Access to health services

Summary of RSN policy messages

- Review the allocation formula used for Clinical Commissioning Group funding.
- Deliver on the stated aspiration that more of the NHS budget is spent locally.
- Have NHS service reviews take more account of accessibility and transport links.
- Resolve or remove the financial debt burden hanging over some smaller hospitals.
- Encourage trainee GP and Practice Nurses to fill vacancies in rural areas.
- Rural proof, carefully, proposals to expand 7 day-a-week opening of GP surgeries.
- Help the small number of rural GP practices threatened by the phase-out of MPIG.
- Test and roll out initiatives which would benefit rural patients, such as telemedicine.
- Work with Ambulance Trusts so they improve their response times in rural areas.
- Ensure the planned expansion of mental health care reaches rural communities.
- Revise funding allocations for public health urgently, to put them on a fair footing.

Context

Rural areas score relatively well on measures of health outcomes. Those born in rural areas have a longer life expectancy than those born elsewhere. Similarly, rural residents are less likely than residents elsewhere to die prematurely from cancers, heart disease or a stroke.

However, in comparison with the national profile, a high proportion of the rural population consists of older age groups and this differential is projected to grow over time. At the 2011 Census 21% of the rural population, but only 15% of the urban population, were aged 65 or over. This matters since age is the main determinant of demand for health services.

Rural issues

Among key rural issues are the following:

- Resource allocation: rural areas lose out under the system through which NHS funding is allocated to individual Clinical Commissioning Groups (CCGs). Places with the highest burden of chronic illness, disability and mortality are those with the oldest populations – often rural and coastal. However, the funding formula gives more (per head) to urban areas with

younger populations. It creates large disparities in the amount available to treat patients with serious conditions.

- GP recruitment: there is a growing concern about the number of GPs and Practice Nurses due to retire soon, coupled with existing difficulties filling vacancies in many rural areas. Some rural communities could soon be left with inadequate primary health cover.

- Physical access to services: Department for Transport 'accessibility indicators' confirm that significant parts of the rural population would find it difficult to reach health care facilities by public transport or walking, especially those in smaller settlements. This holds true for GP surgeries and is particularly true for access to hospitals.

- Hospital centralisation: there has been a tendency to centralise provision, in part to create centres of excellence. The clinical and financial case for specialisation needs to be balanced against ease of access for dispersed rural populations. Otherwise, it can leave patients and their visitors with difficult journeys, especially arduous where regular treatment is required.

- Financial deficits: a number of hospital trusts serving rural catchments have moved into significant financial deficit, with some recently put into 'special measures' by the Department of Health (DH). This has arisen, at least in part, because of the funding allocations, as well as debt they have inherited.

- Ambulance response times: response time targets for 999 call-outs are frequently not met in rural areas. Moreover, average response times across geographically large Ambulance Trust areas can mask poor performance in rural places. This poses a risk to those needing emergency care. Although rural roads can be slower or longer, this issue needs to be addressed.

- Funding for public health: rural areas are losing out, as Government funding allocations to local authorities are still largely based on historic patterns of spend, rather than need. This creates enormous differences in funding (per head), with some areas receiving five times as much as others. A promise to reform these funding allocations was ducked in 2014 to "retain stability".

Government policies

The Conservative Party's 2015 Manifesto included the following pledges:

- Deliver a real terms increase in funding for the NHS of at least £8 billion, by 2020, to support the NHS Action Plan. Ensure there are enough doctors, nurses and other staff to meet patients' needs.

- Create a 7 day-a-week NHS, with GP surgeries open every day (and into evenings) and with better weekend staffing levels at hospitals. Patients aged over 75 to be given a same day GP appointment.

- Integrate health and social care through the Better Care Fund and pilot new approaches to join-up services between the home, clinics and hospitals. This topic will be covered further in a RSN briefing note on older people.

- Increase funding for mental health care and ensure therapists offer treatment in every part of the country. Enforce new access and waiting time standards for people experiencing mental ill-health.

There were other pledges which seem less likely to have a rural dimension, such as those on GP surgery regulation and funding for medical research.

RSN policy messages

The Rural Services Network considers that:

1. DH should ask its Advisory Committee on Resource Allocation (ACRA) to review the allocation formula for CCGs, so that funding better reflects local levels of demand for NHS services. Most of the NHS expenditure is clearly demand driven. The formula's current emphasis upon deprivation would only make sense if NHS services were preventative.

2. Government should pursue rigorously the stated wish of the NHS Chief Executive to see more of its budget spent locally, so that rural communities gain easier access to non-specialist treatments.

3. When undertaking service planning and review exercises the NHS should take more account of access for rural communities and the availability of public transport.

4. Government should resolve the financial deficits facing some smaller district hospitals, giving them more flexibility or removing their burden of historic debt. It would be unacceptable if this were allowed to affect their future viability.

5. Government should take urgent action to train more GPs and Practice Nurses. It should encourage trainees to spend time in rural practices and consider ways to incentivise them to join rural practices.

6. Plans to expand 7 day-a-week opening of GP surgeries will need careful rural proofing. The benefits must reach rural communities. Equally, implementing this policy must not, inadvertently, undermine small rural GP practices.

7. DH should resolve the threat facing a small number of GP practices that result from it phasing out the Minimum Practice Income Guarantee. Where practice closure would leave patients with access problems, solutions must be found.

8. Government should invest in initiatives which test and roll out care delivery models that have real potential in rural areas. This may include telemedicine and outreach services, the former requiring good rural broadband networks.

9. Government should work with Ambulance Trusts to help them improve their response times in rural areas, so that those needing emergency care are not put in any greater danger.

10. The Government promise of extra funding for mental health services is welcome. It should ensure that improved access to therapists and treatments reaches rural communities and is not simply focussed on urban centres.

11. Public health funding for local authorities urgently needs to go onto a fairer footing, with allocations based on need and demand. This should take account of extra sparsity costs that result from serving dispersed populations.

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RURAL SERVICES NETWORK

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