# Rurality, Sparsity to exit COVID-19 lockdown

## INTRODUCTION/BACKGROUND

The RSN emailed the Directors of Public Health in all of its County and Unitary member Councils as well of all of the members of the Rural Health and Care Alliance.

We said " As you may have noticed in the RSN weekly Bulletin, The Rural Services Network (in partnership with the Rural Coalition, the National Centre for Rural Health and Care, Action with Communities in Rural England and the Plunkett Foundation) recently wrote a letter to Matthew Hancock, Secretary of State for Health and Social Care, to ask that he consider the vulnerability and circumstances of rural communities when devising a COVID-19 exit strategy. A copy of the letter can be found here.

Following on from the letter a meeting is being convened with ourselves, fellow signatories and government officials in DHSC (via Defra) to discuss the vulnerability and circumstances of rural communities and the short, medium- and long-term practicalities involved in exiting from lockdown. To help inform this meeting we would very much welcome any issues you would like us to raise on your behalf.

For example, would you like us to raise the issue of local control as highlighted in this article from the Guardian, or are there other issues you would like us to raise?"

Those respondents who mentioned it agreed the thrust of the Guardian article - by *Allyson M Pollock, professor of public health, Newcastle University, and barrister Peter Roderick, principal research associate, Newcastle University* - which is referred to above and was about local control or input into testing, tracking and tracing.

**We received replies from**

- Rachel Wigglesworth -, Director of Public Health (Interim), Cornwall Council
- Vince Ion - Chair of the Board Lincolnshire Refugee Doctor project
- Paul Henry - External Funding Specialist Suffolk County Council
- Professor Derek Ward - Director of Public Health Lincolnshire County Council and Councillor Sue Woolley, Chairman of the Lincolnshire Health and Wellbeing Board (Joint Letter)

We are very grateful to them for taking the time to respond.



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RURAL SERVICES NETWORK

## SUMMARY OF THE RESPONSES RECEIVED

**What follows is a summary of the responses received. This summary relates to the Health/Public Health issues raised rather than the broader rural economy/infrastructure issues raised by some respondents. Those issues will be used by the RSN in different survey result report(s)**

**KEY MESSAGE (1): Local Control and Implementation of testing, tracking and tracing under the Local Authority Directors of Public Health (working with local partners) is essential. This must be fully funded by the Government.**

**KEY MESSAGE (2): The vulnerability and circumstances of rural communities must be fully reflected in planning the short, medium and long-term practicalities involved in easing and exiting from lockdown**

## RESPONSES REGARDING KEY MESSAGE (1): LOCAL CONTROL

1.1 We would like government to rural-proof its strategy for easing then exiting lockdown and recovering from the COVID-19 pandemic to ensure it is equitable across all areas of the country. This will help to maximise opportunities for recovery but also to prevent or reduce unintended consequences for those living in rural and coastal areas. We agree with calls for local public health teams to be at the forefront of the next stage(s) of recovering from the pandemic. Whilst lockdown restrictions may be eased consistently across the country, the measures brought forward need to take account of the differences between regions, their populations and infrastructure.

1.2 Contact tracing and testing, case finding, isolation and quarantine are classic public health measures for controlling communicable diseases. They require local teams on the ground, meticulously tracking cases and contacts to eliminate the reservoirs of infection. This approach is recommended by the WHO at all stages of the epidemic.

1.3 With further waves of the epidemic likely, resumption of contact tracing is critical. Each of the four nations needs to institute scores of locally led, nationally co-ordinated and funded teams to trace, find and test contacts. Teams in England and Northern Ireland would be based in local authorities; in Wales and Scotland they would be in local health boards. Their composition should be locally determined, drawing on a range of expertise, especially among directors of public health, field epidemiologists, environmental health



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officers, GPs, local NHS laboratories, NHS 111 and test centres, plus volunteers if required.

1.4 Widely used apps with robust data protection could play a supportive, but not framing, role. In addition, the plans for 50 mass drive-in test centres need to be decisively directed to support local contact tracing, as well as strategically targeting the most at-risk groups.

1.5 Use of an app for contact tracing may be less effective in rural areas as mobile phone and broadband coverage can be poor/non-existent.

1.6 All staff providing "care and support" will need PPE; including staff who would not normally be covered by the "care and support" banner such as sheltered scheme managers, cleaners, housing support officers and repairs staff attending supported living schemes and vulnerable tenants' homes.

1.7 Longer term need to invest in technological solutions (i.e. our First Call Service) to help deliver services to older and vulnerable.

1.8 There is an increasing focus on technological solutions to the C-19 emergency (track and trace app, wellbeing apps, online information, online booking of health appointments, etc). However, many rural communities suffer with poor broadband and mobile networks, making access to these services difficult – especially when everyone is online at the same time!

1.9 Easing the lockdown must be accompanied with robust and widespread COVID-19 testing (for both symptoms and antibodies) and contract tracing. We are ready to support with the national rollout of these. We would also need to be in a position to respond effectively to a potential second rise in infection rates in the country. We would also request prioritisation for COVID-19 vaccination of rural residents in the lower socio - economic statuses when one is available.

1.10 Digital connections. Good connectivity will be crucial for contact tracing (apps), remote working and social connections.

1.11 Like everywhere we welcome good national infrastructure for testing and tracing integrated to regional and local public health teams. We have a few concerns which might be unique to us/some other LAs.

1. We have a older more vulnerable demographic (higher proportion of over 65s, prevalence of risk conditions e.g. CHD, cancer etc.)
2. We have a particularly fragile health and care system with GP practice failure, often 99% hospital bed occupancy, delayed transfers of care back home, care market fragility and lack of skilled workforce e.g. pharmacists etc.
3. As a SW region local authority (at the end of the Peninsula) we have relatively low confirmed cases 19.2 per 100,000 (6th of 14 LAs in SW). So a highly susceptible population to Coronavirus infection.
4. Our economy is dependent on tourism not only holiday accommodation but the related service industry and hospitality of all sorts. In terms of economic



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sustainability, without the summer tourist trade Cornwall see a catastrophic loss of livelihood.

5. We think that testing and tracing is key for prevention of second peak of infections for our local, vulnerable resident, and management of outbreaks in care settings. However, this is a challenge of a different order if you factor in our additional 4 million visitors over the season.
6. Assuming that a national decision will be made on non-essential travel for leisure/holidays – how will the risk to Cornwall and what additional measure could we add to our local test, track and trace approach. What other areas might face similar issues (seaside resorts, lake district, wales) and what have you considered to adapt the approach to mass movement of people?
7. Could this include border temperature checks; immunity certificates; requirement to return home/stay indoors if symptoms; face masks for those with symptoms etc;
8. This will of course depend on the local/national balance of decision making – which is currently not clear to me, and funding available for enhanced approaches.
9. There is also a risk to social cohesion and heightened anxiety if there is an influx of tourist with symptoms.

## RESPONSES REGARDING KEY MESSAGE (2): RURAL VULNERABILITIES

The Vulnerabilities of Rural Communities to exit COVID-19 referred to by respondents (in no particular order of priority) are:

2.1 **Suicide prevention** – To exit from lockdown could be positive – a reduction in suicide - or could result in further increases – business closures, loss of work, relationship breakdowns, homelessness, income, food and money worries.

**For exit**

- Increased short-term investment, but long-term?
- Fewer people seeking support and yet services still here as normal. Maybe surge in demand post COVID-19.

2.2 **Mental Wellbeing** – to exit from lockdown impact on mental wellbeing, particularly for those shielded and vulnerable.

2.3 **Homelessness – end to Rough Sleeping** – initial response was to house all rough sleepers and ensure they could self-isolate/be safe. As time has gone, due partly to their issues, then less able to remain where they have been housed. In addition, resources to support with their complex needs should be factored in as well, as more than a roof over a head

**For exit**

- Shown that rough sleeping can be ended and quickly.
- Lessons are – how to sustain and support homeless rough sleepers to stay off the streets.



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2.4 **Food Poverty** – for some, COVID-19 has resulted in better quality food, improved sustainable approach, more local purchases of food with local businesses benefitting – village shops & local supermarkets, milk deliveries, wholesalers refocussing on home deliveries, butchers (lost restaurant trade, but supplying more home trade) fishing & farming industry – busier and refocussed on supplying local market rather than international market. For others (and many of them), struggle to have and afford food, store and prepare it – white goods broken down etc and increased demand for food banks, community kitchens, support for vulnerable households.

**For exit**

- How do we encourage/support continued focus on local supply and local food production– better for health, better for climate so we all prosper – will customers stay with them or return to old ways?
- Many households struggling to eat, afford to eat. Post lockdown with reduced salaries will this increase?.
- Emergency Food deliveries (patchy delivery - different on ground from Govt rhetoric).

2.5 **Health and Social Care** – demand for regular services has reduced due to fears of using NHS and people not wishing to burden system. Unmet demand, maybe a surge demand later.

2.6 What happens to healthcare system when temporary additional spaces/accommodation is withdrawn – back to bad old days? Currently using 3 hotels across Cornwall – what happens if and when they are needed again for holiday trade.

2.7 **Inequalities and COVID-19** – nationally, reports suggest that illness hits poorest hardest. Whilst Cornwall has a low number of cases and low number of deaths, we remain one of the poorest parts of England.

**For exit**

- How do you home school?
- What of digitally denied households, cannot afford broadband, IT kit, electricity etc.?
- Low income so less able to cope with COVID-19 change
- Take up of Universal Credit – has this helped?
- Is now the time for a Universal Basic Income to ensure everyone has the basic income to live on?

2.8 **Staffing Related Issues**

- Staff shortages in care homes due to a high number of staff self-isolating.



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- Need for more volunteers due to increase in demand and as many of the usual volunteers are 70+ and therefore self-isolating.
- Shortage of ICU beds and PPE.
- Labour pressures in the agricultural sector.
- How can we use the post COVID19 experience the improve the recruitment of healthcare professionals to Rural communities? This is an important feature of our work recruiting Refugee doctors to be part of our scheme already running in Grimsby and later this year in Lincolnshire.
- Recruitment and retention of health and care staff.

**MORE GENERAL ISSUES RAISED**

3.1 Need to develop more bungalows/sheltered/extra care schemes, particularly in rural areas and provide resources to assist people with decision making and actual move. This will help with hospital discharge and long- term sustainability of rural communities as it will free up other accommodation for rent and sale.

3.2 Need to invest in adaptations to property to help people remain in their homes.

3.3 There are higher percentages of older people in rural communities and in general, age is a significant factor in the severity of the symptoms and the ability to recover quickly. This may put an increased demand on rural health services.

3.4 If the lockdown is eased and people start visiting their 2nd homes from urban locations, this could increase the transmission of C-19 in rural and coastal communities.

3.5 The general sense of isolation and of being left behind. This is an issue in "normal" times and may be exacerbated as government and media focus is on getting cities and large urban areas operational again.

3.6 We support elements of the lockdown restrictions being eased to enable the local economy to resume; however, we also have concerns about the risk posed to the health of our residents from a potential influx of tourists from more densely populated urban areas that still have higher infection rates. It might be sensible to prioritise certain economic sectors to serve local communities but with a degree of caution about opening up too fast. In Lincolnshire, we particularly recognise the value of:

- Roles in food production for national wellbeing.
- Small businesses and alternative delivery methods e.g. takeaways, hairdressers, and outdoor roles (window cleaners, gardeners, builders, etc.). We have particularly large numbers of small businesses and sole traders, whose return to normal could secure their future. Residents in



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rural areas have adapted to online shopping and home deliveries; whilst this is positive, it could also affect the future of rural high streets, independent shops and sole traders who may not be eligible for business grants.

3.7 The report 'The impact of the COVID-19 pandemic on our towns and cities' (Centre for Towns, 23 April 2020) named these towns (Skegness, Mablethorpe & Sleaford) as suffering a disproportionate negative economic impact as a result of the tourism sector and small businesses and independent traders being closed down for a prolonged period. Coastal towns in particular lack the existing resilience to be expected to cope well.

3.8 Reports have shown that deprived areas are likely to have been hit harder by COVID-19. Lincolnshire's East Coast stands out as being amongst the most deprived 10 per cent of neighbourhoods nationally. Whilst infection rates have been low to date, these could increase significantly with an influx of tourists, but without this, deprivation could worsen. Specific consideration of the needs of struggling coastal towns would be a valuable extension to rural proofing. The Index of Multiple Deprivation (IMD) is, however, biased in favour of urban deprivation and under-plays rural deprivation issues which need to be understood and recognised.



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