**APPG Follow up responses – 4 detailed follow ups with some reflections linked to a telephone discussion with Cornwall**

**Overview**

a) Percentage of Older People in rural - Variability in the understanding of the detailed distribution of health and care recipients below the district level – this covers all 4 authorities who reported back and Cornwall who gave some telephone testimony.

b) Pinchpoints – West Sussex list is definitive and covers the other 4 respondents namely:

i) **Increased travel**. Rural areas by nature of their population have lower numbers of customers requiring care than in built-up urban areas and customers are geographically more widely spread.
ii) **Costs to ensure viable and sustainable services**. With increased travel and consequently less direct time spent with customers, this means lower income and higher costs.
iii) **Economic factors**. As an example, house prices can be significantly higher in some rural communities, meaning that care workers are less likely to be able to live within these communities. This can subsequently increase their travel to work in rural areas and create difficulties recruiting and retaining staff in these areas.
iv) **Large volumes of care**. Some residents require two care workers to provide their care in their own home. The workforce challenge increases the difficulty in accessing care for these rural residents, as to access two people to provide care and arrive at the same time increases the practical challenge of delivering services.
v) **Nursing**. The ability of voluntary and community sector organisations and private sector providers to recruit nurses is a challenge and for the reasons above this is also heightened in rural areas.

C) Prevention – This involves being more flexible with care providers in terms of service specifications, paying higher rates in rural settings, looking at outcomes based contracting models, experimentation with ICT solutions. The work Sian Lockwood will cover about community enterprise solutions in Somerset is also inspirational.

**More detailed responses.**

**(a) the percentage of older people in rural areas with health and care needs and what local authority strategies are for projecting this forward [how does this compare to urban areas?]**

*Northumbria*

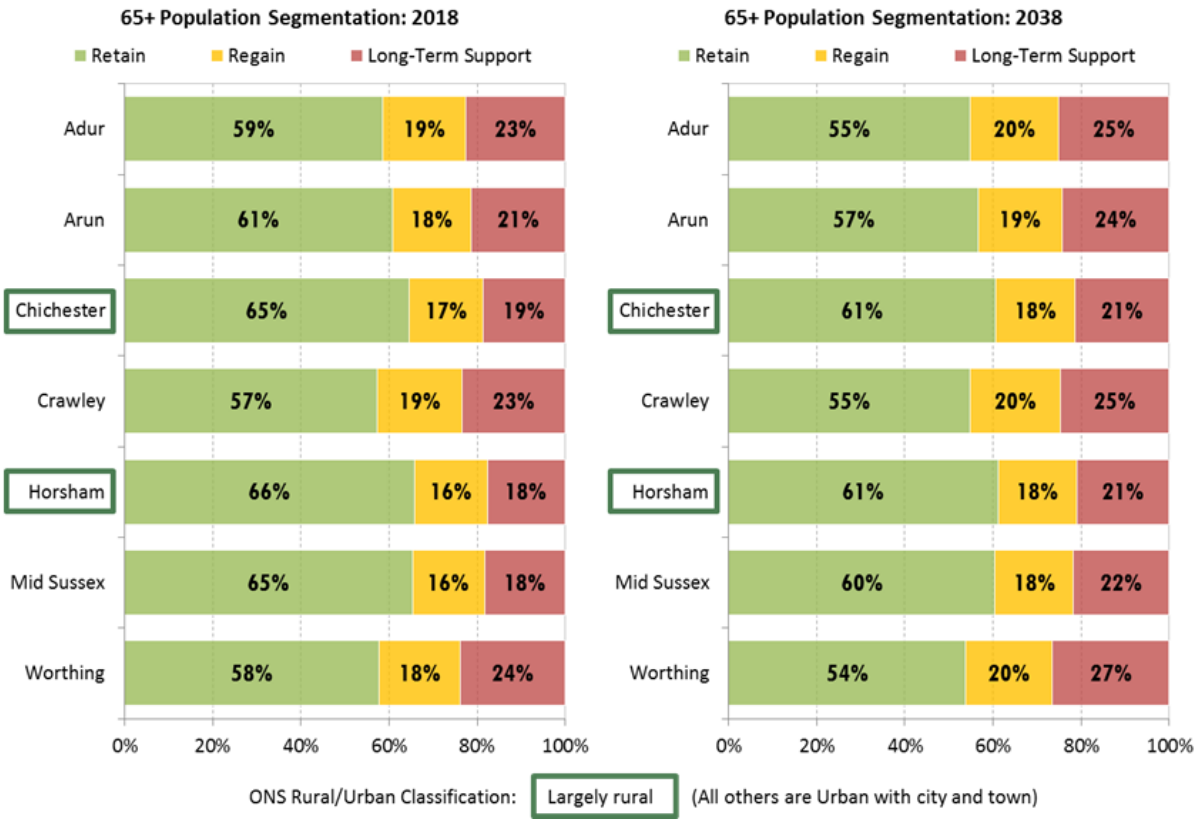
We certainly have a higher proportion of older people, and of people in the oldest cohorts of older people, in some of our most rural areas (though there are various

complications – commuter villages along the Tyne Valley different from remote hamlets in North Northumberland). But we basically use ONS stats when we want to understand that, rather than cooking our own. We've not tried very hard to estimate comparative age-specific rates of care needs, which would raise further complications about the different social and economic histories of different communities – for instance in South East Northumberland, which we think of as urban, long-term ill-health is commoner among people in their fifties and sixties, and more of the population are at income levels where they are likely to look to us for help rather than making private arrangements.

*West Sussex*

West Sussex has two districts classed as 'largely rural' by the ONS; Horsham and Chichester. 30-year population projections used by the council segment district/borough populations into the following groups based on need:

- Retain – people who are in good health, with day-to-day activities limited a little or not at all
- Regain – People who have some problem with daily activities and are in fair or bad health
- Long-term support – people who have significant problems with daily activities are in bad or very bad health




Rural districts have a slightly lower percentage of older people with high care needs (in the 'long-term support' segment) than urban districts/boroughs. This is projected to remain similar in the future, with every district showing a 2-4%

increase in the proportion of older people in the 'long-term support' segment and a 1-2% increase in the 'retain' segment. The population segmentation model is derived from census data combined with ONS population projections.

*Hampshire*

The response we gave to your earlier questionnaire gave our figures for the percentage of people we support who live in rural areas: they were 19% of over 65s we support are in rural areas, 20% of the over 85s we support. You're obviously aware of the preventative work we are doing in the technology enabled care (TEC) field, as I understand our TEC partner Argenti are presenting some of their work in Hampshire at the APPG. TEC has huge potential to benefit clients in rural – as well as urban – areas now and in the future as technology develops, and we look beyond traditional telecare solutions towards robotics and cobotics.

*Lincolnshire*

Don't have a precise breakdown. Overall know that the rate of ageing is slowing within the population and this will be a key factor over the longer term making the growth in demand more manageable.

**(b) where the rural pinch points are in terms of those people who put the greatest pressure on local authority budgets and how these are distinctive from urban areas**

*Northumbria*

Our biggest difficulties are certainly in the most remote rural areas, with travel time being a major reason for that.

*West Sussex (these also echo Cornwall who briefed me on the phone but didn't send an e-response as promised)*

Recruitment and retention of a workforce sufficient to meet the demand for services is one of the biggest challenges. Whilst this is equally an issue in urban areas, it is perhaps more pronounced in rural areas for the following reasons:

vi) **Increased travel**. Rural areas by nature of their population have lower numbers of customers requiring care than in built-up urban areas and customers are geographically more widely spread. This means travel between customers is greater within domiciliary care provision, which increases costs and is regularly cited as an issue in recruiting care workers to cover these areas. In addition, in residential and nursing care the distances travelled to work may be greater than when working in urban areas, leading to a greater challenge in recruiting to cover services in these areas.

vii) **Costs to ensure viable and sustainable services**. With increased travel and consequently less direct time spent with customers, this means lower

income and higher costs. In addition, with limited numbers in the populations in rural areas when compared to urban, services could be less stable as volumes are not as high to ensure regular and consistent ongoing income.

viii) **Economic factors**. As an example, house prices can be significantly higher in some rural communities, meaning that care workers are less likely to be able to live within these communities. This can subsequently increase their travel to work in rural areas and create difficulties recruiting and retaining staff in these areas.

ix) **Large volumes of care**. Some residents require two care workers to provide their care in their own home. The workforce challenge increases the difficulty in accessing care for these rural residents, as to access two people to provide care and arrive at the same time increases the practical challenge of delivering services.

x) **Nursing**. The ability of voluntary and community sector organisations and private sector providers to recruit nurses is a challenge and for the reasons above this is also heightened in rural areas.

*Hampshire*

No response to this question

*Lincolnshire*

Increasing number of younger adults with ageing carers which may have social care needs

Younger adults getting less NHS care with longer life expectancy – a bill for life

Volume care can be provided for older people acute care needs for others are far more challenging

Common elements linked to rurality, workforce as an issue, 180-degree hinterland, poor communications links prohibit commuting

**(c) If/how Local Authorities are planning for these health and care needs – in terms of examples of prevention and/or new approaches to managing funding**

*Northumbria Response*

We're doing fairly obvious things – paying higher rates to home care providers in the most rural areas, encouraging the use of direct payments, and making the most of community resources. We're also looking at ways to help older people move into market towns when it becomes harder for them to manage life in remote villages and hamlets – there's plenty of anecdotal and small-scale survey evidence of older people wanting to do that, and finding it difficult – and in individual cases, we have made a big difference to older people's lives, and substantially reduced

their care needs, by enabling them to move from remote and unsuitable houses into well-designed accommodation in a rural town. But we've never managed to get anyone to produce robust statistical evidence. If there's a single thing that it would be useful to us to get out of this exercise, it would be some national encouragement for serious academic research into the choices older people make, or would like to be able to make, about where they live in rural areas (including both migration to rural areas on retirement or later, and movements between settlements and housing types – both issues need to be considered together; for instance many of the older people who moved into a McCarthy and Stone scheme in Alnwick were moving from Tyneside rather than moving out of unsuitable former family homes in the local area

*West Sussex Response*

The council has developed a number of initiatives to meet the challenges of providing care in rural communities including:

i) Providing a block of funding for a 3-4-month period to establish domiciliary care providers in areas which have been challenging to source sufficient care to meet demand. This enables providers a guaranteed income in the area in response for establishing a round which can then operate as the start of a viable service from which to grow.
ii) Working in partnership with health colleagues on bed-based services by commissioning blocks of beds to support residents being discharged from hospital.
iii) Rates for service provision including enhancements for rural areas to support covering of additional costs incurred in providing services in rural communities.
iv) A pilot for an outcomes-based service in a specific community to encourage recruitment through payment for shifts and flexible delivery to customers.
v) Focus on provision of technology enabled care and meals to people in their own home in order to support customers through alternative sources of support where it meets their needs.
vi) Working on best practice in moving and handling to support people with updated equipment and techniques which can be provided by one care worker where it is appropriate to do so.

*Hampshire Response*

Our new Strategy document may be useful to give a flavour of the work we are doing, for example around demand management and prevention.
http://documents.hants.gov.uk/adultservices/publications/AdultsHealthandCareFiveYearStrategy.pdf

Another key area where we should be able to support people better in rural areas in the future is our new Help to Live at Home framework for care at home. We have moved away from standard pricing across the county to a more tailored approach to ensure that we can get the care we need in more rural areas, which of course often costs more and can be less attractive to providers because of the

time/travel costs.

*Lincolnshire Response*

Lincs Care Assoc (Linca) seeking to tackle some of this – in a dialogue with the Council about commissioning strategies, longer planning horizons and more certainty, review of rates for carers overall is ongoing.

Other initiatives –direct payments eligibility increasing, co-design discussions. Direct payment support provider setting up groups of carers who can support each other.

Individual service fund offers – working with small providers. New flexible approach but cost neutral – home care providers are being more flexible with their workforce – rather than 4 calls a day as routinely specified they are being enabled to deliver a person centred approach to care.