing innovative partnerships to address the health inequalities that exist within and between rural communities.

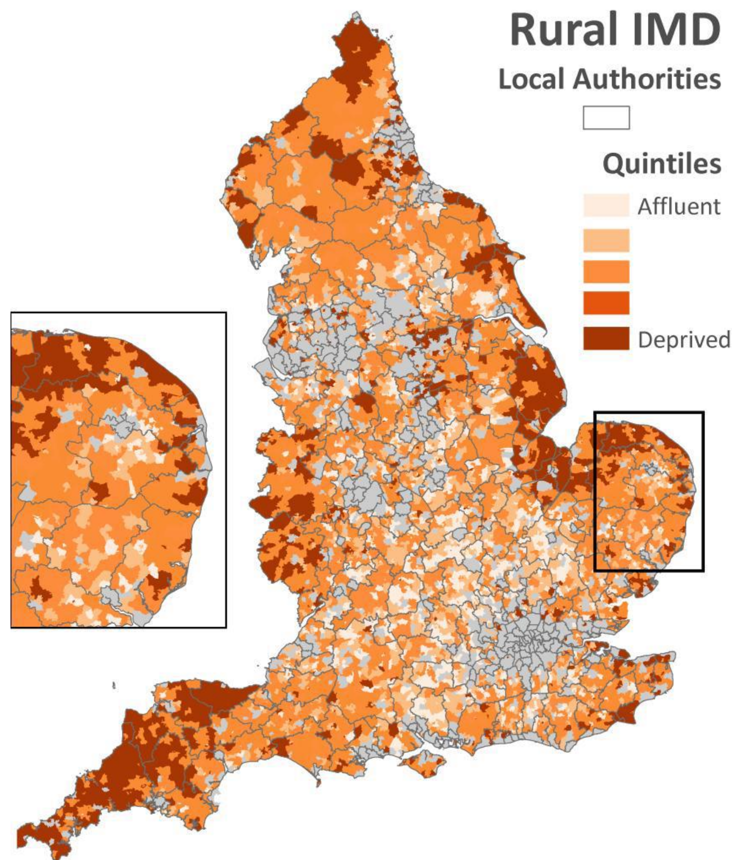
4.3 The report includes a range of case studies from county, district and parish councils and describes initiatives to support rural communities across the life course, such as housing needs and fuel poverty, use of technology to provide care services in areas with digital exclusion, improving access to services such as NHS health checks, alcohol and drugs services and sexual and reproductive health through to supporting victims of domestic violence. These case studies highlight how local areas are co-creating innovative solutions to address their challenges and are shared for adoption elsewhere.

4.4 A set of key impact questions are suggested for consideration for local decision makers in their development of plans and strategies for rural communities. The report is expected to be launched at the LGA's public health conference next month.

Epidemiological analysis and mapping

4.5 The Small Area Health Statistics Unit (SASHU), MRC-PHE Centre for Environment and Health, Imperial College in collaboration with the PHE Rural Health Group explored if the Carstairs Index and the English Index of Multiple Deprivation, could be modified to make them more sensitive to displaying rural disadvantage in England. The methodology used was to remove all urban areas as identified by the Office for National Statistics Urban-Rural Area Classifications and to create a Rural Carstairs Index re-standardised for rural areas only and to display the heterogeneity of the Indices of Multiple Deprivation (IMD), with rural IMD mapped using quintiles specific to rural areas. The findings were presented at the PHE Annual Conference in 2016, published on the SASHU website and a paper has been submitted for peer review publication. Figure 1 below shows the rural IMD quintiles.

Figure 1 Rural Index of Multiple Deprivation



4.6 The method was effective in displaying much greater heterogeneity in rural areas than was apparent in the original indices. In particular, the level of deprivation experienced by some coastal communities such as Cornwall, Norfolk and Lincolnshire is much higher than other types of rural communities.

4.7 The spatial analyses were shared widely with Directors of Public Health, with positive feedback from those working in rural areas. The DsPH confirmed that the observed patterns mirror their experiences and first-hand knowledge on the ground and have aided targeting of resources locally.

4.8 The PHE Rural Health Group have also held detailed discussions with NHS Scotland on the use of epidemiological and socio- economic data to devise more accurate and precise ways of identifying the needs of and inequalities in rural communities. It has been recognised in Scotland that the Scottish Index of Multiple

Deprivation (SIMD) does not provide a sufficient level of granularity to identify the pockets of rural deprivation that exist in sparsely populated areas. A range of alternative indicators, available at small population levels, have been used to demonstrate the heterogeneity and diversity of rural population. This work has helped inform the development of the University of East Anglia index of rural disadvantage described in paragraphs 4.12-4.13.

4.9 We are also exploring whether data collected by Citizens Advice Bureau (CAB), including the reasons for seeking advice, may provide an indication of rural need and show changes over time. A rural issues network of CABs is in place and contact will be made to see if there are areas of mutual interest**.**

Increasing levels of daily physical activity in rural areas

4.10 Specific barriers to daily physical activity, particularly walking and cycling, were identified during the development of *Everybody Active Every Day*[i] and highlighted in the framework. Consequently PHE has undertaken specific work with Living Streets to explore barriers and opportunities for walking and cycling in rural areas, with findings published in Town and Country Planning November 2016 which included a pilot study at PHE Porton. [ii]

4.11 PHE has taken a universal approach to supporting increased levels of physical activity through its national social marketing campaigns such as *One You* and *Change for Life*. Local Authorities can access and adapt campaign materials to meet local needs and several rural counties and districts have utilised the *One You* campaign materials (Norfolk, Cornwall, Devon, Cheshire East and Torbay).

Identifying gaps in access and service delivery for rural communities

4.12 PHE has developed the SHAPE (strategic health asset planning and evaluation) tool, which is a web-enabled, interactive and evidence-based application which informs and supports the strategic planning of services and physical assets across a whole health economy. The tool has recently been updated with new content and additional functionality. It links national datasets for clinical analysis, public health, primary care and demographic data with estates performance and facilities location. Local Authorities and PHE centres have started to use the SHAPE tool to explore patterns with regard to geographical access to services in rural areas. In the West Midlands, in response to a request from DsPH of Shire Counties, PHE's West Midlands Knowledge and Intelligence services team have used the SHAPE tool to explore patterns with regard to geographical access to services in rural areas.

4.13 Progress has been made in developing an index of rural disadvantage (IRD) with the University of East Anglia (UEA) which incorporates measures of access and travel distance to key services, using data that is routinely available to local authorities. PHE rural group acts as an advisory group to the development of this index. A final version of the index is in preparation, working with Norfolk County Council and this will be shared with NHS England and Local Authority partners to test its applicability in identifying gaps in access and service delivery. The UEA team now have access to the SHAPE tool and will be looking at its usefulness in mapping some of the indicators in the UEA IRD.

Workplace health and wellbeing in small and medium-sized enterprises

4.14 Employment is a specific challenge in rural environments, with specific issues that

include a greater proportion of small and medium-sized enterprises (SMEs). PHE's health and work programme is specifically targeting support for SMEs, including expanding its offer for employers who may not be ready or able to adopt a holistic approach to health and wellbeing through the provision of specific employer toolkits developed with businesses for businesses on key health issues for them.

4.15 PHE has published a Mental Health Toolkit for Employers and is currently working with Business in the Community in producing a digital musculoskeletal toolkit for employers to address musculoskeletal disorders at work alongside a suicide prevention and intervention toolkit. These toolkits build on the existing best practice and consider the transferable learning between business sectors and businesses of different sizes. PHE has worked through Business in the Community to influence its members (Top FTSE 500 businesses) to share the toolkit through its supply chain in order to target SMEs including in rural areas.

Housing and the Green Deal

4.16 The (then) Coalition Government introduced a scheme rewarding councils for bringing empty homes back in to use through the New Homes Bonus. Figures published in April 2016 showed that the number of empty homes is now at its lowest level since records began. This equates to a drop of over a third from 318,642 in 2004 to 203,596 in 2015.

4.17 These data is to be analysed to determine if there are any difference in rural versus urban reduction in empty housing stock. The Government's new housing White Paper launched on February 7 2017 will be reviewed and any opportunities for PHE and partners to increase and improve rural housing stock identified.

4.18 The Green Deal, which promotes energy saving home improvements, closed to new loan applications in July 2015. The scheme remains in place, however finance options for energy efficiency improvements are now only available through approved green deal providers. New legislation came into effect in April 2016 such that residential private landlords will not be able to unreasonably refuse consent to a tenant's request for energy efficiency improvements where Green Deal finance or subsidies are available to pay for them.

4.19 From April 2018, private domestic and non-domestic landlords will need to ensure that their properties reach at least an E EPC rating, or have installed those improvements that could be funded using available Green Deal finance or subsidies available to pay for them, before granting a tenancy to new or existing tenants.

4.20 PHE will continue to work with partners to promote the Green Deal where appropriate and make stakeholders aware of the new legislation and how it can be applied to support people living in fuel poverty.

Workforce development needs for rural communities

4.21 Through the PHE Rural Health Working Group a series of exchanges and discussions have been held with colleagues in Scotland. These conversations were wide ranging and included NHS Scotland's approach to training of health care professionals and recruitment & retention of GPs in rural areas.

4.22 The Remote and Rural Healthcare Educational Alliance (RRHEAL

http://www.rrheal.scot.nhs.uk/) is part of NHS Education for Scotland (NES). RRHEAL works across all the remote, rural and island areas of Scotland helping to coordinate remote and rural healthcare education development and support education and training for the remote, rural and island workforce. It aims to increase access to affordable, sustainable education, training and development opportunities using available digital technologies, together with face to face learning.

4.23 NHS Education for Scotland also offer one-year GP Rural Fellowships which provide opportunities to develop the generalist skills required to work in some of the most remote and rural areas. There are two types of Rural Fellowship - 'Standard' and 'Acute Care'; up to 12 rural fellowships are available each year.

4.24 PHE are linking with Health Education England (HEE) to share the work from Scotland and support HEE's actions to increase placements of training in rural areas.

Research and Development opportunities

4.25 There are limited actions that PHE can directly take in relation to promoting this action. However there are opportunities to support partners better placed to take forward potential action and these include:

a) High interest in the Midlands and East Region from NHS England, Health Education England and the Academic Health Science Networks on having a joint collaborative with PHE on rural health, starting with a workshop planned for May 2017.

b) In addition, PHE Director for Midlands & East was invited to take part on a scoping discussion on developing a national centre for rural health and care, which involved the local acute NHS trust, Local Authority, academic partners, Chief Executive of NIHR, Health Education England, East Midlands Academic Health Science Network, private sector and the local economic partnership. Research and workforce development have been identified as part of a set of key potential work streams for inclusion in the scope for the centre.

5. Next Steps

5.1 We will continue with the approach described in this paper with a view to strengthening our work on rural health through

a) Identifying potential opportunities using the links we are developing with other government departments, in particular DEFRA and DBEIS, and our efforts to support the Housing White Paper'
b) Ensuring greater alignment between local, regional and national work, involving both our health improvement and health protection leads.

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February 2017

Appendix 1: Update against Board Watch List on Rural Health – January 2015

Public Health England Board
Actions from the meeting of 28 January 2015

Rural Health

Lead Board Member: Richard Parish

The observations and suggestions are exclusively those of the external panel members and participants and are not PHE policy, although they are considered carefully by PHE in reaching a considered position on each of the public health themes in its business planning and priority setting process.

External panel observation in January 2015		Comment/Progress
1.	There is opportunity for greater collaboration between NHS England and PHE on rural health issues, for example, identifying potential gaps in delivery with respect to access, choice and distance.	Update provided in paragraphs 4.12-4.13 of main paper: Further development of the PHE SHAPE tool for planning and evaluation is being used by LAs and NHS to explore patterns of rural access to services. University of East Anglia's rural disadvantage index includes an access indicator and PHE's rural working group has acted as an advisory group for the work.
2.	There is scope for PHE to assist local authorities in their efforts to increase levels of daily physical activity in rural areas.	Update provided in paragraphs 4.10-4.11 of main paper. PHE working in collaboration with Living Streets to explore opportunities to increase walking and cycling in rural areas.
3	There is scope for local government, PHE and others to work together to address the issue of empty (rural) housing stock.	Update provided in paragraphs 4.16-4.20 of main paper. Need to explore any new opportunities provided in the Government's recent Housing White Paper
4	PHE and its partners could work together to strengthen the "green deal" to further incentivise landlords to undertake remedial work to damp and/or uninsulated properties	Update provided in paragraphs 4.16-4.20 of main paper. PHE will continue to promote the Green Deal where appropriate.
5	The design and delivery of research and development programmes in health and care organisations serving rural areas could enhance the career options for their staff.	Update provided in paragraph 4.25 of main paper. PHE is involved in scoping discussions regarding the establishment of a National Centre for Rural Health and Care, which has research and workforce development as potential strands.
6	PHE could explore how it could	Update provided in paragraphs 4.14-4.15 of

	support and mobilise small and medium-sized enterprises in providing workplace health and wellbeing services	main paper. PHE has published a Mental Health Toolkit for Employers and is targeting support to SMEs.
7	The workforce should be trained to address the needs of rural communities and individual career paths, including nurses, general practitioners and specialist clinicians.	Update provided in paragraphs 4.21-4.24 of main paper. Review of Scottish initiatives undertaken and will be shared with Health Education England.
8	Consider models in other countries with large rural populations in adapting healthcare training to their needs.	Update provided in paragraphs 4.21-4.24 of main paper. Review of Scottish initiatives undertaken and will be shared with Health Education England.
9	Enhance the value of detailed epidemiological data for localities provided by PHE, through research to interpret the data	Update provided in paragraphs 4.5-4.9 of main paper. Spatial maps produced demonstrating rural disadvantage and review of Scottish approaches to identifying needs of rural communities. The joint LGA/PHE report, soon to be published identifies aspects of need and signposts decision makers on areas to consider in developing strategies for improving outcomes in rural areas.

[i] https://www.gov.uk/government/publications/everybody-active-every-day-a-framework-to-embed-physical-activity-into-daily-life
[ii] health inequalities in the urban fringe and rural localities, Rachel Lee, Town & Country Planning , November 2016