Rural Services Network

East Midlands Regional Seminar / Networking Event

31st July 2019

West Suffolk Council, Bury St Edmunds

Attendees:

Name	Organisation
Cllr Peter Stevens, Chair of Regional Seminar Event	West Suffolk Council
Cllr Roy Brame, Vice Chairman	Breckland Council
Cllr Lynda Turner, Chairman	Breckland Council
Martin Fagan, Secretary	Community Heartbeat Trust
Matthew Issom, Chief Executive	Dispensing Doctors' Association
Dr Richard West	Dispensing Doctors' Association
Julia Catterwell, Communities Officer	East Suffolk Council
Cllr Bob Wicks	Fenland District Council
Molly Boreham, Communications Assistant	Flagship Housing Group Ltd
Cllr Amanda Nunn	Harborough District Council
Cllr Louise Richardson	Leicestershire County Council
Niz Smith, Project Co-ordinator	Linkage Community Trust
Digby Chacksfield, Director	Rural Enterprise East
Cllr Jessica Fleming	Suffolk County Council
Cllr Mary Evans	Suffolk County Council
Cllr Mike Chester	West Suffolk Council
Cllr Susan Glossop	West Suffolk Council
Cllr Brian Harvey, Chair	West Suffolk Council
David Collinson, Assistant Director Planning & Regulatory Services	West Suffolk Council
Charlotte McCallister, Housing Specialist Strategy & Enabling Officer	West Suffolk Council
Julie Salisbury, Housing Specialist Strategy & Enabling Officer	West Suffolk Council

Speaker	Organisation
Sheila Childerhouse, Chair	West Suffolk NHS Foundation Trust
Kate Pym	Pym's Consultancy
Jonny Haseldine, Parliamentary Assistant	Office of Anne Marie Morris MP

Organisers Attending	Organisation
Kerry Booth, Assistant Chief Executive	Rural Services Network
Ivan Annibal, Director	Rose Regeneration

Apologies: (See Appendix)

Councillor Stevens from West Suffolk, chaired the meeting and welcomed all delegates to West Suffolk.

Kerry Booth, Assistant Chief Executive from the Rural Services Network, gave an overview of the work of the RSN and outlined the campaign, 'Time for a Rural Strategy' with particular emphasis on the 'asks' for Rural Health and Wellbeing.

SEMINAR SESSION

Speaker 1 – Jonny Haseldine (Anne-Marie Morris MP Parliamentary Assistant)

Subject: Parliamentary Inquiry into Rural Health and Care

The All Party Parliamentary Group (APPG) on Rural Health was founded in 2016. It launched a Parliamentary Inquiry on rural health.

The Department of Health have recently committed to engaging with the APPG and the National Centre for Rural Health and Care.

The Rural lobby is quite strong, particularly in the House of Lords.

The APPG Inquiry has had 4 sessions already and has 3 Co-Chairs:

- Bishop of London
- Anne-Marie Morris MP
- Richard Parish (National Centre for Rural Health)

The first thing considered by the Inquiry was the meaning of the word 'Rural' as unfortunately, Government has different definitions of rural across departments.

Some issues were highlighted by Jonny including:

- ➔ Training – 75% of doctors/nurse start work where they trained -> this is naturally in cities so rural miss out
- ➔ Time constraints – home visits take longer, cost more.

What isn't working in rural health?

- Centralisation – staff shortages/withdrawal of services
- Data – don't have at meaningful level not measuring rural outcomes. Not measuring rural outcomes.
- Risk – need to change how we view 'risk'. Rural doctors can't always operate in ways they need to due to rules and regulations.

Session 4 – Workforce challenges

England has no minimum levels of nursing, while Scotland and Wales do.

Should there be training bursaries so that students in rural areas who have to travel more to get to placements, are recompensed.

Engagement with 3rd sector is crucial and full of opportunities.

Speaker 2 – Sheila Childerhouse (Chair of West Suffolk NHS Foundation Trust)

Subject: Rural Workforce Perspectives

#teamwestsuffolk

- Difficult to get past 'chocolate box' view of rural areas this is how Parliament views rural areas.
  In Suffolk higher proportion of over 65 compared to working age and this section places much more significant demands on healthcare services.
- Statistics conceal pockets of deprivation due to affluence around them.
- Big difference in life expectancy between wards in Suffolk, i.e. 9 years for men in certain areas.
- Funding is not everything, but it makes a difference!
- The GP scene is very complex and working together with integrated teams is good. Need more joint training, for example rotational posts across social care nursing and primary care.
- Occupational therapists – an example of working well in rural areas.
  - 70% of our OTS are employed in rotations including social services mental health, community and acute.
  - A good example – Aylsham & District Care Trust
  They developed with the local landowner an old district hospital building to create a number of facilities including private housing; housing with care; sheltered housing; GP surgery; Community centre which provided range of services for community.

  Overall:
- ➔ Need rural proofing to understand role that health services provide in rural areas.
- ➔ Data is vital to understand impacts and outcomes.
- ➔ Integration of services is key.
- ➔ Need flexible systems and budgets

Speaker 3 – Kate Pym (Pym's Consultancy Ltd)

Subject: Technology and the patient perspective

- Pyms Consulting work with innovators that bring technology into rural healthcare, they also work on service redesign to incorporate technology to provide appropriate solutions.

Issues in rural idyll:

- Poor transport;
- Spread of healthcare provision;
- Availability of care services.

Challenges in rural:

- Travel time and cost;
- Lone workers;
- Rural isolation;
- Unheard populations;

- Recruitment and retention;

There are a number of difficulties experienced by patients with multiple conditions, who need to attend a number of different appointments:

- For patients with multiple conditions – they need multiple appointments
- Due to transport issues, in rural areas may need daughter/son to have time off work to take them, prepare them, deal with this.

How to address this?

Lincoln – Digital Portal to make appointments savings of £100 000's as have reduced 'failure to attend' appointments through the creation of a portal which enables patients to accept appointments, cancel or rebook.

https://www.digitalhealth.net/2019/04/digital-portal-helps-reduce-patient-do-not-attend-rates-in-lincolnshire/

Derby diabetic foot clinic challenges.

https://diabetestimes.co.uk/digital-foot-ulcer-system-pilot-yields-positive-feedback/

The clinic wanted to support patients to have treatment at home or in the community due to large waiting times but were hesitant to make transfer of care to podiatry team in community.

A pilot study, which was funded by the East Midlands Academic Health Science Network, has enabled accurate analysis of wound healing and sharing of images and data across care settings to be possible. It has also helped patients as they can be seen closer to home and evaluation in their progress to assess health economic impacts a new model of care.

Failure to attend at patient + elective admissions naturally is > 35 000 a month.

An appointment isn't just about not turning up, there are a number of reasons why patients are unable to make appointments due to their conditions, transport availability etc.

How do we make it easier for patients to attend appointments and receive the treatment they need and deserve?

NETWORKING SESSION

There was a general discussion around the delegates of various issues relating to rural health including the following points:

- GP's over age of 50 take home more money over 3 days than over 5 days a week, due to punitive tax rules affecting their pensions. Need to change the incentives. Needs a change in philosophy about the ceilings in relation to taxation. We are losing the most experienced GP's as this affects them the most.
- Outreach workers – problems in risk assessment for utilising farms
- Older peoples forums, STP's, pilots, lots of different organisations but they don't all work together. "All talk + no action"
- Need joined up thinking i.e. social prescribing – A Doctor may suggest 'join up to a lunch club' but no transport to get there.
- Why is change so hard in the NHS?

- Even something simple, like cancelling an appointment is near impossible.
- Call from Doctor to cancel appointment but wouldn't leave message so didn't know it was cancelled 'number witheld'. Meant attended appointment that had been changed but didn't know about it
- Developments in IT is pretty rapid and agile; however, procurement is not. Long drawn out process to get through procurement process.
- Need to be able to enable hospitals to procure themselves without lengthy framework agreements.
- Could hospitals do appointments on postcode basis – would help community transport to scoop up all patients in one go?
- Rural GP do better than urban GP generally and they do a little bit of everything but not in same volume as other areas so harder to provide specialist clinics.
- PCN need over 30,000 patients in order to work, an area of 28,000 patients does not meet the criteria for receiving social prescribing funding as too small but can't get 30,000 patients as it is sparsely populated area and the distance would be too big!
- Recruitment – when there's higher risk as doing more complex procedures in rural areas that aren't done often, need more senior members of staff who have more experience but that costs more.
- Training –those trained and working in urban centres have different approach to risk.
    - i.e. chest pains – send ambulance.
    - but in rural areas – big risk due to time to get to them.
- Historically, there were informal teams of nurse/doctor/social worker/OT etc who could chat over coffee and informally work together without lengthy procedures and paperwork. This no longer happens but it made working and caring for patients easier.
- Technology – great when it works but terrible when it doesn't. IT won't provide a camera for laptop, so Doctor can't do web conferencing. They are behind in infrastructure.
- Some rural GP's don't have access to electronic prescription services.
- Despite raising it – doesn't happen as 80% is easy and 20% that is hard – isn't being enabled.
- 'Choose + book' – didn't work as if patients are able to choose appointments, but you don't have many slots available, it is difficult to manage demand and priority.
- Need to think about these things and how they affect rural communities differently.
- Martin Fagan, of Community Heartbeat Trust talked about Defibrillators in villages as part of wider healthcare plan + training + neighbourhood plan etc.
- Orkney Islands – last month of pregnancy spend in Aberdeen as no maternity services there.
- Lots of good initiatives but not all being shared.
- There is a relationship between obesity, health conditions and over use of antibiotics. They wanted to therefore do a programme for teenagers on healthy eating to try to prevent obesity in later life but the Department for Education said no, this isn't to do with us. How can we get groups / Departments working together?
- Need sharing of ideas across health.

Richard West (Chair of Dispensing Docs + GP) set out 7 potential solutions to improve rural health

- What outcomes do we need to achieve? How can we join up?
    1) Enabling risk – allow senior professionals to work to level trained

2) Encourage joint working – attitudinal and also praising staff for working with others
3) Encourage rural apprenticeships –If you generally gain employment where you train, encourage people to train in rural areas. This is relevant for everyone from Receptionist, nurse assistant, care assistants etc
4) Provide the basics of IT, i.e. camera!
5) All central policies need rural proofing
6) Rural hubs – all services based in one place
    a. i.e. OT/Physio/Care/Nurse.
7) Local groups and volunteers need joining up + including in frameworks

- Cllr Stevens highlighted how West Suffolk has drawn some agencies into a shared service but the challenge is to get at the small and medium sized practices to make this work more effectively.
- There should be more Section 106 money from developments to support rural health.
- Doctors IT facilities is currently supplied by NHS, GP IT Futures
- Small companies trying to sell IT services into this, but procurement and rules are so complex that only IBM can deliver it!!
- The rules don't allow active compatibility so don't have to enable technology to talk to each other which creates more problems and difficulties when trying to develop improvements and efficiencies or different ways of working.
- Brian Harvey (Chair of West Suffolk Council) highlighted the issues with county lines for drugs and alcohol. What is Government doing on substance abuse in rural communities? The effect on NHS Trust is taking over consultant doctors' appointments.
- At moment Government doesn't have solutions or dealing with it – various people considering it but needs whole solutions.
- No joined-up approach in rural areas.
- In Suffolk the Crime Partnership is delivering in schools and working well in partnership.
- Could we send note to Health Minister of this meeting? There is a team in his office looking at rural health
- One solution for rural areas is to take services out to people on wheels i.e use an adapted bus for IT training, delivering childrens services etc.
- Well run mobile services can address pockets of need but need to do them well and do them consistently.
- Suffolk have a Rural Coffee Caravan – local charity that delivers information and friendship across Suffolk.
- Suffolk County Council – There was mention of a project with to explore street lights being used to a bracelet worn by elderly residents to see if they are out moving at night and to provide assistance.

The Rural Services Network does work to bring together various sectors and interest groups for example it took some key Youth Organisations and some young people to the APPG on Rural Services to talk about issues for rural youth.

The Rural Services Network also provides the secretariat for the Rural Health and Care Alliance which has been established through a partnership between the National Centre for Rural Health and Care and the Rural Services Network (RSN) and is affiliated to both the

National Centre and the RSN. It aims to provide networking and best practice sharing focusing on Rural Health.

Apologies

Name	Organisation
Su Davies, External Funding Manager	East Northamptonshire Council
Cllr Kim Clipsham	Norfolk County Council
Cllr Ed Maxfield, Leader of Lib Dem Group	Norfolk County Council
Neil White, Political Assistant to Lib Dem Group	Norfolk County Council
Cllr Sarah Butikofer, Leader	North Norfolk District Council
Cllr Florence Ellis	South Norfolk District Council
Darren Henley, Chief Executive	Arts Council
Cllr Emma Corlett, Labour Group Deputy Leader	Norfolk County Council
Jane Ives, Managing Director	Wye Valley NHS Trust
Libby John, Pro-Vice Chancellor	University of Lincoln
Cllr Bill Handley	South Cambridgeshire District Council
Cllr Sarah Trotter	South Kesteven District Council
Cllr Tony Stowe	East Hertfordshire DC
Cllr Wharmby	Derbyshire County Council
Karen Soons	Suffolk County Council
Derek Ward, Director of Public Health	Lincolnshire County Council
Cllr Steve Bunney	West Lindsey District Council
Cllr Keith Scarff	Mid Suffolk District Council
Cllr Marion Rushbrook	West Suffolk Council
Richard Flinton, Chief Executive	North Yorkshire County Council
Cllr Owen Bierley	West Lindsey District Council
Diane Dakers, Innovation & Product Development Manager	Karbon Homes