State of Rural Public Services 2013

A report by the Rural Services Network

November 2013

Rural Services Network

The Rural Services Network (RSN) is a membership organisation devoted to safeguarding and improving services for rural communities across England. Some 200 organisations from a range of services are in membership, including local authorities, public bodies, charities and voluntary groups. It is the only network to focus specifically on service provision in rural England.

The RSN has three main purposes:

- **Representing** the case for a better deal for rural service provision;
- **Exchanging** useful and relevant information; and
- **Developing and sharing** best practice.

The RSN exists to ensure that services delivered to communities in predominantly and significantly rural authority area are as strong and affective as possible.

FirstGroup Plc

FirstGroup Plc is the leading transport operator in the UK. It is one of the largest bus operators in the UK, running around a fifth of local bus services. First has a fleet of 7,400 buses which carry approximately 2.3 million passengers every day. It has invested £160 million in around 1,000 new vehicles between 2011 and 2013.

First works closely with Government, local authorities and stakeholders across its networks to create successful relationships that will realise maximum efficiencies and greater benefits for customers, particularly through reduced journey times.

Brian Wilson Associates

Brian Wilson Associates is an independent consultancy providing policy advice, research and evaluation services to its clients. Areas of expertise include rural policy and rural proofing, service delivery and public service reform, community action and neighbourhood planning, local governance and tackling inequalities.

Brian Wilson managed the research, analysis and writing of this State of Rural Public Services 2013 report. Richard Inman of the RSN ran the surveys and Nick Payne of the RSN advised on the health services chapter.

Contact details: brian@brianwilsonassociates.co.uk

Foreword

Once again it is my pleasure to introduce an edition of the annual State of Rural Public Services report from the Rural Services Network. During the four years that we have been publishing such a report we have examined a wide range of services, all of which make an important contribution to the quality of life for our rural communities and to successful rural economies.

I am always fascinated to learn from the innovative examples of rural service delivery which the report contains and which I know have been sent in by members or associates of the Rural Services Network. In tough times we need to share such ideas more than ever.

Our 2013 report covers three service areas, which are health care, post offices and public transport. The NHS has been undergoing considerable restructuring, not least with the creation of local Clinical Commissioning Groups and with the transfer of public health responsibilities to local government. The post office network, whilst thankfully not subject to widespread closures, is altering with the roll out of a new approach – Post Office Locals – in rural areas. Significant changes have also been implemented which affect the way local bus networks are funded and regulated. It is an important role for those of us concerned with the wellbeing of rural communities to track and monitor how such policy changes play out. We need to know whether rural communities are benefitting fully from policy opportunities and we need to identify where policies are not working or are having unintended consequences.

The economy may be showing stronger signs of recovery, but Rural Service Network members are only too aware that the public funding position remains as difficult as ever. Indeed, the worst may be yet to come, as cuts bite deeper still and affect basic services. Last autumn's spending review announced further significant cuts in Government financial support to local government, which will come on top of the 28% cut imposed by the previous review.

Rural buses rely heavily upon the subsidy available from local authorities, so are particularly vulnerable in these circumstances. Health budgets have been broadly sustained, though face rising demand and costs. This is especially true in rural areas with their older populations. From a rural perspective the fact is the allocations for NHS and public health services are heavily skewed towards London and urban centres and with no allowance made for sparsity costs. We should be asking how it can be that for every £1 per resident given to the East Riding of Yorkshire for its public health, Westminster is given £5 per resident. Where is the evidence to justify such a difference? A fairer deal for rural areas would, at least, ease the pressure from budget cuts affecting the local government sector.

It is evident that rural communities are feeling the cutbacks. In a recent Rural Services Network survey 65% of rural parish councils said the quality of public services had got worse

over the last five years. Bus services – along with road maintenance, street cleaning and care for the elderly – are where those cuts are most acutely felt.

The Rural Services Network welcomes the independent rural proofing review that has recently been set up under the chairmanship of Lord Cameron of Dillington. We have no doubt that his review will examine Whitehall policy making on some of the issues covered in this report. The Rural Services Network stands ready to contribute, where we can, both to this independent review and to the longer-term rural proofing work of the Rural Communities Policy Unit based in Defra.

I hope this 2013 report is seen as another valuable contribution to the rural policy debate.

Councillor Roger Begy OBE
Chairman, Rural Services Network

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Summary of findings

This fourth report in the State of Rural Public Services series concentrates on three policy areas, which are health services, post offices and public transport. Its aim is primarily to inform and stimulate policy debate about rural service provision, and to share ideas amongst local policy practitioners.

It gathers together existing, recent evidence from a wide variety of sources to identify the main issues and trends associated with those service topics. It also draws upon the knowledge and experience of the Rural Services Network membership, not least by outlining some interesting examples of local policy implementation and delivery.

Applying the 'rural definition' to the 2011 Census data, some 9.3 million people live in rural England, which is 18% of the country's population. The rural population increased by almost 6% over the previous decade.

Health services

Health services have been subject to very significant restructuring and reform. This includes the establishment of local Clinical Commissioning Groups; and the transfer of responsibility for public health to local authorities.

Overall the rural population scores better than the urban population on measures of healthiness. Those born in rural areas have a longer life expectancy and rural residents have fewer years lost as a result of premature death from cancer, stroke and heart disease.

However, a significantly greater proportion of the rural population consists of older age groups. 21% are retired in rural England, compared with 15% in urban England. This means that actual demand for health care services is highest in rural areas, especially those places which attract retirees.

The allocation of NHS funding to different areas is based both on their population age profile and factors like deprivation – two things with very different geographies. The result is that rural areas receive lower NHS allocations (per resident) than urban areas. The logic behind the placing of such weight upon deprivation factors is highly debatable, since the delivery and management of NHS health care has little to do with preventative health measures.

Public health work is preventative and budgets for this are allocated to local authorities from 2013/14. However, the extent of the differences in those budgets is enormous, favouring urban areas and especially London. Westminster received five times as much grant per resident as the East Riding of Yorkshire.

Rural populations are less likely to have local access to health facilities, such as GP surgeries and (especially) hospitals. 64% of residents in villages live within 4 kilometres of a GP surgery, compared with 100% or urban residents.

Featured examples of rural delivery include: the Airedale Telehealth Hub in Yorkshire; and a Neighbourhood Health Watch scheme in Devon.

Post offices

There are nationally set criteria for access to the post office network and relatively few post offices have closed in the last few years. The main change is the programme to turn 2,000 outlets into Post Office Locals, where they will be based inside another retail outlet and will share its staff and counter.

In March 2013 there were 6,429 post offices in a rural area (UK figure), which is 55% of the network's outlets. Although numbers have stabilised recently, this makes the rural network 31% smaller than it was in the year 2000.

A survey run by the RSN for this report shows that reasons for local closures included declining patronage, sub-postmasters/mistresses retiring and the closure of co-located shops, as well as the closure programme that was implemented during 2007-09.

Survey respondents were on balance quite favourable towards the Post Office Locals model. The three main advantages they cited were: the convenience of having a shop and post office under one roof; that it brings more footfall into the shop; and that it (at least) retains a local post office.

They also cited some disadvantages to the Post Office Locals model, the main ones being: slow service because the post office and shop share a queue; a limited range of post office services available; and inadequate privacy or security for financial transactions.

Featured examples of rural delivery include: Wittersham post office counter in Kent; and the planned Grampound outreach post office in Cornwall.

Public transport

Significant changes have been taking place to local bus service regulation and subsidy arrangements. They include devolving a large part of Bus Service Operators Grant (BSOG) to local transport authorities, who can apply it according to local circumstances.

Many rural bus services are uncommercial and depend on local authority subsidy, making them vulnerable to cutbacks which result from the significant reductions taking effect in local authority revenue funding. This follows a 20% reduction in the level of BSOG in 2012 (which was recently spared from further cuts).

The number of local bus journeys made in rural areas increased up to about 2008, before plateau-ing and then falling back somewhat. Similarly, figures show the proportion of rural households with access to a regular bus service rose significantly until 2008, before falling

back a little. Less than half (47%) of those living in smaller rural settlements have access to a regular bus service.

The number of community transport organisations, however, grew considerably by 2011/12 at which point there were more than 600 in rural England. The rural organisations were smaller than their urban counterparts and relied heavily upon (48,000) volunteers.

Rural community transport organisations receive only half as much local authority funding (per resident) as their urban equivalents. Conversely, they raise much more of their income from fares revenue.

Underlining the importance of transport, those in smaller rural settlements travel 45% more miles than the England average. They rely much more on the car and they spend more on travel. In 2009 households in the smallest rural settlements spent £90 per week on travel.

Featured examples of rural delivery include: Cambridgeshire Future Transport; and the Transport Study in North Dorset.

All three service areas covered in this report are subject to major change. In the case of health services this flows from nationally driven (NHS) reforms, the rural implications of which warrant careful monitoring. With post offices the question is whether the roll out of the Post Office Locals model can deliver a more sustainable rural network. Changes affecting local public transport are largely budget driven. In some cases the impacts have been mitigated, including where local authorities and operators work together to find solutions. Nonetheless, service losses beg some serious questions about the impact on rural communities (including the most vulnerable) and how far or how well alternative transport options can plug gaps where subsidised bus routes are withdrawn.

Introduction

This is the fourth report in an annual series produced by the Rural Services Network (RSN). Its aim is to highlight trends in rural service provision and to stimulate policy debate about the needs of rural communities, including challenges to and good practice in service delivery.

Previous reports have covered various topics, including broadband, affordable housing, primary schools, business support services, libraries and cultural services, leisure and environmental services, facilities for young people, services for older people, fire and rescue services and actions to address fuel poverty. Those reports can be accessed via the RSN's website.

In the State of Rural Public Services 2013 report the focus is on three topical issues, which are: the post office network; health care services; and public transport. All of these have a considerable impact on rural quality of life and all feature regularly in policy discourse. In all three cases there is a strong rural dimension to their successful delivery.

The report pulls together different types of evidence and information, using up-to-date sources wherever possible. Existing research and statistics produced by other organisations are widely quoted, including the Statistical Digest of Rural England which is produced by Defra. Web searches and published material have been reviewed to understand the policy context. An online survey was circulated to parish and town councils in selected rural areas to generate further information about rural post offices. Specific sub-groups within the RSN membership were asked to provide some additional evidence about health care and public transport. Follow up contact was made with a few of those members and parish councils in order to gather material for short case studies on innovation in rural service provision.

Where possible statistics quoted in this report refer to the formal rural-urban definition, since this carries the status of being a National Statistics definition. Moreover, it is capable of analysing data at a very local level. According to that definition 'rural' is any settlement with a resident population of less than 10,000. This is often disaggregated further into rural towns (3,000 up to 10,000 population), villages (500 up to 3,000) and hamlets or isolated dwellings (up to 500). The definition is being updated to reflect new data from the 2011 Census, but aside from population statistics the information available at the time of writing this report still refers to the 2001 Census-based definition of settlements.

The new 2011 Census data shows that in England there were 9.3 million people living in a rural area, which comprised 18% (or almost a fifth) of the total population[1]. This is actually lower than the rural population in 2001 (19%), but great care should be taken in interpreting this. It is not indicative of a shrinking population. Rather, most of the decrease reflects the fact that some settlements which in 2001 were rural have since expanded in size (to over

[1] Defra, 2013 (1)

10,000 population) making them technically now urban. If that definitional change is excluded from the calculation the population of rural areas has been increasing (e.g. by 5.8% between 2001 and 2010).

Population of rural England (2011 Census)

	Population	Proportion of England total
Rural towns and urban fringe	4.7 million	8.8%
Villages	2.9 million	5.5%
Hamlets and isolated dwellings	1.8 million	3.3%
All rural areas	9.3 million	17.6%

Not all statistics are available at the settlement level: many statistics are only produced at the local authority level. Where this is the case the Defra rural classification is used, which recognises three types of rural area based on their degree of rurality. The most rural are the R80 local authority areas, where at least 80% of the population lives in a rural settlement. In the R50 local authority areas have between 50% and 80% living in rural settlements. (The R80 and R50 areas are often jointly referred to as Predominantly Rural areas.) Finally, there is a category of Significantly Rural local authority areas which have between 26% and 50% living in rural areas or in larger market towns.

The local authority based classification gives a slightly higher figure for the rural population of England (24% or around a quarter, rather than the fifth using the rural definition).

The majority of the research and drafting for this report was carried out by Brian Wilson Associates. Richard Inman for the RSN assisted with the survey of parish/town councils and the information requests to members. Nick Payne, who has established a Rural Health Network for the RSN, helped with the policy context and evidence sourcing for the health care services chapter. Graham Biggs, Chief Executive of the RSN, had oversight of the project.

Those who responded to the online survey and requests for information must be thanked for contributing significantly to the report. By providing grounded evidence from rural areas they have added a unique (RSN membership) dimension and have brought some reality to the research and statistics. Contributors to the Rural Health Network Conference in October 2013 should also be acknowledged for helping to shape the content of that chapter.

Health services

Access to health care is something we all care about and in a rural context that must include physical access as a result of geography. This is likely to be especially important for certain age groups, not least older people who are more frequent users of health services and whose mobility may be deteriorating.

The very significant policy and structural changes affecting the NHS should therefore be of considerable interest to anyone with a concern for the wellbeing of those living in rural areas.

The policy context

The Kings Fund[2] has called the changes brought about by the Health & Social Care Act 2012, "the most wide ranging reforms of the NHS since it was founded in 1948". Its main reforms came into force in April 2013.

They include the creation of Clinical Commissioning Groups (replacing Primary Care Trusts), which are led by GPs and other clinicians. These are the 211 local bodies which manage around 60% of the NHS budget and which now commission the majority of services, including emergency care, elective hospital care, maternity care, community and mental health services.

There is a new regulator, called Monitor, which oversees the operation of the NHS commissioning 'market', including the prices that are set for NHS services. At a local level, 152 Healthwatch bodies[3] have been established to represent and to act as a voice for the users of health and social care services.

Local authorities have been given the prominent role in delivering public health outcomes, including the reduction of health inequalities. In this they are supported by an Executive Agency called Public Health England and they work to a new public health outcomes framework. These changes follow the Healthy Lives Healthy People strategy[4] (or White Paper) that was published in late 2010.

Upper tier local authorities have established and now host Health and Wellbeing Boards, which seek to co-ordinate the preventative work of key players, including public health, the NHS, adult social care and children's services, so that it meets the needs of the local population.

A further piece of reform of particular rural note is the proposed change to the GP contract. GP surgeries with small patient lists, which are disproportionately found in rural areas, have been in receipt of something called the Minimum Practice Income Guarantee (MPIG) to help

[2] Kings Fund, 2013 (1)
[3] Healthwatch England, 2013
[4] Department of Health, 2010

them remain viable. It is currently proposed to phase out the MPIG[5] over a seven year period starting in 2014.

Other longer term developments can clearly be seen to play into the provision of health care for rural communities. They include the move towards more centralised specialist medical services and the scope for greater use of telemedicine (predicated on improved broadband provision). Trends in public transport provision - the subject of a later chapter – are equally important in terms of rural access to health services.

Evidence – the population's health

Demand for health services is much higher amongst some population groups than others, not least older people. Recent analysis[6] based on the 2011 Census shows that:

- 21% of the population of rural England is aged 65 or over; whilst
- 15% of the population of urban England is aged 65 or over.

Indeed, in the more sparsely populated rural areas the 65+ age group makes up around 25% of the population. The projected growth in numbers of older people is likely to increase demand for health and adult social care services in rural areas, perhaps especially in popular retirement locations.

On the other hand, those living in rural areas are on average healthier than their urban counterparts. This is true in terms of life expectancy and premature deaths from common causes.

In the most rural (Rural 80) local authority areas a newborn male baby is expected to live to age 80, which is two years longer than if born in a predominantly urban area. For a female baby Rural 80 life expectancy is almost 84 years, which is one and half years longer than if born in a predominantly urban area. Many factors affect life expectancy and a combination of them may explain these differences.

Life expectancy at birth in years, 2009-11

	Male	Female
Rural 80 areas	80.2	83.9
Rural 50 areas	79.7	83.4
Significantly rural areas	79.6	83.3
Predominantly urban areas	78.2	82.5

Source: Office for National Statistics

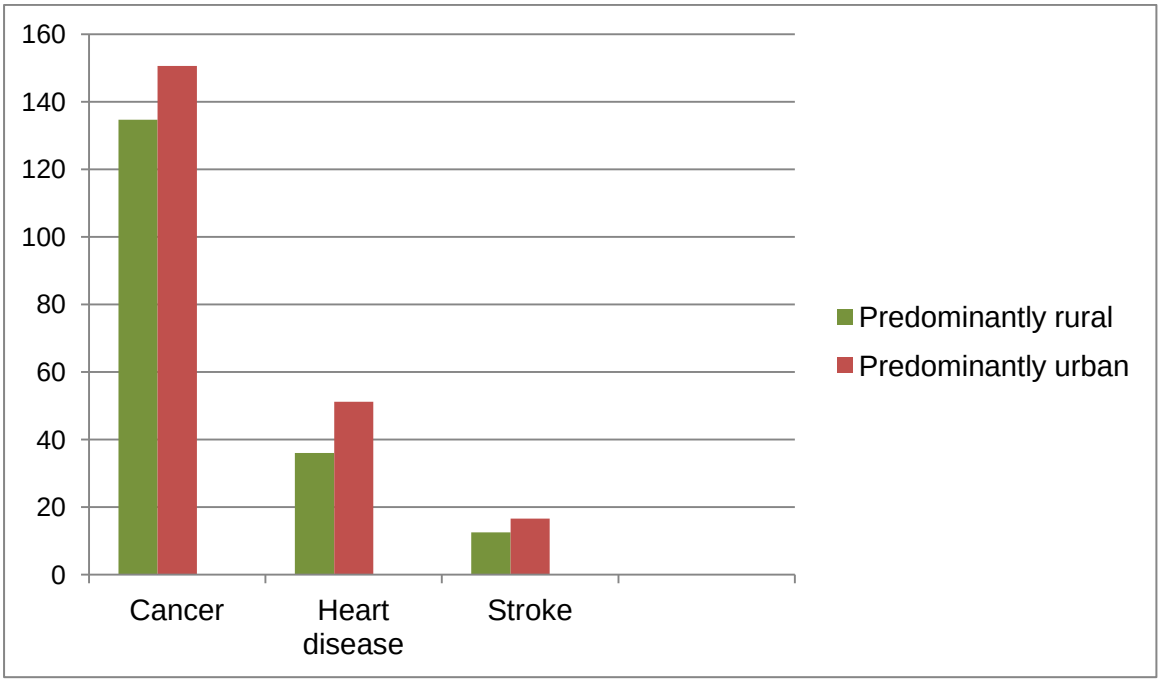
Life expectancy is extending in all types of area. A baby born in a rural area in 2009-11 is expected to live about three years longer than one born in 1998-00.

Analysis of deaths from cancer, stroke and heart disease is based on a measure of 'potential years of life lost', which is how much longer a person would typically have lived if they had not died of that condition. The higher the number, the more premature the death was. The chart below shows that premature death levels are lower in rural than in urban areas for

[5] Rural Services Network, 2013 (1)
[6] Defra, 2013 (1)

cancer, coronary heart disease and strokes[7]. This is speculative, but it could be that migration to rural areas brings in more affluent people with healthier lifestyles. Similarly, it could be that rural areas are disproportionately across the south of the country and it reflects a north-south divide in health outcomes as much as any rural-urban differences.

Potential years of life lost per 10,000 population from certain conditions (2008-10 data)



Source: National Centre for Health Outcomes Development

The pattern for suicide is rather different. If anything, rural areas score marginally worse than urban areas in terms of potential years of life lost from suicide. The 2008-10 figures are:

- 26.5 years of life lost per 10,000 population in rural areas; and
- 26.2 years of life lost per 10,000 population in urban areas.

If a more detailed disaggregation of local authority types is used, this shows the highest levels to be in Other Urban areas (28.6) and in Rural 80 areas (27.3). It is important to note that these figures are for all residents in these areas, which may mask high levels associated with specific groups e.g. suicide among farmers has been a particular concern.

Evidence – funding for health services

The Advisory Committee on Resource Allocation (ACRA) is undertaking work for the Department of Health to review the NHS resource allocation formula. This is seen by some commentators as long overdue, given the extensive changes that have taken place in the health system[8].

[7] Defra, 2013 (1)
[8] Kings Fund, 2013 (2)

Research by Professor Sheena Asthana[9] concludes that the current approach to NHS funding fails to promote the goal of 'equal opportunity of access to health care for equal needs'.

While need for health care is shaped by the interaction of age and factors such as deprivation, those areas grappling with the highest burdens of chronic illness, disability and death are those with the oldest populations. However, these places do not receive the highest NHS allocations. Rather, the most deprived areas are the most generously funded – places which have high morbidity and mortality given the age of their populations, but not the highest morbidity and mortality in real terms.

Rural areas, which are demographically ageing but tend to have lower than average levels of social deprivation, lose out under this system. Thus, although areas such as East Lindsey (Lincolnshire), Arun (Sussex) and New Forest (Hampshire) have the highest rates of cardiovascular disease in the country – and Dorset, Somerset and East Sussex the highest rates of cancer – they receive far less funding per head than areas such as Newham, Tower Hamlets or Birmingham, which have young populations with low rates of chronic disease.

Mortality, morbidity and funding allocations for PCTs in 2010/11

	Mortality rates per 100,000 population, from:			Allocation per capita
	All causes	Cancer	Circulatory diseases	
Dorset (oldest population)	1,159	334	399	£1,560
Tower Hamlets (youngest population)	441	137	147	£2,084

Source: Asthana S

These differences in allocations are accompanied by large differences in expenditure e.g. on cancer patients. They range from just roughly £4,000 per patient in Dorset in 2010/11 to just under £16,000 per patient in Islington and Camden.

Indeed, recent discussions about hospital 'failure' have cited the context of the varying funding environments in which hospitals find themselves. Asthana reported in the Health Services Journal[10] that non-specialist acute hospitals with the highest number of excess deaths typically have significantly older catchment populations, a poorer funding context and significantly lower numbers of doctors, nurses and cleaning staff.

The targeting of NHS resources at deprived areas appears to stem from concerns about health inequalities, the prevention of which is not addressed by the delivery and distribution of NHS health *care*. At the same time, this approach could be said to divert resources from the areas with chronic disease loads that require curative care and management.

That NHS resource allocation is not more closely related to the needs of an ageing population has been debated recently. However, NHS England have expressed the view

[9] Asthana S, 2013 (1)
[10] Asthana S, 2013 (2)

that poor health outcomes in deprived areas are a function of 'unmet need' for health care services, so there seems little prospect rural areas will receive a larger share of the funding.

There is also a rural dimension to the proposed phasing out of the Minimum Practice Income Guarantee (MPIG), which distributes £110 million to small GP surgeries. According to the Department of Health around 100 GP practices are thought to rely heavily upon the MPIG[11]. Many, though not all, are in rural locations. In most cases their loss in NHS income is said to be small (under £2,000 per year), but there is a wide variation and some stand to lose around £75,000 per year, which could mean losing one doctor. The overall position is complex because of other funding changes due to take place. It is understood that this is being looked at again by Department of Health.

Public health budgets that were transferred to local authorities in 2013/14 in general provide substantially more funding for urban than for rural areas[12]. Whilst it may not be surprising that the very lowest allocations are for some Home Counties in the south east, there are also low allocations for rural authorities in the midlands and north. If East Riding of Yorkshire were to receive the national average allocation, its public health budget would almost double (giving it £24 more per resident or an extra £8 million in grant overall).

Public health grants to local authorities

Local authority area	Allocation per head of population	
	2013/14	2014/15
Surrey (the lowest)	£20	£22
East Riding of Yorkshire	£25	£27
Rutland	£27	£28
Devon	£27	£29
Cumbria	£28	£31
Shropshire	£29	£32
Leicester (city)	£60	£66
Birmingham	£72	£73
LB of Westminster (the highest)	£132	£133
England (average)	£49	£51

Source: Department of Health

Allocations for the current year (2013/14) are based upon historic levels of spending on public health. The way they have been calculated works against many rural areas for two reasons:

- Urban areas were more likely to have been given funding to target areas of deprivation; and
- A Market Forces Factor pushed significant funding into the capital as a sort of London weighting.

As the table above shows, Westminster receives five times as much per resident as places like East Riding of Yorkshire, Devon and Rutland. Whether evidence exists to justify this scale of discrepancy must certainly be open to debate and challenge.

[11] Pulse, 2013
[12] Department of Health, 2013

The calculation does not include any weighting for additional costs of delivery in rural areas. Shropshire Council, for example, points to the fact that it has seventeen market towns spread across the county and it cannot realistically deliver public health services from one central accessible location. Hence, it needs to duplicate its services and incur higher staff travel costs.

In theory these allocations are supposed to move away from their historic base and towards a target level. However, because the Department of Health has uplifted budgets for all areas in 2014/15 the rate of progress towards target levels is damped down[13] and the urban-rural gap is barely closed.

Evidence – access to health facilities

In 2010 there were 1,987 GP surgeries located in a rural area of England (which was almost 20% of the total)[14]. However, only 1,247 of these were principal sites for those surgeries. They were numerically split quite evenly between rural town locations and village/hamlet locations.

Also in 2010 there were 213 hospital located in a rural area (which was 11% of the total). As might be expected, these were mainly in rural town locations.

An analysis of 2011 data[15] calculated the percentage of households living within set distances (by road) of these service outlets. It found that those in the smallest settlements were notably less likely to live near to a GP surgery and those in all types of rural area were less likely to live near to a hospital.

Proportion of households living within given distance of services, 2011

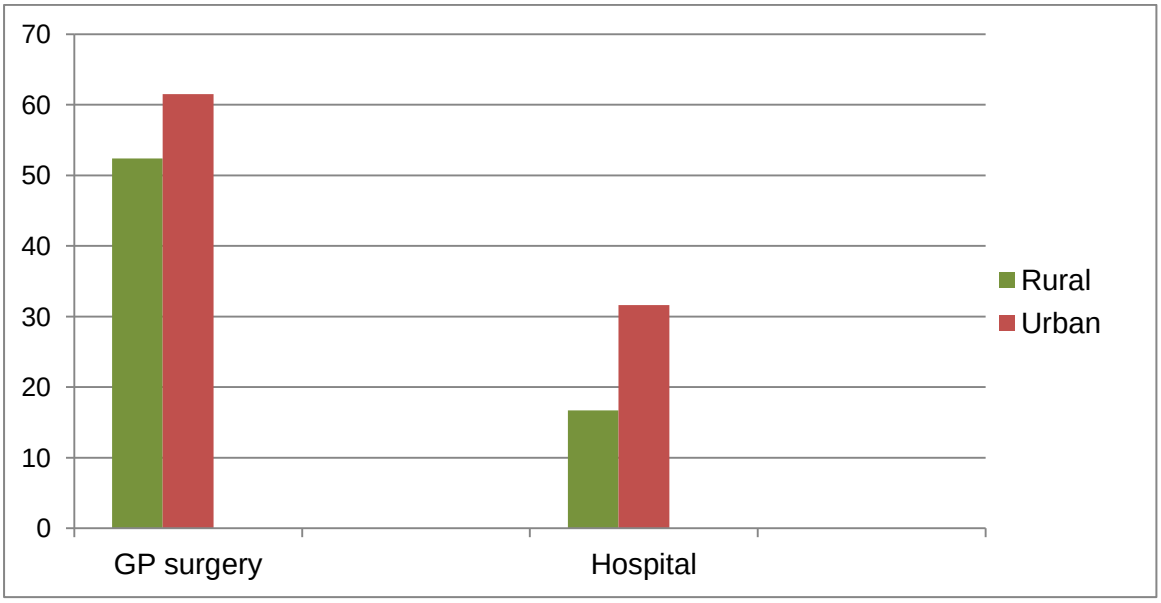
	GP surgery (within 4 kms)	Hospital (within 8 kms)
Urban areas	100%	97%
Rural towns	97%	60%
Villages	65%	52%
Hamlets/dispersed homes	69%	55%

Source: Defra Note: for simplicity the figures shown above are those for 'less sparse' areas.

Information from the Department of Transport's accessibility measures lead to a similar conclusion. They show that fewer rural residents are likely to travel to health services by public transport or by walking than their urban counterparts[16]. As the chart below illustrates, the difference is particularly stark for travel to hospitals, which rural people are only half as likely to access by public transport or walking.

[13] For example, Shropshire's target allocation for 2014/15 is £35, but its actual allocation is only £32.
[14] Commission for Rural Communities, 2010
[15] Department of Environment Food & Rural Affairs, 2013 (2)
[16] These figures are based on the time needed to reach a service and people's willingness to travel by different means (based on the National Travel Survey).

Proportion of population likely to travel to service by public transport or walking, 2011



Source: Department for Transport accessibility indicators

Local solutions

A body of case study and guidance material was created in 2012, known as the Rural Proofing for Health Toolkit[17]. This online resource, which is aimed mainly at the commissioners of health services, was created by the Institute of Rural Health with Defra funding.

The toolkit contains rural advice and some case studies relating to six health policy considerations: patient safety; partnership working; the workforce; access to services; patient choice; and self care. Examples of good rural practice which are cited include:

- A pharmacy that is accredited as a Healthy Living Centre to provide a range of services (Beaminster, Dorset);
- An Ambulance Practitioner responding to emergencies and supporting health professional (around Pickering, North Yorkshire);
- Farming on Prescription, where patients with mild mental health issues can be referred to a care farm as part of their treatment (Norfolk);
- A tele-dialysis facility which reduces patient travel needs by offering video-conferencing between a main hospital renal unit and a satellite dialysis unit (Scottish Highlands).

The examples of innovation in health service provision below are two that were presented at a Rural Health Network conference held in October 2013.

Example: Airedale Telehealth Hub, Yorkshire

Airedale NHS Foundation Trust serves a population of 220,000 across 700 square miles and comprising much of the Yorkshire Dales. It includes villages where travel time by public transport is almost two hours, perhaps to come in for a 15 minute hospital appointment. The

[17] Institute of Rural Health, 2012

Telehealth Hub uses technology to provide three types of service remotely. These are: remote monitoring for patients with long-term conditions; online coaching to enable self-care; and remote secure video-consultations to provide clinical consultation.

A particular issue is older people in nursing and residential care homes, who may find it hard to cope with regular travel to hospital. There are resource issues too for care homes, as they often like to escort residents to hospital. After successful early trails, Airedale has massively expanded its use of tele-consultation, which will soon be used with over 100 care homes and by 75 patients in their own homes. Interestingly, some are now where contracts have been commissioned from outside the catchment area of the Foundation Trust, showing that geography really is no barrier to the use of tele-consultation.

In the case of care homes consultations typically involve a member of staff sitting with the resident/patient, whilst linked up via a device e.g. laptop, to the Telehealth Hub in Airedale hospital. This hub is staffed round the clock by specialist nurses, who have access to hospital consultants should they be needed. This use of tele-consultation has delivered large benefits. Unplanned hospital admissions from care homes have dropped by 45%, hospital bed days are down by 60%, average length of hospital stays has fallen by 30% and A&E visits dropped by 69%.

There are inevitably challenges in introducing such an approach, including some technical issues, though cultural and collaboration issues are seen as more important barriers to overcome. Airedale notes that to succeed tele-consultation must be integrated with the care pathways used by health professionals and should not simply be seen as an add-on.

Example: Neighbourhood Health Watch in Devon

The first Neighbourhood Health Watch scheme started in 2011, based on the same principle as watch schemes to tackle crime, but with a health focus. There are now seven such schemes, six of them in Devon where they are supported by a project facilitator.

In each case there is a local co-ordinator who recruits and holds information about the scheme volunteers, and who matches them up with the needs of clients. The aim is to reduce pressure on statutory health services and to reduce isolation, which is known to relate to stress and poor health.

Beyond that the schemes vary locally in what they offer. Typical examples are lift-giving to hospital appointments, collecting prescriptions, supporting people following a bereavement, enabling full-time carers to take a short break and looking after pets when their owners are in hospital. One real success has been encouraging volunteers to cook an extra portion of food, sometimes, to provide a vulnerable neighbour with a home-cooked meal.

Key contacts for the schemes are local GPs and police PCSOs, to whom more serious issues can be signposted. Indeed, it was a GP who helped establish the first neighbourhood health watch scheme and who describes that scheme as her “eyes on the ground”. Significant concerns about someone’s welfare may need police advice or intervention.

The Neighbourhood Health Watch operating in Newton St Cyres has its hub in the local pub, where the landlord is the local scheme co-ordinator. Following donations they have set up an internet cafe in the pub and have laptops which can be taken out to clients’ homes.

A basic seven step guide has been produced by the project facilitator to help anyone with an interest in setting up such a scheme. It is available at.

http://www.neighbourhoodhealthwatch.org.uk/about/how-to-start-a-nhw-in-your-area-a-guide-for-communities/

The evidence in this chapter points to above average health outcomes for typical rural populations, but it also indicates there is growing demand from an ageing rural population, and that issues arise from isolation and poor access to health care facilities. Funding for health services in rural areas is noticeably lower than it is in urban areas. There is, therefore, good reason to monitor the rural implications of the large-scale and ongoing changes which are reshaping the delivery of health services and to capture good practice which can help to address rural needs. There is also good reason to follow the resource allocation work of ACRA, which has said it is keeping under review whether there is additional sparsity costs associated with the delivery of community health services[18].

[18] Government, 2013

Post offices

The village sub-post office has been a widely characterised as an integral part of the rural landscape. It is a means to deliver a wide range of postal, financial and government services locally within communities. Indeed, the network claims to sell or deliver around 170 products, albeit not all of them will be available through smaller rural sub-post offices. Since most rural post offices are co-located with a village shop or general store, they also help to sustain those services. It is widely recognised that communities derive social value from the existence of the post office network – a value which has been estimated at £2.3 billion annually[19].

However, the network has been subject to change over a prolonged period as a result of various factors – some policy-driven, some market-driven. By and large policy responses have had the same objective, to try and make the rural network more financially sustainable.

The policy context

In 2010 the Coalition Government published a policy statement called, Securing the Post Office Network in the Digital Age[20]. This stated that there was to be no programme of post office closures. It also committed to maintaining a UK-wide network of at least 11,500 post office outlets and it set out five access criteria, two of which are especially relevant for local rural communities. They are that:

- 95% of the total rural population should live within three miles of their nearest post office outlet; and
- 95% of the population in every postcode district should live within six miles of their nearest post office outlet.

In 2012/13 the Post Office network met all five of the access criteria: indeed, 99% of the rural population were within three miles of a post office[21].

The current position could therefore be seen as a period of relative stability, certainly if it is compared with 2007 to 2009 when the Network Change Programme was implemented and there were widespread closures.

The 2010 policy statement also announced that £1.34 billion would be invested in the post office network over the four years 2011-15. Part of this was the subsidy for the network and part was to fund a programme of modernisation. That modernisation itself splits into two components, one of which is investment in 4,000 Main Post Offices and that involves some of them being relocated into other premises such as supermarkets.

The other component, of particular note for rural areas, is the creation of 2,000 Post Office Locals, where the post office service is moved into another nearby retail outlet, such as a

[19] NERA Economic Research, 2009
[20] Department for Business Innovation & Skills, 2010
[21] Hence, there is still room for some rural closures without breaching these access criteria.

village shop or petrol station. Post office counters have long been found within shops, but the Post Office Locals approach differs in one key respect. Namely, the post office and other retail service share the same staff and are delivered from the same counter. There are also some restrictions on the range of services that are offered at a Post Office Local.

In essence this programme of modernisation both revamps a good proportion of the post office network and moves many of its outlets to a lower cost operating model. The post office watchdog, Consumer Futures, has work in-hand to review the impacts of the programme.

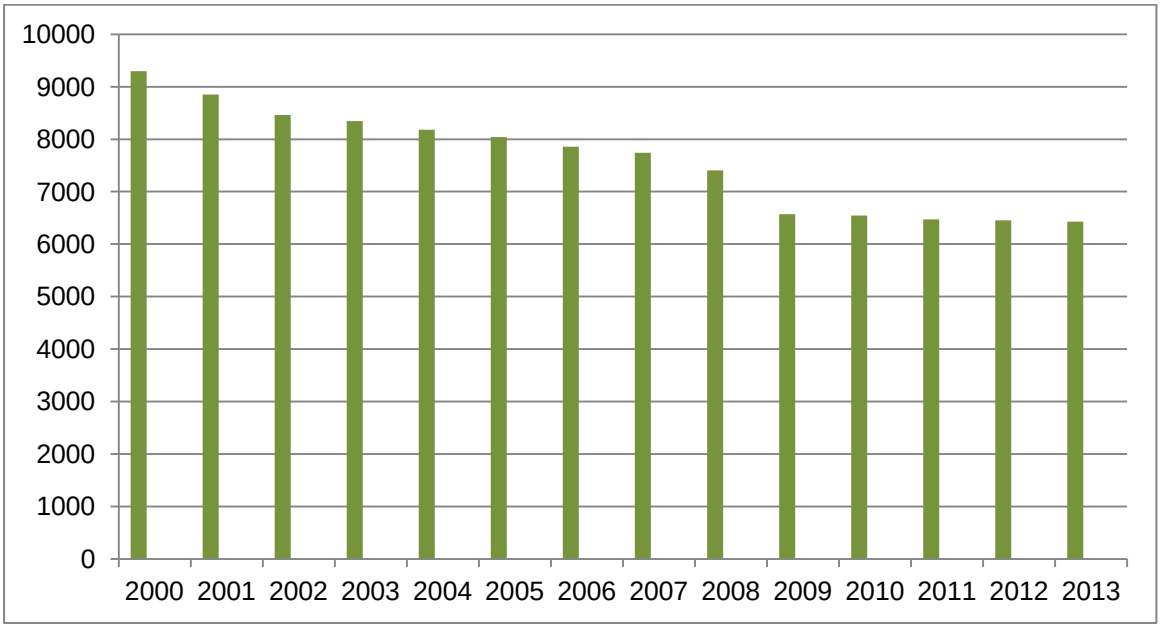
Two other policy developments should be noted. First, is that in April 2012 the Post Office and Royal Mail were formally split into two distinct businesses. When this happened they signed a ten year commercial agreement that post offices will continue to sell mail and parcels services[22]. Second, is that the Postal Services Act 2011 made provision to take Post Office Ltd out of the public sector and turn it into a mutual business at some future date. Although that is clearly the Government's ambition, it says this will only happen when the business can demonstrate long term commercially viability[23].

Evidence and trends

At March 2013 there were 11,780 post offices across the UK. Disaggregating these by type:

- 83% of them were categorised as sub-post offices;
- 9% of them were outreach (including mobile and home service provision); and
- 8% were main post offices (both Post Office operated and franchised)[24].

Number of post offices located in rural areas of the UK, 2000 to 2013



Source: plotting of data in Hough D, 2013

[22] Department for Business Innovation & Skills, 2013
[23] Department for Business Innovation & Skills, 2012
[24] Technically this breakdown by PO type refers to 2012, as data is not yet available for 2013.

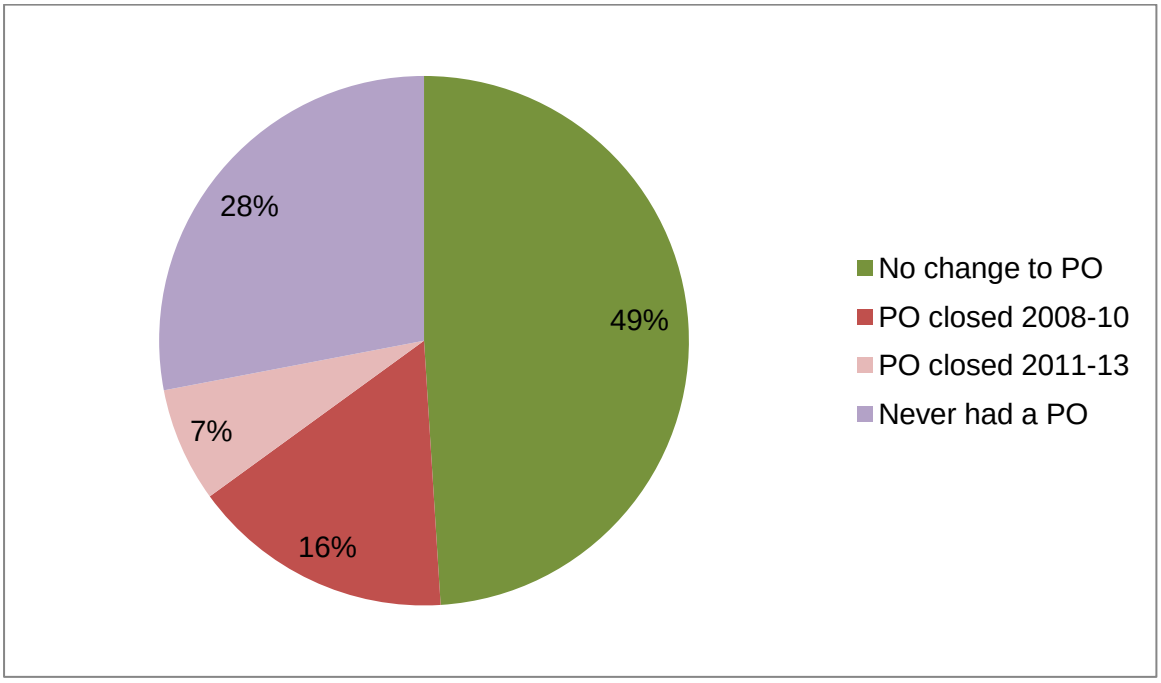
As the chart above shows, in March 2013 there were 6,429 post offices (55% of the UK total) which were located in a rural area[25]. In the year 2000 there had been 9,294 post offices in a rural area, which means that 2,865 or 31% of rural post offices have closed during the last thirteen years. This represents a substantial decrease, though it is a slower rate of decline than in urban areas (41%). This could, of course, be justified on the grounds that alternate outlets are much easier for people to reach in urban areas.

By far the most precipitous fall in the number of rural post offices occurred between 2008 and 2009, when there were 840 closures. This coincides with the implementation of the Network Change Programme.

Around 370 parish and town council contacts responded to a short online survey that the RSN ran in September 2013 for this report in eight geographically spread rural counties. They represent a broad cross-section, with 31% having a population under 500, another 20% between 500 and 999, another 37% between 1,000 and 4,999 and a final 12% with a population of 5,000 or more.

As the chart below shows, the largest group of survey respondents (49%) were in parish/ town areas that had a post office and had not experienced any closures during the last six years (since 2008). However, almost a quarter (23%) had seen a post office closure during that period. Others were in parish/town areas that had no post office throughout the period.

Post office changes within parish/town council areas, per cent of survey responses



Source: RSN online survey, September 2013

It may be significant that these respondents report a much faster rate of closure during the three years 2008 to 2010 (inclusive) than during the three years 2011 to 2013 (inclusive).

[25] Hough D, 2013

Many of the respondents were able to state the main reason why a post office had closed in their area. These were:

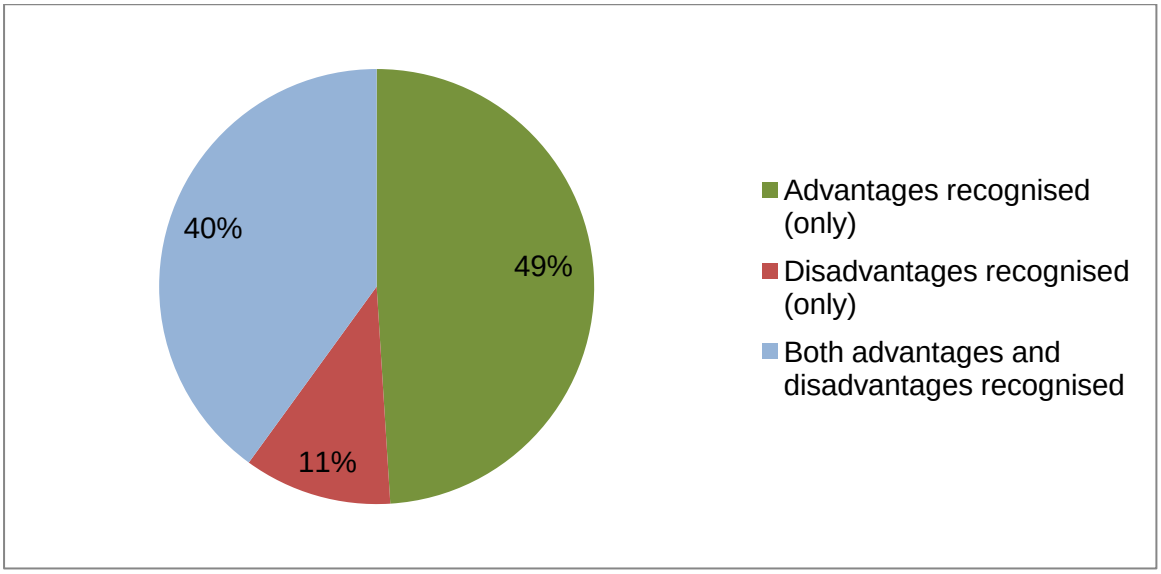
- Financial position with reducing patronage, sometimes meaning that a viable business could not be sold on (17 cases);
- Post Office decision, which was presumably linked to a closure programme (16 cases);
- Retirement of the sub-postmaster or sub-postmistress, with no-one able or willing to take on the business (15 cases);
- Closure of the shop within which the sub-post office was co-located (11 cases);
- Closure was followed by a re-opening, variously within a shop, as a Post Office Local and as an outreach service (8 cases);
- Other reasons given, such as business management issues (4 cases).

Sub-postmasters, who predominate in rural areas, are self-employed and have signed a contract with the Post Office to deliver their services. They receive two payments: one is a fixed or core payment and the other is a fee per customer transaction e.g. per stamp sold. According to the Rural Shops Alliance a sub-postmaster in a typical rural shop might earn £12,000 per year. Over two-thirds of this (£8,400) would be the core payment and the remainder (£3,600) would be from transaction fees[26].

Watchdog, Consumer Focus, undertook research in the places where the Post Office Locals model was being piloted[27]. They found that customers liked the longer opening hours that were offered by most PO Locals, but they criticised the limited range of services, the lack of privacy and the quality of service offered.

The latest RSN survey of parish/town council contacts finds there are both perceived advantages and disadvantages to the approach amongst those with some experience or knowledge of it. On balance those views are mostly positive, as the pie chart below shows.

Per cent recognising advantages or disadvantages to Post Office Locals approach



Source: RSN online survey, September 2013

[26] Commons Select Committee for Business Innovation & Skills, 2012
[27] Consumer Focus, 2011

The main advantages to the Post Office Locals model that were cited were:

- It is more convenient for customers to have post office and retail services under one roof (mentioned 25 times);
- It at least means that the community retains a local post office outlet (25 times);
- It brings additional trade into the village shop, making it more sustainable (22 times);
- It makes the village shop more of a community focal point or social hub (6 times);
- It means the post office is now open for longer (shop) opening hours (3 times);
- It means the post office is in a more convenient location for residents (3 times).

The main disadvantages in the Post Office Locals model that were cited were:

- Slow service, as the post office and shop share the same queue (mentioned 18 times);
- The more limited range of post office services available at a PO Local (15 times);
- An ordinary shop counter affords inadequate customer privacy and shop security (13 times);
- The shortage of space in the outlet for both post office and shop business (5 times);
- Staff having not been trained sufficiently in the post office services (4 times);
- Limited opening hours of the outlet where the PO Local is based (4 times);
- It being further to travel to the PO Local than to the previous post office (3 times).

Local solutions

There is nothing unusual about a rural post office being co-located within a village shop or convenience store. However, the latest RSN survey shows that post office services are being delivered in a wide variety of (sometimes surprising) locations, often on a part-time basis. Examples include from petrol stations, pubs, community-run shops, village halls, libraries, a heritage centre, a church, a community market, a sports pavilion, a private house and a domestic garage. Two of these are explained in the boxes below. A number of respondents also mentioned having a mobile service, with a van that visited their community once or twice a week.

Example: Wittersham in Kent

Wittersham is a village five miles north of Rye with around 1,000 residents. It used to have a sub-post office in the front room of a house that offered a limited range of services. When that was lost there was a search for alternative premises, which concluded that a satellite post office at the Tuesday morning community market was the viable option.

Since 2003 the market has had a post office counter that opens for an hour or so and which is run by the Sub-Postmaster from Lydd. It is set up within the clubroom behind the village hall, where there is a pull down counter and an internet connection. Despite the informality of the location the range of services offered (which includes, for example, road tax discs) is actually slightly broader than it was in the old sub-post office.

The Parish Clerk notes there are always people using the post office counter and that residents like to support a local service. Indeed, a survey undertaken for a Parish Plan found that a post office came out top of the list of services that residents said they would use.

Some also noted they had a Post Point service. This is where a community or local retailer takes the initiative on a voluntary basis in places that have no post office. An outlet agrees to be a place where local people can weigh and post parcels and, in some cases, offers a few other basic postal services.

Example: Grampound in Cornwall

The village of Grampound lies between Truro and St Austell. Because of a retirement, its village shop has recently closed and the sub-post office that is based in that shop is due to close. Post Office Limited was unable to find an alternative, nearby outlet that was willing and able to host a Post Office Local, so they proposed there should be an 'outreach' post office service.

The Parish Council, which is keen to support local services, owns a heritage centre (the local museum) which is well located in the middle of the village. It has agreed to offer that as the outreach venue at a nominal rent. A Sub-Postmistress from a neighbouring village has agreed to take on responsibility for running the service, which is expected to open for two half days per week. Although residents are sad to see the closure of the village shop, they are pleased that a post office will still be operating.

From one perspective, it could therefore be said that the rural post office network is in a period of some stability, given that closures are less common than they have been for some time. On the other hand, the modernisation programme means that the way post office services are being delivered continues to alter, not least through the rapid roll out of the Post Office Locals approach. There is a considerable amount riding on the current changes and investment, and whether they can bring about a more financially stable situation by 2015. Rural communities will be hoping so, but they have seen 'change programmes' before and will no doubt wish to see the evidence.

Public transport

Public transport allows people to access employment, training, service and leisure opportunities. Its availability and affordability is particularly important for those on low incomes, with limited mobility or without access to a car. For vulnerable groups, including many older people, it helps overcome isolation and provides them with independence. Inevitably, in rural areas with scattered populations there are challenges in providing public transport networks which meet users' travel needs at a reasonable cost.

For the purposes of this report public transport is interpreted as meaning the provision of a public service, which could be financially supported by local authorities/the public sector or it could be operated on a commercial basis. Almost all services will be run by commercial, voluntary or community sector operators.

The policy context

In 2012 the Department for Transport published 'Green Light for Better Buses', a document setting out reforms of the subsidy arrangements and regulation for local buses outside of London. Its stated aims were to attract more people onto buses, improve value for money for taxpayers and give local (transport) authorities more influence over bus networks in their areas. Interestingly, from a rural perspective, it differentiated between a need "to promote more bus use on commercial urban and inter-urban routes on the one hand, but on the other, to help local councils deliver value for money and innovation in the procurement of supported services ..."

The document focused on four areas for action, which were:

- Reforming Bus Service Operators Grants (BSOG), the partial rebate of the duty paid on fuel by bus operators, by devolving to local authorities that part of it which relates to services they support financially;
- Incentivising partnership working between local authorities and operators, by top-slicing part of the BSOG budget for an initiative called Better Bus Areas;
- Improving competition and ticketing, by encouraging things like tickets which can be used with different operators or for multi-stage journeys;
- Helping local authorities procure more flexible and innovative transport options where services are not commercial.

It also confirmed the retention of the concessionary fares scheme in its current form[28].

The devolution of BSOG to local authorities is not due to take effect until 2014 and that money will initially be ring fenced (until 2017)[29].

[28] Except that age entitlement to it will rise in line with age entitlement to the State Pension.
[29] Department for Transport, 2013 (1)

It should also be noted that the overall size of the BSOG budget was reduced by a fifth from 2012/13, though it was spared from further cuts in the latest round of public spending announcements[30].

Bus services in rural areas are less likely to be commercially viable and more likely to be supported by local authority subsidy than those in urban areas. More services are therefore at risk from the general reductions in local authority funding. The Rural Services Network described the combination of factors at work in its written evidence to a Commons Select Committee, thus[31]: *"Rural bus services are under severe financial pressure from the combined effect of rising fuel prices, reducing local authority revenue budgets, less reimbursement for concessionary fares and a 20% cut to Bus Service Operator Grant."*

According to the Campaign for Better Transport 41% of local (transport) authorities cut their spending on supported bus services in 2012/13 alone, with those cuts totalling £18.3 million.

Two other funding streams should be mentioned. One is the Local Sustainable Transport Fund which is making available £600 million between 2011 and 2015 to 77 local authorities, for transport projects to cut carbon emissions and create economic growth. A number of the winning bids are in rural areas, including one aimed at visitors to the Lake District, one improving public transport for travel-to-work in Cornwall and one improving transport on the Isle of Wight to promote the area as a green tourism destination. A number of Wheels to Work (rural moped loan schemes) are also funded, for example those in Devon and the East Riding of Yorkshire.

Government also distributed some £20 million to 76 local authorities in England as a contribution to the establishment and development of community transport services in rural areas. This was targeted at areas where many services are (financially) supported.

Evidence – journeys made

People living in rural and urban areas make roughly the same number of transport journeys (trips by any mode) as each other. However, those in rural areas travel considerably more miles. As the table below shows, residents in small rural settlements travel 45% further than the England average, whilst urban residents travel 8% less than that average[32].

Trips made and miles travelled per person, 2006-09 (indexed where England = 100)

	Trips per person	Miles per person
Urban areas	99	92
Rural towns and fringe	103	128
Villages and dispersed	103	145
England	100	100

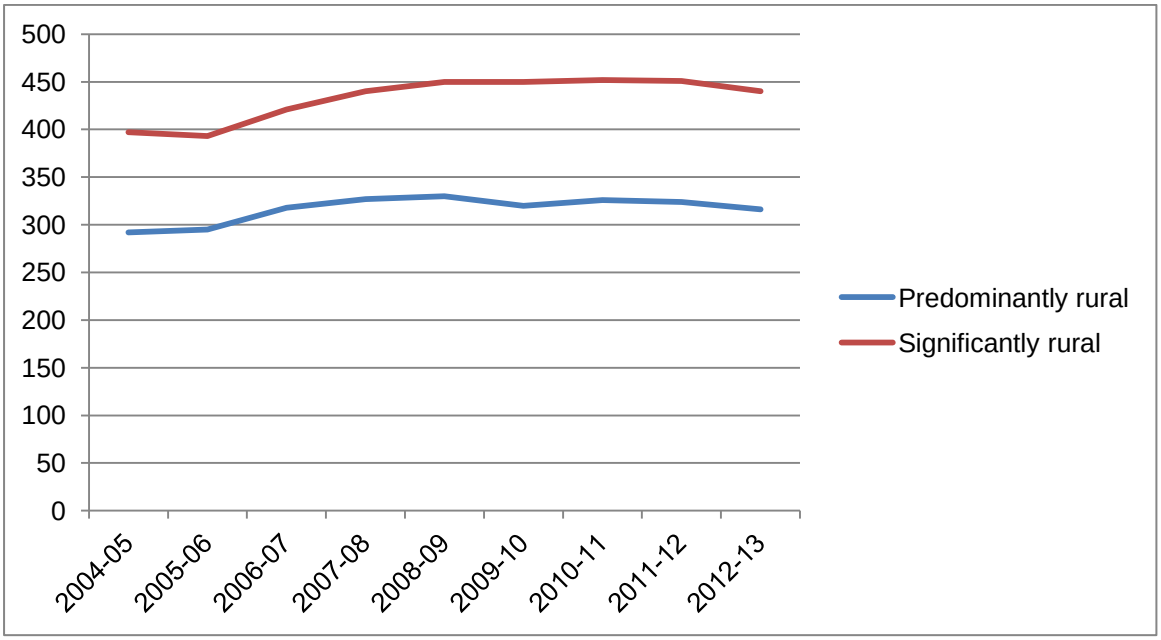
Source: DfT National Travel Survey

Focussing just on local buses, data collated by the Department for Transport shows that the number of passenger journeys made in rural local authority areas increased during the mid-

[30] Rural Services Network, 2013 (2)
[31] Commons Select Committee on Environment Food & Rural Affairs, 2013
[32] Defra, 2013 (1)

part of the last decade (the latter part of this being when free concessionary fares for older people were introduced), before plateau-ing and then declining a little over the last couple of years. The chart below finds this pattern to be broadly true for both predominantly rural and significantly rural local authority areas[33].

Passenger journeys made on local bus journeys (millions)



Source: Department for Transport

In 2011/12 the average (net) level of government funded support for each passenger journey that was made on a local bus outside a metropolitan area was 69p. This breaks down into:

- 17p from local (transport) authority revenue subsidy for uncommercial services;
- 37p from reimbursing concessionary fares; and
- 16p from Bus Service Operators Grant (BSOG).

Measured in constant prices, the average level of government funding peaked in 2009/10 before falling back by around 5p per passenger journey by 2011/12, largely as a result of reducing local authority revenue subsidy. The figure for 2012/13 (not yet available) may be lower still, not least because it will include the reduction in BSOG.

Evidence – availability and access

In smaller rural settlements less than half (47%) of households have access to a "regular bus service", defined by the Department for Transport as an hourly or better service which is within 13 minutes walking distance. That figure doubles to 96% when measured for urban households.

By this measure the availability of regular bus services in rural areas improved between 2002 and 2008, then fell back again by 2009. That recent service deterioration appears to be most evident in the smallest settlements. It would be interesting to have more recent

[33] Department for Transport, 2013 (2)

data, to see whether this reversal was a blip or a trend (the latter being possible, given the financial position).

Proportion of households with an accessible regular bus service

Year	2002	2005	2008	2009
Urban areas	93%	95%	96%	96%
Rural towns and fringe	76%	80%	83%	82%
Villages and dispersed	39%	49%	50%	47%
England	87%	89%	90%	91%

Source: DfT National Travel Survey

The Campaign for Better Transport has an interactive map on its website[34] where the number of supported bus services reported as cut or reduced is shown for different areas of the country. The map shows such cuts to be widespread, though not reported in every area. The scale and nature of cuts varies locally, and in some cases it has been possible to reverse cuts to supported services through engagement between local authorities and local operators. This kind of partnership working can, for example, lead to minor adjustments in commercial services so that they help plug gaps caused by lost supported services.

It may well be that the main impact is on supported services during evenings and Sundays. Some local authorities are also known to be scaling back their concessionary fares schemes where they have historically provided enhancements over the statutory minimum. Others are reviewing their support for non-statutory school transport, in particular where parents are provided with direct financial assistance.

Evidence – community transport

The community transport sector, however, appears to have expanded in the period to 2011/12[35]. According to a 2012 report on the state of the sector in England:

- More than 600 community transport organisations were operating in rural areas (a third of the national total);
- Some 8 million passenger journeys were made on community transport in rural areas over the year;
- An impressive 48,000 volunteers were helping community transport schemes in rural areas; and
- Around 2,000 people were employed by community transport organisations in rural areas.

The report also finds that community car schemes are many times more prevalent in rural than in urban areas.

[34] The map can be accessed at http://www.bettertransport.org.uk/campaigns/save-our-buses/map

[35] Community Transport Association, 2012

As information in the box below shows, rural areas have a relatively high number of community transport organisations, given their population, but typically those organisations are small-scale.

Rural areas have around 30 community transport organisations per million inhabitants (urban comparator is 13).

Organisations in predominantly rural areas carry around half as many passengers as those in predominantly urban areas.

Community transport organisations in rural areas rely more on volunteers and less on employees than those in urban areas.

The evidence also shows[36] that in 2011/12 community transport organisations in rural areas received only half as much local authority funding as those in urban areas (measured in terms of pounds per resident). Of course, total revenue funding allocations for rural local authorities are markedly lower than those for urban local authorities and this may have most affect on their ability to pay for discretionary services.

Local authority funding for community transport organisations in 2011/12 (£s per resident)	
Predominantly and significantly rural areas:	Predominantly urban areas:
£700	£1,400

The funding mix varies, too. Rural community transport organisations depend more on fares revenue and less on grant income than those in urban areas. That said, as a group local (transport) authorities in rural areas managed to maintain their level of grant funding for community transport schemes over the three years up to 2011/12[37].

Predominantly rural organisations got 41% of their income from fares (predominantly urban comparator is 13%).

Predominantly rural organisations got 17% of their income from public sector grants (predominantly urban comparator is 44%).

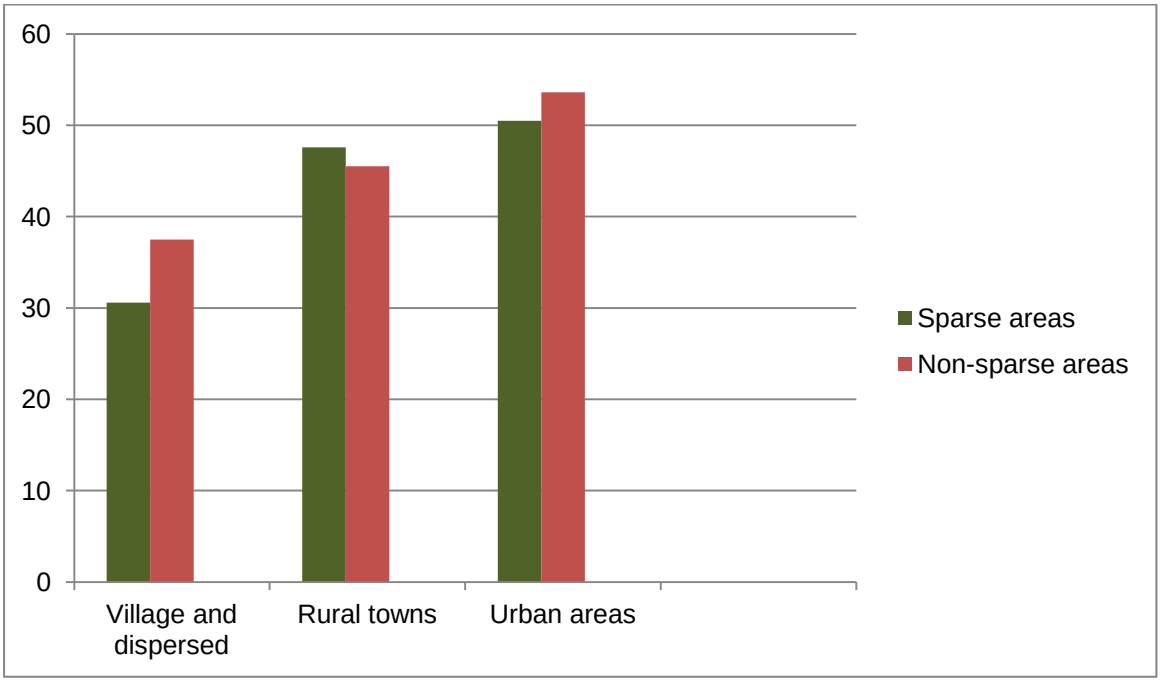
The share of income from contracts is similar in predominantly rural areas (35%) and predominantly urban areas (39%).

The Defra Rural Digest[38] presents results from applying an 'overall accessibility' measure. This takes eight different public and commercial services[39], and estimates the likelihood of

[36] Community Transport Association, 2012
[37] This may have been helped by the Supporting Communities Transport Fund, with its rural focus.
[38] Defra, 2013
[39] The eight are primary schools, secondary schools, FE colleges, GP surgeries, hospitals, town centres, supermarkets and employment centres.

their target populations (e.g. those aged 5 to 10 for primary schools) accessing them by public transport or by walking, given the time it would take to do so and people's willingness to make journeys of that length. As the chart below shows, it confirms the view that people would be less likely to access this range of services by public transport or walking in rural areas, especially in the smallest settlements.

Overall accessibility measure: likelihood of using public transport or walking (2011)
Where 100% would mean everyone is likely to do so and 0% that no-one is likely to do so



Source: Department for Transport

Of course, it is inevitable that any such overall measure will mask variation among different services. When services are measured individually the analysis shows, for example, that rural access to a GP surgery is considerably better than that to a hospital.

Evidence – car use and travel costs

As previous editions of this report have shown[40], car ownership levels are relatively high in rural areas, even among those on low incomes – reflecting the paucity of public transport for many as an option. Data also finds that those living in rural areas do more of their travelling by car than their urban counterparts. The table shows those in the most rural settlements travel 87% of their mileage in a car – 58% as a driver and another 29% as a passenger.

Proportion of annual miles travelled that are made by car, 2006-09

	As a car driver	As a car driver or passenger
Urban areas	49%	77%
Rural towns and fringe	55%	85%
Villages and dispersed	58%	87%
England	51%	79%

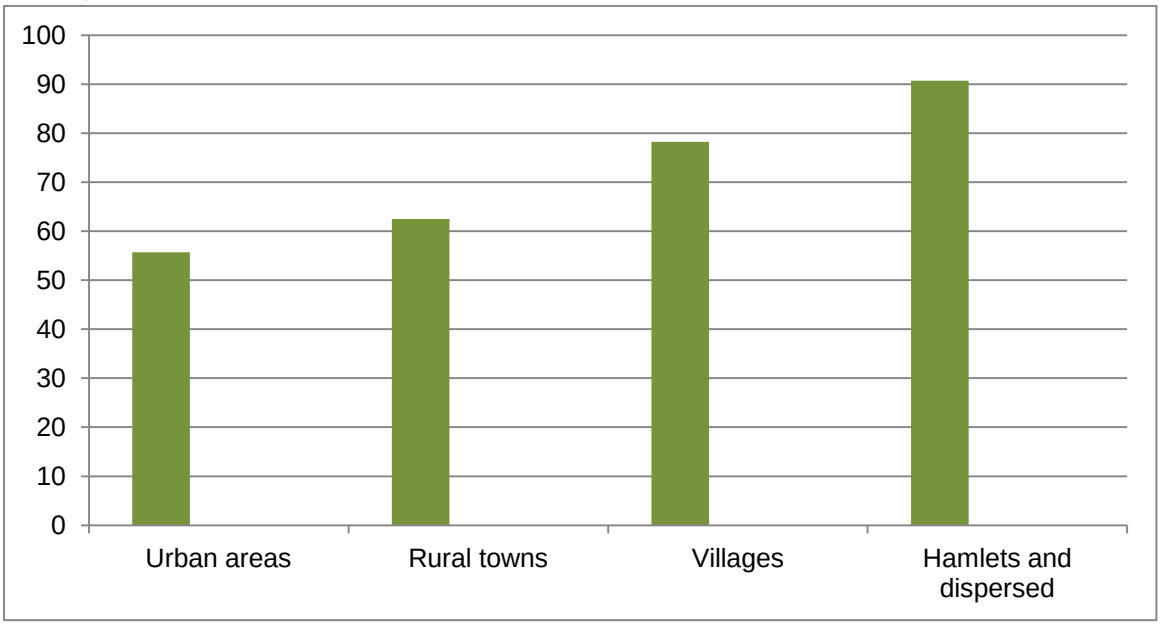
Source: DfT National Travel Survey

[40] Rural Services Network, 2011

Research in 2012, looking at the forecourt price of diesel, found that the cheapest price on offer in rural areas was more than 4 pence per litre above the equivalent in urban areas[41]. This price differential may result from a combination of less competition among retailers, lower turnover in rural locations and higher distribution costs to remoter filling stations.

Evidence clearly shows that rural living is correlated with higher transport costs. Households living in the smallest rural settlements spent over £90 per week on transport in 2009. This was £35 more (or 63% more) than households in urban areas.

Weekly households expenditure on transport (£s in 2009)



Source: ONS

There is also a rural-urban gap, though not such a stark one, if the measure adopted is spend on transport as a share of total household expenditure. On that basis, the share in smaller rural settlements was around 18% while in urban areas it was 14.5%.

Local solutions

A recent report by the Commons Select Committee for Environment, Food & Rural Affairs[42] concluded that the need in rural areas is for interconnected services using different modes e.g. feeder bus services to rail stations, and for more flexible transport options e.g. demand-responsive, for the most isolated areas to get people to bus routes. It noted the importance of making best use of what is already there, including transport provision laid on by health and education services.

Strong partnership working can maximise the benefits from what transport can be provided commercially. Combining the needs of education transport and mainstream bus users, and making minor adjustments to commercial services (perhaps using 'de minimus' funding) can

[41] Countryside Alliance, 2012 (based on PetrolPrices.com data)
[42] Commons Select Committee for Environment Food & Rural Affairs, 2013

yield significant advantages for all concerned. Sometimes, it may also be that funding transport to take people to other public services is more efficient than funding an expansion of those services.

Improving service provision is certainly not an easy goal to pursue at a time of such severe pressure on local (transport) authority budgets and the resulting scope for innovation may be curtailed. However, a need to reduce expenditure can sometimes be a further driver for change, as the example below from Cambridgeshire shows.

Example: Cambridgeshire Future Transport

With significant pressure on its budgets, Cambridgeshire County Council decided in 2012 to phase out subsidised (mainly rural) bus services and to introduce instead an approach based on targeted invested. This is part of a programme known as Cambridgeshire Future Transport (CFT). Its aim is to create a transport system which is both more financially sustainable and which better reflects local transport needs. The focus of the work is continued access for communities to education, training and key public services.

The programme is built around engagement with individual local communities and parish councils, to review access needs and arrive at agreed (whilst affordable) solutions. It is being taken forward on an area by area basis. Evidence is gathered about current travel patterns, passenger experiences, barriers to transport use and opinions on future options. Modes of transport, routing, ownership and ticketing are all in scope. Meetings are held with community groups to review the evidence, explore options and design solutions. Representatives of local businesses have also participated in the process.

There has been a lot of learning from this approach, including about the length of time that community engagement can take. However, it is now starting to deliver results. One example is a new bus service linking villages between Whittlesford and Cambridge city, which runs past the local health centre and connects with Cambridge's park-and-ride.

Similarly, in Hampshire a substantial cut in Government funding in 2011 led to a countywide Bus Subsidy Review and the search for alternate solutions where a traditional bus service was no longer affordable. The County Council developed the Cango demand responsive service and it extended the reach of dial-a-ride services, remodelling them to meet the needs of a broader client group. The County has developed a self-help toolkit for local groups and parish councils that wish to map existing provision, assess local demand and develop their own solutions. Its offer to them includes start-up grants and technical advice.

The next example, from North Dorset, illustrates a partnership that is doing exactly what the Commons Select Committee suggested, by working hard to make best use of what transport exists.

Example: Travel study in North Dorset

A Travel Study undertaken jointly by North Dorset District Council, Dorset County Council and the area's local community partnerships made use of surveys and workshops to conduct a comprehensive review of public and community transport, as well as specialist services such as medical transport. The result was an Action Plan, which has led to a better designed bus framework, although this is undergoing further review as a result of the funding

constraints.

Various initiatives have also been progressed. Feedback from the study showed that access to medical services was a key issue. Better access to information has been provided, with a single point of contact for the NHS Patient Transport Service and a single point of contact for all Community Car schemes, along with cross-referral between the two.

Another initiative will see two Community Car schemes pilot the provision of transport for young people in very rural areas. Previously these have just been generally used by older people. It is also proposed to expand a project which makes use of school transport during the day, through a volunteer-run project to offer outings for people who are socially isolated.

First Group Buses report that on the Dengie Peninsula in Essex the County Council reviewed all of its (financially) supported bus services – an area where there is only one commercial service. A straight re-tendering of these services was not seen as feasible because of budget cuts. The local authority consulted communities about a number of options, the outcome of which has been a proportion of supported services again being awarded, but the more lightly used routes being replaced by a connecting taxi-bus demand responsive service.

Two other solutions which are community-led are reported by Rural Services Network members. One is the Sustain Eden Project (Cumbria) which is establishing a community bus to serve residents in outlying settlements, as well as visitors to the area. This initiative has been made possible with funding from the Big Lottery, Eden District Council and Alston Moor Parish Council. The exact model has yet to be decided upon, but it is likely to operate as a timetabled not-for-profit service, driven by volunteers and feeding in to other transport services in the wider area.

Meanwhile, two neighbouring parish councils in Herefordshire have set up three new bus services each month in response to requests from their communities. Two are return evening services running once a month into Ross-on-Wye and Hereford respectively, whilst the third is a daytime service running monthly to Ledbury. Fownhope Parish Council and Dormington & Mordiford Parish Council established the first of these in 2012 as a six month trial with some of their own funding. Grant funding in 2013 has enabled further development.

In conclusion the provision of supported bus services, a particular feature of rural areas, is under real strain as a result of pressures on public expenditure. There has, though, been growth in the number of community transport organisations (up to 2011/12). Their role is usually most effective where it fills gaps in provision and can feed into more traditional transport services on busier routes. There is still good evidence of innovation taking place in rural transport provision, some of it stemming partly from the funding pressures. This often arises from strong partnership working and good engagement with users. The case for such innovation is ably made by the statistics that seek to measure levels of access for rural communities.

Concluding comments

This report has drawn upon a range of evidence to examine rural trends, features and practice across three service areas – health care, post offices and public transport. There are both some common themes and some contrasts which emerge. They could in all probability be applied to a much wider range of public service provision.

The post office network, with more than half its outlets in rural areas, has been fairly stable in its size for the last few years. On the other hand evidence shows that local transport provision in rural areas, which improved considerably until around 2008, has deteriorated somewhat since and there is widespread expectation of further decline. In some cases, this may be mitigated by replacement with other transport solutions. It can, however, be little coincidence that local public transport is the one area examined in this report which has been heavily reliant, at least in rural areas, upon local authority funding (or subsidy). The access implications for rural communities and especially the most vulnerable within those communities must be cause for concern.

All three of the service areas are subject to great change, whatever their financial situation. The post office network may be stable numerically, but a significant part of the rural network is switching over to the Post Office Locals model. Evidence in this report shows rural communities to be reasonably favourable towards them, especially if it makes the difference between retaining and not retaining a post office. But a number of practical constraints are also identified with the model. The bottom line will be whether it makes the rural post office network more financially sustainable over the longer term: whether it can break the cycle (or downward spiral) which has led to various reviews of the network and its viability during the last fifteen or so years.

Perhaps the most radical set of changes are those affecting health services. They are not, of course, rural-specific but they will have rural implications. These changes are still in their early stages, making those implications hard to determine or assess. Will the newly established Clinical Commissioning Groups be more alive to local rural needs than their predecessor organisations or not? Will they mean there is more (local) variation in future in the way that NHS services are provided to rural communities? There are equally significant rural questions that arise from the pressure to scale-up and specialise hospital provision. At a theoretical level this is not a trend which favours rural circumstances.

Local action by rural communities or community-based organisations is also much in evidence from this report. It features most strongly in the public transport chapter. In some cases rural communities are taking the initiative to fill service gaps and improve provision, whilst in other areas local (transport) authorities are engaging with communities in the difficult decisions they are faced with about where to save money and what alternative provision to put in place.

The example of the Neighbourhood Health Watch schemes in Devon shows that volunteer action also has an important role to play in that sector. A key feature underpinning their success is the close working relationship that exists between the community volunteers and the professionals (GPs and police).

The set of six examples which are featured in this report show, if nothing else, that innovation in rural service delivery remains important and attractive. Perhaps that is particularly so when the challenges of rural delivery have to be met during such difficult times for the public finances. Almost all of the examples underline the relevance of taking a flexible approach which can be adapted to local needs and circumstances. Unsurprisingly, this was one of eighteen underlying principles of good practice that was identified by research[43] for Defra last year. Those underlying principles are effectively design features of local policy and delivery that are typically used in order to meet rural needs. While they cannot pretend to give 'the' answer, they ought to offer useful considerations in any policy review process.

Like the previous editions, this report aims to highlight issues and stimulate debate about both challenges and solutions to successful rural service delivery. For practical reasons it has focused on three areas, but it is hoped the findings will be of wider interest than those with direct responsibility for those services. This policy agenda will come under scrutiny over the coming months thanks to the independent review that has been set up to examine rural proofing in Whitehall. Its findings will be awaited with interest.

Previous editions

Previous years' editions of this report covered the following topics:

2012 – Broadband; business support and advice services; fire and rescue services; actions to address fuel poverty.

2011 – Public transport; cultural services and libraries; parks, leisure and environmental services.

2010 – Primary schools; affordable housing for local people; facilities for young people; services for older people.

These reports can be accessed on the Rural Services Network website.

[43] Hindle R, Wilson B and I Annibal, 2012

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