jit joint improvement team

SUPPORTING PEOPLE IN REMOTE AND RURAL AREAS: A FRAMEWORK FOR ANALYSIS

INTRODUCTION

This report was commissioned by the Joint Improvement Team, Scotland, and has been written by Professor Bob Hudson of the University of Durham. It has three aims:

- to briefly summarise evidence on the specific problems faced by people living in remote and rural areas who need support to improve their health and wellbeing;
- to explore the ways in which these needs have been addressed nationally and internationally;
- to develop a framework for further policy analysis and exploration.

The issue of specific (and greater) problems endured by remote and rural areas is far from new. In Scotland it was the subject of the Dewar Report[1] as far back as 1912, which highlighted many difficulties with service provision and led to the formation of the Highlands and Islands Medical Scheme. Much of the subsequent examination of the issue has tended to focus on rural health care rather than on social care or the wider services context. In their study, for example, Craig and Manthorpe[2] conclude that the debates on rural health care and social care respectively '*appear to be travelling along parallel but not well-connected tracks'.*

Although much of the research is indeed on health care, this report will be looking at the wider picture on rural and remote issues. People of all ages see their quality of life as closely bound up with their health, family and social networks, their home, and their capacity to remain independent. Whilst it has always suited service providers to distinguish between their respective contributions, service users and carers are more interested in receiving integrated support that is cognisant of their wider lives. Arguably this is even more important in rural and remote areas than in urban settings.

It is important that any examination of services and support takes place within a clear framework of principles and policies which give purpose to any particular

[1] Dewar Report (1912), *The Highlands and Islands Medical Service Committee. Report to the Lords Commissioners of His Majesty's Treasury.* Edinburgh: HMSO.

[2] Craig, G and Manthorpe, J. (2003), *Fresh Fields. Rural social care: research, policy and practice agendas.* York: Joseph Rowntree Foundation.

arrangements. At a broad level this framework has been set by the four high level outcomes embracing wider agendas of public services reform in Scotland[3]. These are:

- improved health,
- improved well-being,
- improved social inclusion and
- improved independence and responsibility.

In similar vein, in a review of integrated health and social care services for older people across Europe, Leichsenring[4] concludes that there is no relevant policy paper at national or European level that fails to underline the following common themes:

- people in need of long-term care should be supported as long as possible in living at home;
- residential home places should be reduced and different kinds of services and providers developed;
- social inclusion should be guaranteed;
- preventive and person-centred approaches should be developed;
- family and informal support should be strengthened;
- there should be ‘whole system’ coordination of provision.

This is all much in line with the Scottish National Outcomes framework, and will form the underpinning assumptions of this report.

DILEMMAS IN REMOTE AND RURAL SERVICES AND SUPPORT

An important starting point is to dispel assumptions and define terms. As Pugh et al note in their comprehensive briefing paper[5] there is still a tendency on the part of some people to idealise rural life and make inaccurate assumptions about the quality of life. The authors note that this can erect barriers to the recognition of social problems and the development of effective responses to them, perhaps especially where policy decisions are taken in central and urban settings.

A second initial issue is that of definitions. This is not just a matter of semantics, because the way in which rurality and remoteness get defined can determine political decisions about compensating for disadvantage. Defining terms is not a straightforward matter – a review by Hogg for the Scottish Executive Policy Unit[6], for example, concluded that ‘*it is nigh on impossible to draw a definitive line between remote rural areas and non-remote rural areas’* (p2). The general distinction is between non-urban settings (rural) and further outlying areas (remote), and notwithstanding the pessimism expressed by Hogg he went on to define remote communities in terms of distance from major population centres of over 30,000 and

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[3] http://www.scotland.gov.uk/Topics/Health/care/JointFuture/NationalOutcomes

[4] Leichsenring, K (2004), Developing integrated health and social care services for older persons in Europe. *International Journal of Integrated Care*, September 2004.

[5] Pugh, T., Scharf, T, Williams, C and Roberts, D (2007), *Obstacles to using and providing rural social care.* Research Briefing 22. London: Social Care Institute for Excellence.

[6] Hogg, K. (2000), *Services in Remote Rural Areas.* Scottish Executive Policy Unit. Edinburgh.

smaller population centres of over 3000. By this definition around 170,000 people, mostly living in the north and west, are more than two hours drive from major population centres. As Turbett[7] notes, this is a significant geographical area comparable with the communities described in the Australian and North American literature on remote rural social work.

It is estimated that rural Scotland accounts for 98% of the Scottish landmass and is occupied by 18% of the population (around a million people). The Scottish Highlands and Islands area is one of the most sparsely populated in the EU with a population density of 9.5 people per square kilometre compared with the Scottish average of 65.5 and the EU average of 116[8].

Other countries face similar issues albeit on a larger scale – in Canada, for example, about 95% of the territory is rural and around 30% of the population lives in rural and remote areas[9]. And while more accessible areas in rural settings are witnessing net migration, the more remote areas are declining and ageing[10]. This mirrors some important demographic trends across Scotland over the next two to three decades when it is projected that there will be increasing numbers of older people, diminishing numbers of working age adults and a smaller pool of unpaid carers[11].

The literature across various countries identifies common problems in delivering support and services in remote and rural settings – access and resourcing, workforce issues and user/patient outcomes.

Access and Resources

People in rural areas are generally not well served by health and social services, and the problems that they face arise from a range of factors which either makes it less likely that any service is available in the first place, or which make it difficult to access and use what *is* provided. Although some health threats are specific to rural areas, and there are differences in the prevalence of some diseases, the main issues are service delivery and access. In the case of the UK, the study by Gould and Moon[12] identifies the following reasons why remote areas experience a 'penalty' in service provision:

- having to provide a certain standard of service to meet statutory and professional requirements although population numbers may be low;
- the need to cater for fluctuating populations of temporary residents;
- the high proportions of older people;
- the costs of transporting goods;

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7 Turbett, C. (2004), A Decade after Orkney: Towards a Practice Model for Social Work in the Remoter Areas of Scotland, *British Journal of Social Work*, 34, pp 981-95.

8 Highlands and Islands Enterprise (2001), *Highlands and Islands Enterprise Economic Information.*

9 The Kirby Report (2002), The Standing Committee on Social Affairs, Science and Technology, Parliament of Canada.

10 Findlay, C et al (1999), *The Impact of Migration on Rural Scotland,* Agricultural Policy Coordination & Rural Development Research Programme.

11 Remote and Rural Steering Group (2007), *Delivering for Remote and Rural Healthcare.* NHS Scotland.

12 Gould, M. and Moon, G. (2000), Problems of Providing Health Care in British Island Communities. *Social Science & Medicine,* 50, pp 1081-1090.

- the need to pay incentives to recruit and retain professionals.

Evidence from other countries reveals a similar picture. In the case of Canada, Nagarajan[13] claims that '*the most serious problem for residents of rural and remote areas is access to health care'* (p2). This is being exacerbated by the trend within medicine to increase the degree of specialisation, which tends to be associated with centralisation. In these circumstances, small local hospitals can offer less experience to practitioners in training, and may lose accreditation for junior doctor training posts. In addition, legislation like the European working time directive means that more staff are needed to run a unit continuously.

The access and resource issue is not, however, confined to health care. Lack of access to services also has a disproportionately large impact on the quality of life of several groups such as older people, families on low incomes and younger people. Moreover, Pugh et al (*op cit*) point out that most studies of existing provision are '*innately conservative*' because they reflect what is provided rather than what may be needed. Expectations may also be lower, and this can influence perceptions of need[14]. Overall, the research shows:

- older people are less likely to be receiving lower level supportive services such as domiciliary care and other home support, compared with those living in urban areas;
- costs of rural services are usually higher because of the geography of rural area and the smaller, dispersed populations within them;
- poor transport networks mean that service users and carers who do not have private transport are less able to access public services - older people, people with disabilities, young people and carers are especially likely to suffer such 'transport poverty';
- there is evidence of more resources being incurred because of longer health stays, reflecting the difficulties of discharging patients to homes which are distant from healthcare centres and providing comprehensive home-based care.

In a national policy context that seeks to provide an acceptable level of service to all people in terms of quality, effectiveness, accessibility and outcomes, these dilemmas require a response. It is generally accepted that this will have some cost implications through a 'sparsity allowance', but the practicalities of fairly calculating any such compensation are complex. Indeed in Scotland at the moment it is thought that the current formula for NHS funding has over-predicted need in rural and remote areas - the new funding formula will redistribute resources accordingly, with the Western Isles especially badly affected.

Workforce Issues

The research reveals a series of inter-linked workforce issues connected to rural and remote support, the most obvious of which is *recruitment and retention.* Lack of access to the right sort of support is a common problem in every country, and has

[13] Nagarajan, K (2004), Rural and Remote Community Health Care in Canada, *Canadian Journal of Rural Medicine,* 9(4) pp245-51.

[14] Scharf, T. And Bartlam, B. (2006), *Rural Disadvantage: quality of life and disadvantage amongst older people*. London: Commission for Rural Communities.

been reported in Scotland, Australia, New Zealand and the USA. It is not a simple matter of financial incentive, since the determinants of professional location include many factors such as lifestyle, access to schools, opportunities for spousal employment and others.

A second factor is *professional isolation.* In the case of social work, Turbett (*op cit*) notes that staff are cut off not just from supervision and peer support, but also from practical assistance, choice over resources and secondary referral points. He suggests that: '*coping with the challenges this can throw up will stretch the innovatory skills of even the most imaginative social worker'* (p988). The review by Craig and Manthorpe (*op cit*) similarly concluded that professionals working in rural areas '*often have to respond intuitively or 'on the hoof', especially where structures and processes have not been put in place explicitly to support their work'* (p42).

Asthana and Halliday[15] come to several conclusions in respect of professional isolation across health and social care:

- rural general practices do not tend to have as good ancillary services (such as physiotherapy and counselling) as their urban counterparts;
- patients can have no choice of practice or practitioner, which can affect willingness to seek advice about such issues as contraception, HIV testing or domestic violence;
- maintenance of skills can be a problem in areas such as dentistry and mental health;
- difficulties can be experienced in providing the right level of multi-disciplinary input to groups such as children with complex needs, and adults with severe disabilities.

Finally (and paradoxically in view of the professional isolation) is the issue of *professional visibility* in the sense of the lack of anonymity that is especially acute in remote areas. Working and living in the same small community can bring its own problems, with movements and relationships more easily observed, and the expectation of being permanently 'on duty' to fellow residents. However, it is also important to note research that suggests that many rural practitioners do value the engagement that working in small communities can bring[16].

User Issues

The high visibility of professionals has its parallel in the high visibility of people who use services. Wenger's research on social networks[17] has shown how daily life in many small communities is often more socially exposed – anonymity is not possible in places where one's movements and relationships may be easily observed and noted. As Pugh et al (*op cit*) note: 'While *this informal surveillance may prompt helpful interventions from friends and neighbours, it can be problematic for those*

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[15] Asthana, S. And Halliday, J. (2004), What can rural agencies do to address the additional costs of rural services? A typology of rural service provision. *Health & Social Care in the Community*, 12(6), pp457-465.

[16] Lonne, B. And Cheers, B. (2004), Practitioners Speak: balanced account of rural practice recruitment and retention. *Rural Social Work*, 9, pp244-54.

[17] Wenger, C. (2001), Myths and Realities of Ageing in Rural Britain. *Ageing and Society*, 21(1), pp117-130.

whose problems do not elicit a sympathetic response'. This could affect people in situations involving domestic violence, mental health problems and alcohol misuse.

More broadly, there is clear evidence that people in remote areas have poorer service and support outcomes compared with their urban counterparts. Remoteness is associated with higher levels of psychiatric disorder in several countries[18] and a high incidence of suicide has been documented in the Scottish Highlands (Godden and Richards, *op cit*). In Canada, the Kirby Report (*op cit*) bluntly concluded that the health of a community appeared to be inversely related to the remoteness of its location – the further away the community, the worse the health status of the population. And again, in Australia, it is claimed that rural people are more likely to experience serious physical or mental health problems – but less likely to seek services[19]. Most recently this sort of evidence has been summarised in the report of the NHS Scotland Remote and Rural Steering Group[20].

Common Problems: Different Solutions

This part of the report has emphasised the common problems shared across remote and rural areas in several countries. However, these communities do not constitute a single, homogeneous population, and it would be unwise to assume that a 'one size fits all' solution would be appropriate. The local social context matters greatly, and as Pugh et al (*op cit*) note: '*attempts to innovate or develop services without consideration of the nature and capacity of communities, appear to be doomed to failure'* (p6). The following section of the report reviews the range of strategies and interventions that have been attempted or proposed.

SUPPORTING RURAL AND REMOTE COMMUNITIES: STRATEGIES AND INTERVENTIONS

Many attempts have been made (or proposed) in the various countries facing rural and remote problems to address the complex issues involved. These can be grouped into six broad inter-related categories:

- distance support strategies
- workforce strategies
- supporting independence strategies
- area-based strategies
- rural proofing strategies
- partnership strategies

DISTANCE SUPPORT STRATEGIES: TELEHEALTHCARE

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[18] Strauss, PR et al (1995), Identification of Depression in a Rural General Practice. *South Africa Medical Journal*, 85:pp 755-9; Pakriev, S et al (1998), Prevalence of mood disorders in the rural population of Udmurtia. *Acta Psychiat Scand*, 97:pp169-74.

[19] Kuipers, P et al (2001), Developing a Rural Community-Based Disability Service. Australian Journal of Rural Health, 9, pp22-28.

[20] NHS Scotland (2007), Delivering for Remote and Rural Healthcare: *Final Report of the Remote and Rural Workstream.*

The emergence of new forms of technology which permit support to be given 'at a distance' from the patient or service user seems to offer an innovative way of delivering support in rural and remote communities. The recent JIT report on developments in Scotland[21] defines 'telecare' as '*the remote or enhanced delivery of services to people in their own home by means of telecommunications and computerised systems'* (p3). It notes that the term can cover both care and health services, though the latter are often described as 'telehealth'. Finch et al[22] make an even wider conceptualisation by using the term 'telehealthcare', contrasting this with telemedicine and e-health, as shown in the table below.

	TELEMEDICINE	**TELEHEALTHCARE**	**E-HEALTH**
EXAMPLES	• Teledermatology • Telepsychiatry • Telecardiology	• Telemonitoring of chronic diseases • Telephone advice services	• Online information services • Electronic health records • Decision-support systems • e-booking of appointments
FEATURES	• Electronic linking of patients and health professionals over time or distance • Usually acute consultation for diagnosis and treatment	• Electronic linking of patients and health professionals over time or distance • Usually for management and maintenance	• Tools to support work practices of health professionals • Resources for patients and public for health management
PATIENTS	• Experimental subjects	• Routine patients	• Informed and self-managing

The JIT report usefully distinguishes between three phases of development:

- *first generation:* user-activated devices where a call handler can organise a response of some kind, possibly by a neighbour, relative or friend acting as a key holder;
- *second generation:* sensors that can monitor the home environment, vital signs, physiological measures and lifestyle;

[21] Joint Improvement Team (2008), *Telecare in Scotland: Benchmarking the Present, Embracing the Future.* http://www.jitscotland.org.uk/action-areas/themes/telecare.html

[22] Finch, T et al (2007), Future Patients? Telehealthcare, roles and responsibilities. *Health & Social Care in the Community*, 16(1), pp86-95.

- *third generation:* the increasing availability of broadband, wireless and audio-visual technology offering scope for 'tele-consultations'.

The report also gives a comprehensive account of the development of telehealthcare in Scotland, beginning with local partnerships in the late 1990s and (since 2006) through the Telecare Development Programme which has made £8.35m available to local care partnerships in the two year period 2006-8. Here the aim is to encourage the adoption of second generation approaches as a mainstream form of service provision, followed by third stream interventions. Addressing the problems of remote and rural communities will be at the heart of this expansion, and a detailed strategy for the period to 2010 is imminent. Scotland is not alone in seeing telehealthcare as an important new form of intervention and support. In England the Government is committed to ensuring that a telecare service is installed in all homes that need it by 2010[23] helped by an £80m Preventative Technology Grant. More recently £12m has been shared across three 'whole system demonstrator' sites to explore more fully the potential of technological support. Elsewhere in the UK, a £9m Telecare Capital Grant has been made available in Wales for the period 2006-9, and all 22 Welsh councils have now produced telecare strategies.

Outside of the UK the same trends are evident:

- in the *Netherlands* the Koala Project is aimed at using technology to support people with long-term health issues in their own homes;
- in *Finland* there have been successes in using videoconferencing to diagnose dermatological conditions and to remotely review ECGs and X-Rays;
- in *Norway* the focus is on the development of an effective inter-organisational electronic framework rather than specific telehealthcare services;
- in *Denmark* alarm systems are widely used, but few people have automatic monitoring systems installed;
- in *Italy* the emphasis has been upon specific telehealth applications.

None of this suggests that other places have made significantly greater progress in the telehealthcare field than the home countries, but in all cases expectations of benefits are running high. In England the Commission for Social Care Inspection[24] foresees a hugely increased role for telehealthcare, whilst more broadly a telecare 'benefit matrix' (below) that identifies the benefits for a range of stakeholders has been developed by Doughty[25]. In all, the picture looks very positive, and this is the position taken in the JIT report (*op cit*):

'Many *countries recognise the potential benefit from adopting a telecare approach to mainstream service provision. Most are taking active steps to mainstream service provision...Scotland can consider itself to be in the vanguard of countries progressing to mainstream telecare service provision'* (p13).

[23] Department of Health (2005), *Building Telecare in England.*

[24] Commission for Social Care Inspection (2006), *Time to Care?*

[25] Doughty, K (2007) Telecare, telehealth and assistive technologies: do we know what we're talking about? *Journal of Assistive Technologies*, 1(2).

Telecare Benefit Matrix (Doughty 2007)

Service Users	Informal Carers	Social Services	Housing Providers	Health Economy
Increased choice in location and type of care	Peace of mind	Greater sense of satisfaction for professional staff	Reduced voids in sheltered housing	Reduced level of unscheduled care
More responsive services	Improved Quality of Life	More effective use of staff time	Increased demand for specialist homes	Reduced emergency admissions
Improved Quality of Life	Respite opportunities	Reduced Admissions to residential care	Reduced damage to properties	Reduced number of hospital re-admissions
Increased Independence	Reduced stress	Reduced Delayed Transfers of Care	Reduced demand for other services	Reduced Delayed Transfers of Care
Increased chance of “staying put”	Increased independence	Reduced demand for other services e.g. homecare	New role for mobile wardens	Improved medication compliance
Reduced care costs	Improved assessments	Increased system capacity	Improved home security	Reduced ambulance needs

Whilst there can be no doubting the potential of telehealthcare and indeed some proven benefits, it is important not to regard it as a panacea for the problems in remote and rural areas. The research suggests that attention needs also to be paid to a range of other factors identified below:

Practical Limitations

Where the aim is to introduce assistive technology into people’s existing homes then issues of feasibility, acceptability, costs and outcomes will have to be considered. In a major piece of research into people aged over 70 using assistive technology to live as independently as possible, Tinker et al[26] came to several salutary conclusions:

- the extent of adaptation required of buildings in order to meet user needs varies greatly;
- as user needs become more extensive and complex, so the costs of adaptation rise and more properties are encountered which cannot be adapted to meet these needs;
- the degree of adaptability of buildings is largely dependent on their design and configuration;
- the single most important factor affecting adaptability is the number of storeys within a property.

[26] Tinker, A et al (2004), *Introducing Assistive Technology into the Existing Homes of Older People*, King’s College London and University of Reading.

Given the estimate that around 70% of Scotland's housing has been estimated to fall below the Scottish Housing Quality Standard introduced in 2004, the findings of Tinker et al may be of particular relevance.

Practitioner Disengagement

Asthana and Halliday (*op cit*) point to research evidence which suggests that even when electronic information services are provided to rural practitioners, these may not be well used – lack of information, lack of information handling skills, lack of time and perceived peripherality to the job are all identified as major constraints. There are also issues of exclusion for those who do not have access to the internet at work, including those in the voluntary and community sector.

Fragmenting the 'Whole Person'

Some commentators and researchers argue that simply conceptualising telehealthcare as a means of service *delivery* underplays the significance of its impact upon *practice.* In a study of doctor-patient communication in telehealthcare, for example, Miller[27] highlights issues of depersonalisation and impediments to participation that emerge from the teleconsultation 'space'. This difficulty has to be counterbalanced by the policy view that in capturing information about the patient and allowing it to be accessed by multiple agencies, a rounded picture of the 'whole patient' can be identified. Finch et al (*op cit*), however, remain sceptical of these benefits, pointing to the danger of telehealthcare simply dealing with 'bits' of the service user. In this perspective, there is no substitute for 'getting to know' the patient or service user.

User Perceptions

Although patient satisfaction surveys report high levels of acceptance of telehealthcare, Finch et al are critical of the methodological nature of this evidence, concluding that there is: '*...very little understanding of what shifting the means and location of health care implies for patients and their experience of health and illness'* (p88). In particular they are critical of the lack of involvement of patients/users themselves in the design and evaluation of the use of new technologies. Although there is no suggestion that telehealthcare is undesirable or inappropriate, there are concerns that:

- there is no consistent understanding of how the different priorities that patients have for their care might be valued;
- the absence of patients and service users from the process of developing telehealthcare services can only impoverish their design and development;
- decisions about service remodelling are not being undertaken as part of a wider debate about the sustainability of remote communities;
- the potential loss of the physical presence of professionals as a result of more telehealthcare may carry heavy costs for community wellbeing.

WORKFORCE STRATEGIES

[27] Miller, A.E. (2003), The technical and interpersonal aspects of telemedicine: effects on doctor-patient communication, *Journal of Telemedicine and Telecare,* 9, pp1-7.

It is the case in Scotland and elsewhere that people needing support often have a multiplicity of health, care and other social problems. In urban areas these problems might be met by a range of services and professionals, and increasingly these are being integrated or aligned in order to deliver 'seamless' support to individuals. However, this workforce option is rarely available in remote and rural communities, and other strategies need to be pursued. These might be summarised as:

- recruitment and retention strategies
- embedded practitioners
- generalist/substitute practitioners
- inter-professional teamworking

Recruitment and Retention

Typically there are several strands to recruitment and retention strategies. *Specialist training and preparation* arrangements are frequently cited. In the case of community health services, for example, Weller[28] has stressed that undergraduate medical education needs to provide adequate exposure to rural health so that students can see both the challenges and rewards of rural practice. He points to the establishment in Australia of a separate college for GPs to specialise in rural medicine, though acknowledging that this has not been a development without controversy.

In the case of social work it is not uncommon in some countries to offer a rural social work orientation – the University of Calgary in Canada, for example, trains students to work in the Canadian North with a course in 'Rural and Northern Practice'. Turbett (*op cit*) argues for similar specialist options in Scottish social work degrees. However, in both primary healthcare and social work, it is also the case that practitioners will need to be attracted by *financial rewards* over and above those available in urban areas.

A strong view is also emerging that recruitment and retention will be more successful if tied to a strategy of *indigenous recruitment.* In Canada, the Kirby Report (*op cit*) recommended that health care training institutions should make an attempt to recruit students from under-represented groups such as Canada's Aboriginal population, based upon the view that rural students are more likely to return to practice in rural areas. In the UK, the shortage of occupational therapists in rural Lincolnshire is being addressed by developing (in conjunction with Sheffield Hallam University) a local OT degree programme delivered (in part) by local OTs *in situ* in Grantham. The belief here, then, is that rural areas need to 'grow their own' practitioners[29].

Embedded Practitioners

From the user perspective the long distance from centralised services complicates the process of accessing information and this in turn can affect utilisation. One response to this is harnessing the reputational status of 'embedded practitioners' – people who are highly visible in the community and command trust and credibility. The requisite skills needed depend upon the purpose of the intervention. If the need

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[28] Weller, D. (2005), Rural access to healthcare: lessons from down under, *Journal of the Royal College of Physicians*, 38, pp296-7

[29] Andalo, D. Home Grown Talent. *The Guardian*, February 28th 2008.

is to disseminate information and ‘signpost’ people to potential support then a wide variety of roles could be utilised. Asthana and Halliday (*op cit*), for example, identify the potential of training programmes developed for employees and volunteers such as local postmen and shopkeepers. People such as this are in regular contact with vulnerable people in their homes and communities and may be able to link them with service networks.

This ties in with the discussion by Farmer et al[30] of the ‘*community embeddedness’* of some professionals in remote areas, such as district nurses, ‘*who can use their rich knowledge of community and patients proactively to protect and sustain health’* (p677). Embeddedness here refers to the degree of integration with place and people in the community in which practitioners serve, and the authors suggest that their situation and status in the community legitimates them to be ‘*richly integrated in formal and informal social, as well as organisational, networks’* (677). This role can be also be outward-facing from the community, with such practitioners trusted to act as ‘mediators’ for their communities in negotiations with external bureaucrats. However, these advantages do need to be balanced by the issue (raised earlier) of the heavy costs of continuous professional visibility.

Generalist Practitioners

Traditionally, skills have been thought about in a very rigid way, but the relative absence of management accountability and specialisms throws up the opportunity to develop a practice style that fits the shape and needs of remote communities. Turbett (*op* cit) advocates the notion of ‘generalist’ practice – holistic ways to solve problems through refusal to be bound by disciplines or narrow job specifications. Hogg (*op cit*) similarly praises the results from ‘multi-skilling’ health and social care professionals, such as ‘triple duty nurses’ (district nurses, health visitors and midwives) and district nurses carrying out multiple assessments (health, domestic care, benefits checks) in one visit.

This is all much in line with the role of the Generic Support Worker that is proposed in the recent review by the Remote and Rural Steering Group (*op cit*) and is currently being developed and evaluated by NHS Shetland. Such workers will, it is envisaged, work across the health and social care spectrum with formal training and appropriate supervision. Farmer et al (*op cit*) note the evidence that this sort of response can also be found in remote areas of North America and Australia, especially in the case of sick or elderly people. These sorts of approaches do, however, require preparation and training, supervision and updating of knowledge.

Closely related to the idea of ‘generalists’ is that of *practitioner substitution* in which activities traditionally reserved for one professional group are undertaken by another group. Examples include using ‘eldercare’ nurses as (at the outset) substitutes for GPs, and equipped to signpost on to other support where necessary. The use of nurses allows more visits to be made, and for care needs to be monitored and identified earlier. Asthana and Halliday also describe a scheme which, in order to maximise community therapy capacity, trains care assistants from the voluntary, independent and statutory sectors to work to qualified therapists’ care plans.

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[30] Farmer, J et al (2003), Dr. John has gone: assessing health professionals’ contribution to remote rural community sustainability in the UK. *Social Science & Medicine*, 57, pp673-86.

Integrated Teams

The final approach – integrated teams – is one that is familiar in most settings. Hudson[31] has argued that, where effective, such teams can add speed, creativity and flexibility to support arrangements. In the case of remote and rural communities, the case for frontline integration rests upon the fact that there will be a limited number of health and social care professionals available, and their skills and expertise will have to be shared carefully.

The integrated team model is central to the proposals of the Remote and Rural Steering Group (*op cit*) which calls for the development of Extended Community Care Teams (ECCTs). Currently teams within the community tend to be fragmented and disparate in terms of care provided and team location, and this can lead to duplication of effort and disjointed care. The ECCT proposal is that all professional resource within the community must be integrated (both in terms of teamwork and location) and that single-handed general practice should be discouraged.

Where confined to primary care professionals the term Extended Primary Care Team is suggested, but where the wider professionals from social care, housing, education, NHS 24 and the voluntary sector are added, the term ECCT will be used. The aspiration here is that where the balance of an individual's needs shifts from (say) nursing to social care, then the lead role will change to the profession with the most appropriate skills. The report depicts the changes as follows:

CURRENT PRIMARY CARE TEAMS	FUTURE ECCTs
• fragmented • different organisations • duplication • reactive care	• integrated • partnership working • seamless care • anticipatory care

SUPPORTING INDEPENDENCE STRATEGIES

The earlier section on distance support is part of a broader strategy of supporting independence, but other possibilities exist. Two will be covered in this section – extra care housing and personal budgets.

Extra Care Housing

Croucher et al[32] define extra care as models where the housing component:

- allows older people to be tenants, owners or leaseholders, with private living space that is theirs alone;
- where the care component is flexible;
- where the care needs can range from very low to very high dependency levels that might formerly have resulted in admission to residential care.

[31] Hudson, B. (2007), Pessimism and Optimism in Inter-Professional Working: The Sedgefield Integrated Team. *Journal of Interprofessional Care* (2007), 21(1), pp3-15.

[32] Croucher, K. et al (2006), Housing *with care for later life: a literature review.* York: Joseph Rowntree Foundation

Hanson et al[33] report unanimity on the part of service users about the key features – flexible care, self-contained dwellings and homeliness. Flexible care was ranked as the most important, and stress was laid on the importance of providing person-centred care and developing person-centred plans. Users emphasised that flexible care should encompass the possibility for support and care to increase with failing health to avoid a move to a care home or hospital – arguably an even more important factor in more remote areas where this would probably entail moving some distance from the home community. The extra care model may fit well with the needs of remote communities, but it needs to be evaluated against alternative models, especially telehealthcare.

Personal Budgets

The terminology of 'personalisation' and 'Individual Budgets' has rapidly entered the lexicon of social care nationally and internationally. In England, thirteen IB pilot schemes were established in 2006 and an evaluation report is imminent. Unlike Direct Payments these pilots were able to integrate other funding streams - in addition to social services expenditure on adult social care, potential funding was also available through Supporting People; the Independent Living Fund; the Disabled Facilities Grant; the Integrated Community Equipment Service, and Access to Work.

In order to understand the current policy direction and the emphasis on personalisation, it is important to locate this within the wider development of self-directed support and the promotion of independent living. The concept of personalisation which is at the heart of Direct Payments and of Individual Budgets has also been developed through other initiatives, both in the UK, and in other international experience. Lord and Hutchison[34] observed in 2003 that: *"A worldwide paradigm shift is occurring in the disability field. Regardless of whether the focus in physical disabilities, learning disabilities or mental health service users, the paradigm shift reflects a move away from institutional services and professional control towards an emphasis on self-determination and community involvement."*

At the heart of some of this development, in addition to a core emphasis on person-centred planning and individualised response, there has been a parallel focus on the idea of individualised funding, or money provided directly to the person. In reviewing ten such initiatives in Canada, the US and Australia, Lord and Hutchison found that all shared explicit underlying values and principles – typically a commitment to self-determination and community participation and inclusion. The review highlighted the importance of recognising that the budget is only one element of individualisation, and that too much concern with the funding mechanisms, without sufficient attention to other elements such as network building and person-centred planning *"could create a false impression that having money alone would solve serious disability issues."* However, individualised support and funding, *together with* a focus on building community capacity and network building *"can be seen as critical elements of the new paradigm of disability and community."*

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[33] Hanson, J. Et al (2006), *The Essential Ingredients of Extra Care*. University College, London

[34] Lord, J and Hutchison, P (2003), 'Individualised Support and Funding: building blocks for capacity building and inclusion', *Disability & Society,* 18 (1), pp 71-86.

In Scotland the personalisation agenda is less well developed and is still largely locked into a traditional direct payments model that tends to be characterised by restrictions on how the payment can be used, highly bureaucratised monitoring and accountability, and relatively few independent support systems. By contrast both the IB model and the new personal budgets proposed for England[35] involve giving service users and those who support them a much greater degree of control and flexibility in how their 'pot' can be used. The implication here for rural and remote areas is that individual service users or carers can use a dedicated financial allocation to secure support in any way that is safe and legal as long as it helps to meet agreed outcomes. The focus shifts from inputs (service provision) to outcomes and how these can best be met, and raises the possibility of utilising new localised forms of support. It may be that an IB pilot in Scotland that includes some rural and remote settings would be helpful in exploring the usefulness of this approach.

AREA-BASED STRATEGIES

A focus on area-based strategies in rural and remote areas is conceptually underpinned by the notion of '*social capital'* that has been popularised by Robert Putnam[36] in his book *Bowling Alone.* Putnam suggests that *w*hereas physical capital refers to physical objects, and human capital refers to the properties of individuals, social capital refers to connections among individuals – social networks and the norms of reciprocity and trustworthiness that arise from them. In that sense social capital is closely related to what some have called "civic virtue." The difference is that "social capital" calls attention to the fact that civic virtue is most powerful when embedded in a network of reciprocal social relations. A society of many virtuous but isolated individuals is, he argues, not necessarily rich in social capital.

The relationship of professional contributions to the sustainability of remote rural communities is highlighted in the paper by Farmer et al (*op cit*), who argue that professionals are not simply direct service providers but are also deeply embedded in the social networks that make up the fabric of rural life. They argue that:

'*it is important to develop understanding of how key services affect the social and cultural fabric such that they bind communities...If, in the future, fewer services are provided in situ...might a community lose it's sustainability or begin to disintegrate?'* (p679)

This can certainly be construed as a warning about the potential and unintended effects of telehealthcare on remote rural communities.

Where social capital is strong then it can create what the Remote and Rural Steering Group (*op cit*) terms *'community resilience'* – '*a collective and collaborative response within communities to promote independence'* (p13). However, it is widely acknowledged that communities differ economically, socially and politically and it therefore becomes necessary to encourage what might be termed '*community expression'.*

[35] HM Government (2007), *Putting People First: A shared vision and commitment to the transformation of Adult Social Care*

[36] Putnam, R. (2000), *"Bowling Alone: The Collapse and Revival of American Community"* (Simon and Schuster).

The report by Hogg (*op cit*) identifies two general models on how best to improve support in remote rural areas. First a top-down approach in which the Scottish Government identifies 'best practice' and seeks to roll this out more generally – an approach that risks failing to focus on what individual communities want most. Secondly, a sharper focus on the specific communities and a focus on community capacity building skills – Hogg's preferred option. This emphasis on securing a good 'fit' between a service and the community is crucial to ensuring support is acceptable and accessible, and several possible models for attaining this have been identified.

Community-Orientated Practice

Several commentators on rural social work have argued for a model of 'community-orientated practice'. [37] A framework for practice has been developed by Smale et al[38] which envisages locally based practitioners (individually or in teams) 'mapping' problems together with community members who are seen as experts in their own lives. This style particularly suits preventive interventions, which is in line with current approaches to social problems. But Turbett (*op cit*) warns that authorities need to recognise that their traditional performance indicators may not fit with such practice.

Local Area Coordination

Local Area Coordination (LAC) is a model that originated in Western Australia in the early 1990s where it is associated with the innovator, Eddie Bartnick[39] and has tended to be applied in the field of learning disability. It adopts a person-centred approach to enabling individuals and their families to get the support they need within their own communities, and central to the model are the Local Area Coordinators who work from and within the community. Their involvement could take the form of support to:

- build up a social life
- make a contribution to the community
- find employment or volunteering opportunities
- find educational opportunities
- join community groups or activities
- access social care support

LAC has been also used in parts of Scotland and has been the subject of a comprehensive evaluation by Stalker et al[40]. The researchers acknowledged the difficulty of extracting identifiable and measurable outcomes, but note that the LAC sites themselves identified three main areas of achievement – a better overall quality of life for people; specific differences in individuals' lives; and particular areas of work such as transition to adulthood – where they believed they had made a wider impact. Generally it was found that individuals gained improved access to services, support and information as a result of their contact with LACs. Although the LAC model has

[37] Cheers, B. (1998), *Welfare Bushed: Social Care in Rural Australia.* Aldershot: Ashgate; Martinez-Brawley, E. (2000), *Close to Home: human services and the small community*. Washington: NASW Press.

[38] Smale, G et al (2000), *Social Work and Social Problems*. Basingstoke: Macmillan.

[39] Bartnick, E. (2003), *Review of the Local Area Coordination Programme Western Australia.*

[40] Stalker, K et al (2007), Evaluation *of the Implementation of the Local Area Coordination in Scotland.* The Scottish Government.

not been specifically geared to the remote rural context, there could be some very useful transferable knowledge and lessons.

Community-Based Rehabilitation

More specifically within the remote and rural context, Kuipers et al (*op cit*) propose a somewhat similar model to LAC which they term *community based rehabilitation'*(CBR) – an approach in which a community worker is trained to coordinate and develop the community's access to resources, and to foster links with the community. The key features of CBR are said to be:

- developing partnerships and fostering community participation
- supporting and facilitating initiatives taken by people with disabilities, their families and communities;
- a focus on local integration
- the maximisation of formal and informal services

In their review of a CBR approach in Queensland, Australia for disabled people, the authors identified the following benefits:

- a sustainable service model to respond to the needs of people with disabilities;
- greater community awareness of disability issues;
- more community support for people with disabilities and their carers;
- more effective networking and coordination between family members;
- greater informal and community supports for people with disabilities.

RURAL PROOFING STRATEGIES

It is increasingly accepted that policies developed and informed predominantly by urban experience can have unintended effects when applied to rural and remote areas. Some form of '*rural proofing'* strategy has been identified as a way of minimising this likelihood by ensuring that all government initiatives are checked to ascertain their likely impact on rural people and communities. In Scotland, the Scottish Borders Council claimed (in December 2007) to be the first council to have developed a rural proofing policy, but the idea has a longer policy history in England.

Here the Rural White Paper of 2000 resulted in the Commission for Rural Communities being given a statutory role to monitor and report on how policy is developed, and the extent to which policies are meeting rural need. The intention is that as policy is developed and implemented, government and other relevant bodies will:

- consider whether their policy is likely to have a different impact in rural areas because of particular circumstances or needs;
- make a proper assessment of those impacts and, where they are thought to be significant;
- adjust, where appropriate, policy and delivery with solutions to meet rural areas' needs and circumstances.

The evidence to date suggests that rural-proofing is struggling to make an impact. A review of measures designed to reduce social exclusion in rural areas found that (with the exception of Sure Start) the programmes lacked a rural awareness, and concluded that rural proofing had little effect.[41] And again in its second (and most recent) rural proofing report, the Commission for Rural Communities[42] came to the following dismal conclusion:

'*This year, as with many of our previous monitoring reports, we have to report that we are disappointed in the overall performance of government departments...The commitment to rural proof government is not being delivered consistently, and is reliant on the approach of individuals rather than built into the day to day work of departments.'*

All of this suggests that a top-down rural-proofing strategy is likely to have only limited success, and at best it needs to be underpinned by a range of 'bottom-up-measures rooted in the needs and aspirations of remote rural communities themselves. This is consistent with the finding from Hogg's review of service provision in rural areas in 2000 which concluded that '*We have found no legislative or other barriers which only the Scottish Executive can resolve'* (p10).

PARTNERSHIP STRATEGIES

A commitment to joint working has underpinned most of the strategies outlined above, but it is important to also pull out this dimension separately. This strategy can constitute *horizontal integration* (linking parts within a single level of care such as ECCTs) or *vertical integration* (relating different levels of care, such as primary, secondary and tertiary). There are many different strands to the partnership debate, and it is not within the scope of this paper to examine them fully. Leichsenring (*op cit*) usefully distinguishes between:

- developments starting in the realm of health care, such as managed care pathways;
- person-centred approaches that focus upon the holistic needs of individuals rather than the fragmentation of services;
- 'institutional' discourses concerned with strategic coordination. Culminating in a whole-system perspective.

Whilst not confined to remote and rural communities, it is imperative in these areas to ensure that coherent support and services are available for the population of a given geographical area, or for a specific population group over a given geographical area. Reed et al[43] distinguish between five different forms of integration, each of them relevant to remote and rural settings:

- between different service sectors (such as health and social care)
- between professions (such as nursing, social work, medicine)

[41] Community Development Foundation (2006), *An Analysis of the Rural Impacts of Public Sector Interventions to Tackle Social Exclusion.*

[42] Commission for Rural Communities (2008), *Monitoring Rural proofing 2007.*

[43] Reed, J et al (2005), A Literature Review to Explore Integrated Care for Older People, *International Journal of Integrated Care*, January.

- between settings (such as institutions and community)
- between organisation types (such as statutory, private and voluntary)
- between types of care (such as acute and long-term care)

CONCLUSION

The type of care model that is envisaged for remote and rural communities is laid out in the report of the Remote and Rural Steering Group (*op cit*) and shown below.

CURRENT MODEL OF CARE	FUTURE MODEL OF CARE
• self-care infrequent • reactive care • variation in care pathways • multiple visits to secondary care	• self care encouraged • anticipatory care • robust negotiated care pathways • shifting to locally based care

Rural and remote communities do face a range of additional difficulties as compared with their more urban counterparts, but they also possess some indigenous strengths which need to be understood, harnessed and utilised. There is no simple or single 'silver bullet' strategy that can address the 'rural and remote' issue, but rather a raft of measures undertaken by a range of agencies across several levels of governance. If there is one key message emerging from this review it is that whilst the Scottish Government and local partnerships can help to shape the policy context within which support takes place, it is the sustainability of local communities that will determine its impact.

The different approaches might be distinguished along the lines of supply and demand factors respectively. The traditional way of responding to social problems has been to reshape *supply* – central government and local partnerships seek to change the way in which services are structured and delivered. However, it is also important to consider *demand* issues as defined by individuals and communities themselves, otherwise there is always the danger that the supply of services is not meeting needs appropriately. Drawing on the material covered in this report, the following framework constitutes a basis for further analysis:

ORGANISING CONCEPT	POSSIBLE STRATEGIES
Supply Side: Service Location and Mode of Delivery	• Telehealthcare • Professional Recruitment and Retention • Extra Care Housing • Integrated Teams • Changes to Professional Roles and Responsibilities • Development of a 'Generalist Practitioner' Role • Rural Proofing Strategy
Demand Side: Community Capacity	• Social Capital Proofing • Local Area Coordination • Informal Inter-Professional Working • Community Capacity Building • Embedded Practitioners • Community Orientated Practice • Community Based Rehabilitation
Demand Side: Individual Capacity	• Extension of Direct Payments • Personal Budgets • Self-Directed Support/In Control