AGENDA
RURAL SOCIAL CARE & HEALTH GROUP
(incorporating SPARSE Rural Members, Rural Assembly and Rural Services Partnership Members)

Venue: The LGA, 18 Smith Square, London, SW1P 3HZ
Date: Monday 2nd December 2019
Time: 11.00 am – 12.30 pm

ALL NOMINATED MEMBERS AND OFFICERS OF RSN ARE INVITED TO ATTEND THIS MEETING.

The meeting is being held at the **LGA, 18 Smith Square, Westminster, London SW1P 3HZ**. Please click here to view the LGA website and click here to view the location of the venue on a map. The building is located nearest to Westminster, Pimlico, Vauxhall and St James's Park Underground stations. Nearest Railway Stations are Victoria, Vauxhall and Charing Cross.

1. **Apologies for Absence**

2. **Approve the Minutes of the last Rural Social Care & Health Group held on the 8th April 2019.** (Attachment 1)

3. **The Rural Strategy Campaign and the Rural Social Care & Health (Including Mental Health and Loneliness) Issues.**

   To receive and debate the report provided by the Chief Executive. (Attachment 2)

4. **Any Other Business**

   The next meeting of this group is scheduled for the 6th April 2020.

David Inman, Director Kilworthy Park, Tavistock, Devon PL19 0BZ
Tel: 01822 813693
www.rsnonline.org.uk email: admin@sparse.gov.uk twitter: @rsnonline

Local Government Association

Attachment 1

Note of RSN Rural Special Interest Group meeting on Rural Social Care and Health

Title:	**Rural Services Network Special Interest Group** • **Rural Social Care & Health Group Meeting**
Date:	Monday 8 April 2019
Venue:	LGA, Smith Square ,18 Smith Square, London, SW1P 3HZ

Attendance
An attendance list can be found here (to follow)

Rural Social Care & Health Group Meeting 11am – 1pm

1 Apologies for Absence

Members noted apologies for the meeting.

2 Minutes of the last Rural Social Care and Health Group - 12th November 2018

The minutes of the previous meeting were accepted as a correct record.

3 Matters Arising

Minute 6 – Together with the APPG Chair and Vice Chair the RSN Chief Executive, Graham Biggs had met the Minister for Social Care last week. The Minister welcomed the APPG's Interim Report into the Rural Context into Adult Social Care had called for as much further research and evidence as possible.

She had not been able to be forthcoming on any timetable for the publishing of the long-awaited Green Paper.

. It was in draft form but needed approval from the Cabinet Office and the Treasury before publication. The Paper would not be dealing with issues relating to the formula for distributing Government funding to Local Government - that was for MHCLG.

4 Presentation by Mark Allen, Commissioning Hampshire County Council

- Presentation on RSN Health & Social Care Group
- He is the lead for Social Care in Hampshire.

Hampshire County had over 75,000 cases currently, 14,500 were bed-bound, and 3,500 people were in homes owned by Hampshire County Council.

He detailed the approach taken with some people.

Technology programmes had to be driven by providers of Social Care as opposed to IT techies. Recovering the charges involved for these often proved to be counter-productive as those costs were more expensive to recover than the sum being pursued.

There was no technological silver bullet – a range of things were required.

Some 12,000 people across the County were now assisted through this technological approach.

The evidence base was often missing from the provider's current approach. It was possible to detail the individual service but not across Hampshire as a package. Nor did that service necessarily dovetail to an individual's actual needs.

Mark felt that presentations he had heard by Ofcom and Openreach suggested change was afoot It was important approaches kept well up with those changes.

The turn off of the telephone landline analogue systems was apparently anticipated by BT by 2026.

The measurements in terms of social interaction were the most important consideration gained through the approach in Hampshire. Based on those criteria the technological approach had undoubtedly been successful.

Overall the level of health for the clients involved in Hampshire had been improved.

5 Presentation by Jeremy Leggatt, ACRE

THE NHS TEN YEAR PLAN
- Presentation on the NHS 10 Year Plan and Adult Social Care Issues as ACRE see them

The emphasis of his presentation this time was on Health Care as opposed to Social Care.

There were at County level 39 charities previously named 'Community Councils' but now had many varied and different names. They served 11,000 rural communities. Their strapline was 'Nobody should be unreasonably disadvantaged by where they live'. The question posed therefore was 'do rural and urban people receive the same NHS?'

This question had clearly not been asked in the NHS 10 year – in his view this was a major omission in its approach, meaning it had had an urban bias but there was no evidence to suggest it had been posed.

It was also a current question for CCGs.

In Sussex it had been observed that the one CCG without a hospital was operating in a very different way to the other CCGs.

Blue light – targets were continually being missed. He asked if that was the case why were things not approached in a different way – why was there resistance from Ambulance Services to any sort of rural proofing?

The view was, therefore, more and more there was a centralised health service being driven by the bulk of population. This was leading to a two- tier Health Service as rural areas were not part of the equation. It begged the question why/who would people train at a hospital with a largely predominantly rural area that was likely to have to be ten years off the pace.

The trend towards the clustering of services was counterproductive to rural health facilities.

The ten - year overview should have included consideration of the special needs of rural but instead that had been avoided. There was, in his view, a need to move to more specialists driven by overall service and not simply by patient numbers - supported by local services. However, to fund that would need closures of some facilities to pay for that coverage.

Instead there was a threat closures would occur but without commensurate benefit at all.

The deprivation indices needed to be properly considered and rural proofed, as they always favoured, urban areas.

The vital paragraph 2.25 in the ten- year document had not been rurally proofed. Clearly, the will was to allocate to urban areas which were considered to be deprived. This seemed to be the sole target

He felt that rural services would suffer still further during the course of the 10 - year plan.

COMMUNITY ACTION

He begged Authorities to give more backing for community action and not impose ‘statutory systems’ on volunteers. They were there to be trusted. Whilst there would always be financial risk this had to be set against the overall situation. If not taken advantage of volunteers will become frustrated and schemes that could have gone forward will simply not proceed. That would be to the cost of communities.

.

6 Any other business

There was no other business and the meeting was closed.

RURAL SERVICES NETWORK

RURAL SOCIAL CARE AND HEALTH GROUP MEETING 2ND DECEMBER, 2019

REPORT OF THE CHIEF EXECUTIVE: THE RURAL STRATEGY CAMPAIGN AND THE HEALTH/SOCIAL CARE (INCLUDING MENTAL HEALTH AND LONELINESS) ISSUES

1.0 BACKGROUND

The RSN launched its Campaign "It's Time for a Rural Strategy" on 1st March 2019. This followed detailed work by the RSN over the previous 12 months or so, including extensive consultation with its membership.

I would stress that the document which we produced to support the Campaign (which I have generally called a "Template Strategy") was not – and didn't pretend to be – a Rural Strategy. It was a document which articulated why the RSN believed a Rural Strategy was needed, and why certain topics/services should be included within such a Strategy. For each of those topics/services the Template set out (a) **some** key facts; (b) **some** of the challenges and (c) **some** thoughts on things which could help

On 25th April the House of Lords Select Committee on the Rural Economy published its Report entitled "Time for a Strategy for the Rural Economy". Some 90%+ of what was said in the Lords Report was in line with the RSN's Campaign themes and added substantial "evidence" following its Hearings, Debates and Call for Evidence (In addition to written evidence I, on behalf of the RSN gave oral evidence to the Select Committee on two occasions).

The Lords Select Committee also took the view articulated by the RSN that a Rural Strategy should be wide ranging and that the needs of rural areas had been, and were still being, overlooked by Government. Its Chairman, Lord Foster of Bath – who was the Key-Note Speaker at the RSN's National Rural Conference in September - said in the recent House of Lords Debate

"But successive governments have underrated the contribution rural economies can make to the nation's prosperity and wellbeing. They have applied policies which were largely devised for urban and suburban economies, and which are often inappropriate for rural England. This must change. With rural England at a point of major transition, a different approach is urgently needed.

Inevitably our deliberations were wide-ranging. After all, a thriving rural economy depends on many factors: adequate and affordable housing and workplaces, decent broadband speeds and mobile coverage and access to finance, business support, skills and training as well as a fair share of funding for local services such as transport, policing and healthcare. No wonder our report is somewhat weightier than is normal for such documents.

Rurality brings special challenges in all those areas, but we discovered that relatively little has been done to help rural areas address them. Often the policies—or lack of policies—of successive Governments have created obstacles, hindering the success of rural economies so that rural businesses contribute less per head to the national economy than urban businesses. There is a huge disparity between rural and urban service support".

No areas in the Lords Report conflicted with the RSN's position but did touch on several areas which the RSN had not. We subsequently consulted with our membership on those issues saying we were minded to concur with the Select Committee's thoughts and recommendations. No member organisation objected to that proposition.

We should, I suggest, regard the Campaign – with the circa 1,000 supporters signed up to it to date - as having been very successful in significantly raising rural issues up the political agenda. However, we have not (yet!) convinced the Government on the need for a Rural Strategy and so the work must go on

From the outset the RSN said that over the coming months it intended to "add depth and texture" to the "Template Strategy". The discussions at this meeting are part of that process from the perspective of the Health/Social Care/Loneliness issues.

2.0 The Template Rural Strategy Section Entitled "A fair deal on health and social care"

To remind members The Template Strategy Campaign Document said:

"Rural communities, like communities everywhere, need access to high quality health care and some require extra support from social care services. This is fundamental to wellbeing and anything less may pose a health risk. They should not have to pay extra for this (either directly or indirectly).

Key facts

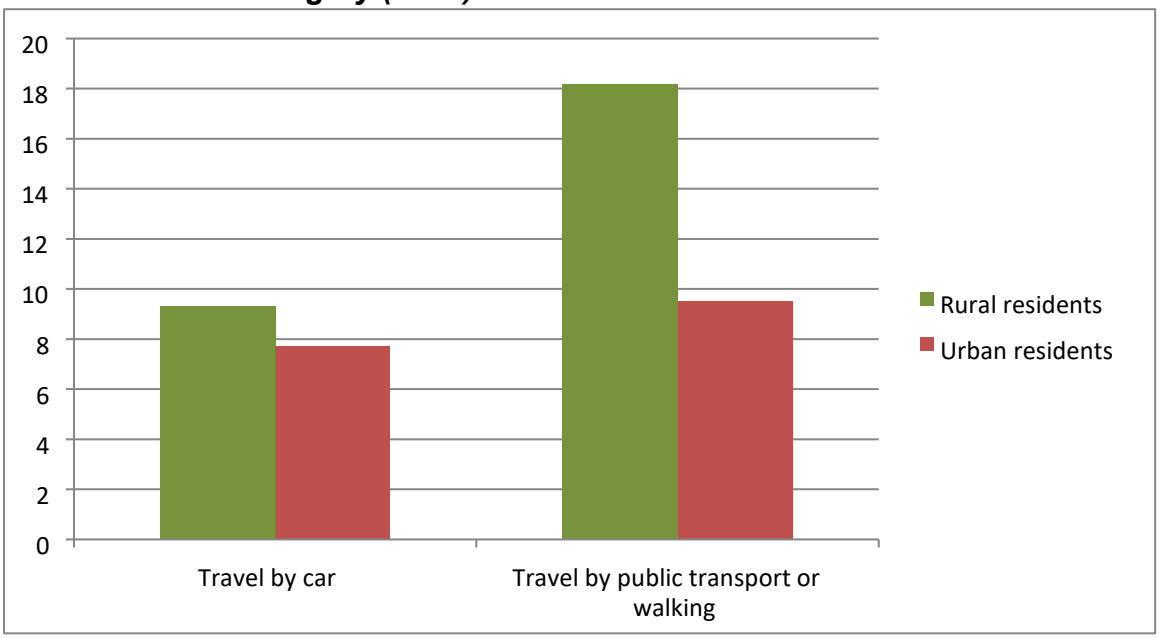
Older age groups form a significant and growing share of the rural population. In 2011 29% of the rural population were aged 60 or over, up from 24% in 2001. Comparative urban figures were 21% in 2011 and 20% in 2001. By 2039 nearly half of all households in rural areas will contain people aged 65 or over.

Rural and urban areas receive similar funding (per resident) under the NHS allocations to Clinical Commissioning Groups (CCGs). This does not reflect the older rural demographic, which places extra demand on NHS services due to chronic illness, disability and mortality.

Rural residents face longer journeys to reach a GP surgery than their urban counterparts. Those who travel by public transport or walk have an average 18-minute

journey, though this figure takes no account of the frequency of such transport and hence any waiting time.

Minimum travel time, in minutes, for average rural and urban resident to reach their nearest GP surgery (2016)



The Government's resource allocation system for local government (Settlement Funding Assessment) provided urban areas with 40% more funding per resident than rural areas in 2016/17. With reducing budgets, spend to meet on growing social care needs risks overwhelming rural county and unitary council budgets at the expense of other services.

Rural residents also face an additional cost burden for the adult social care provision in their areas. In 2017/18 they funded 76% of the cost of its provision through their Council Tax bills. The urban comparator figure was 53%.

Home care providers face various challenges in rural areas, including difficulties recruiting staff and unproductive staff travel time between geographically spread clients. Rates of delayed transfer of care upon hospital discharge are higher in rural than urban areas.

Rates of delayed transfer of care from hospitals in 2016/17

Predominantly rural areas:	Predominantly urban areas:
Rate = **19.2** cases per 100,000 adult population	Rate =**13.0** cases per 100,000 adult population

Almost 12% of all residents who live in rural areas are providing informal care to someone else on a regular basis. That figure doubles to 24% amongst older people who live in rural areas. Both these figures are higher than the urban equivalents.

The rural challenge

On measures of health the rural population can score rather well, but demand for health and social care services is growing and access to them is frequently a concern.

Significant challenges should be addressed by a Rural Strategy. They are:

o Ensuring that patients can get to secondary and tertiary health services;
o Delivering quality primary health care locally within rural settings;
o Making sure social care reaches those who need it in remote locations; and
o Benefitting rural clients through improved health and social care integration.

What would make a difference?

The Rural Services Network believes that the following initiatives should be included within a Rural Strategy for a fair deal on health and social care:

- **A fair allocation of funding to rural areas**: funding for the NHS[1], social care and public health should each be overhauled to reflect actual patterns of demand and to take full account of the extra costs of service provision in sparsely populated areas[7]. As a matter of principle, rural and urban residents should receive equitable service provision. Rural residents should not be paying more Council Tax for fewer services. Despite some additional funding announced in the 2018 Budget, local taxation has become unable to meet the growing need for social care and a case now exists to finance social care services managed by local authorities differently, with their statutory provision fully funded by central Government. This would address the current unfairness and make it easier to cope with future demand.

- **A rural proofed model for health care delivery**: in many areas the NHS Sustainability and Transformation Plans (STPs) propose reconfiguring secondary and tertiary health care services, including A&E, elective and other hospital provision. Often these plans would result in more centralised services. Whilst a medical case can be made for specialising care at one location, this needs balancing against the need for patient (and visitor) access to services, not least from outlying rural areas. STPs should also seek more local delivery for non-urgent treatments at clinics, health centres and community hospitals, whilst improving hospital patient transport.

- **A stronger focus on filling vacancies**: recruiting GPs, care workers and other health or social care professionals is difficult in many rural areas. A growing number of surgeries report unfilled vacancies for family doctors, with postings in smaller or rural surgeries apparently less attractive to trainee and younger health care professionals. It is important that rural communities benefit sufficiently from the NHS fund to attract recruits into hard-to-fill posts. Helpful recent recommendations made by the new National Centre for Rural Health and Care include introducing a spatial component to Health Education England's STAR workforce planning tool and developing centres of excellence in rural health and care delivery.

- **A joined - up approach to health and social care**: options for integrating health and social care services may be constrained in rural areas, but the benefits of doing so are perhaps even greater than elsewhere. To that end, the Better Care Fund has been a helpful (pooled) funding pot, despite giving less to rural than urban areas[2]. The direction of travel indicated by the NHS Long Term Plan is helpful, placing the emphasis on preventative approaches and encouraging innovation. The delayed Social Care Green Paper needs to offer further opportunities to move to a more sustainable and effective approach. It will be important for it to recognise rural service delivery cost issues.

- **A housing policy ready for an ageing population**: the Social Care Green Paper should also address housing issues, such as access to specialist housing for older people and adapting homes for those who live independently. This is important in rural areas where there are typically limited housing choices. Extra funding announced in the Budget for the Disabled Facilities Grant is welcome, though will hardly scratch the surface. New housing should be built to meet the accessibility needs of an ageing rural population. This is more effective and efficient that adapting homes later. Government should work with local authorities, housing associations and the house building industry to ensure that many more new homes are designed and built to meet the Lifetime Homes standard.

3.0 The Lords Select Committee Report: The Government's Response to That Report and Relevant Extracts from The Debate in The House of Lords Report Held On 8TH October, 2019

Attached to this Report is a document which sets out:

- ☐ The Section of the Select Committee Report dealing with Health/Social Care and Loneliness/Isolation.
- ☐ The Governments written response to that Section of the Report: and

- (As an Appendix to that document) Extracts from the Lords Debate on the 8th October

4.0. Next Steps

The Group is asked to consider

(a) Are there any significant rural Social Care/Health/Loneliness issues not referred to yet?
(b) Do we need to make more of the Public Health issues (funding allocations and generally)?
(c) How do we link our issues on Social Care and Public Health to the NHS 10 Year Plan?
(d) Are there specific rural issues relating to Health/Wellbeing for younger rural residents?
(e) Are there specific rural issues relating to specific medical conditions (e.g. Alzheimer's and Bipolar) and issues affecting carers which need articulating?
(f) Which areas of this subject the RSN might prioritise for further action
(g) What those actions might be?
(h) What further "evidence" is available or should be sought to support the case?
(i) What further "lobbying/representational" work should the RSN be undertaking both inside and outside of Parliament?

Graham Biggs

Chief Executive RSN

October, 2019

LORDS SELECT COMMITTEE REPORT CHAPTER 7 DELIVERING ESSENTIAL

SERVICES AT THE LOCAL LEVEL

CHAPTER 7: DELIVERING ESSENTIAL SERVICES AT THE LOCAL LEVEL

Introduction

1. The issues we have covered above make clear that a comprehensive and place- based rural strategy will need to address a range of policy challenges in a way that genuinely reflects the interests of rural economies. This chapter will address some of the other key policy areas on which we have heard evidence in the course of the inquiry. The chapter covers, transport, crime and health services, including tackling loneliness and social isolation in rural areas.

2. As with digital connectivity and housing, it is clear across these areas that— while some positive initiatives are being undertaken, and there are many examples of good practice—the absence of strategic thinking by successive governments has often led to policy failure and to rural businesses and communities suffering from inadequate support and provision compared with their urban counterparts. Each section of this chapter will summarise what we heard of the challenges and opportunities and how a rural strategy might go about addressing them. In each case there is a need for fair funding from central government that reflect the costs of rural provision and differing demographic challenges.

Rural health services

3. We also heard a range of evidence on the challenges of providing satisfactory health care services in rural areas. As well as the common difficulties associated with any rural service delivery, health services present a specific challenge owing to the older population of rural areas. The average age of the population is nearly six years higher in rural than in urban areas (44.6 per cent to 39 per cent) and nearly a quarter of rural residents (24.5 per cent) are over 65. Statistics also indicate that the number of over-65s is increasing much more sharply in rural areas (37 per cent between 2001 and 2015) than in urban areas (17 per cent). This inevitably places a greater challenge on rural health services owing to greater incidences of chronic illness, disability and mortality.

Box 26: Forest of Dean Community Hospital

Forest Economic Partnership (FEP) informed us that as part of developing healthcare provision in the Forest of Dean district, the local NHS has been "actively involved with an Independent Citizens' Jury" who were asked to consider the location of a proposed new community hospital for the area.

The Citizens' Jury considered a range of information, including travel and access issues, taking into account the challenges of transporting patients living in more rural areas. Based on this assessment, the Citizens Jury recommended that the hospital be located near to the town of Cinderford, which was endorsed by the NHS. FEP stated that "this evidence-based decision will support the long-term economic future of the Forest of Dean". This provides a positive example of community involvement in future healthcare planning which helps ensure that the interests of rural residents are fully taken into account.

Service delivery challenges

4. The Rural Services network informed us that, despite their older population, rural areas receive slightly less funding per resident under NHS allocations to Clinical Commissioning groups (CCGs). During our visit to Herefordshire, we heard from local leaders and business groups that a "one size fits all" approach to healthcare did not work for rural areas, and that the local NHS trust was in considerable debt, through inadequate funding rather than poor financial management.

5. These points were echoed in further detail by Billy Palmer of the Nuffield Trust, who told us that there were two main adjustments for rurality, an emergency ambulatory care adjustment and an adjustment for "unavoidable smallness" which accounted for about an additional £45 million to predominantly rural areas. This was, however, offset by accounting for historical expenditure in the formula, which took away £46 million. As he stated, "you are at pretty much net zero. You have failed to give them any additional money".

6. Professor Richard Parish of the National Centre for Rural Health and Care also expressed concern that rural health allocations did not account for additional costs associated with seasonal labour, tourism and second home ownership. He stated that "the health services have to retain a capacity that deals with the peaks as well as the troughs, so there are added costs in that as well".

7. Defra informed us that the ageing society was one of the "grand challenges" set out in the government's Industrial Strategy and that, in studying this issue, it intended to look at specific issues in rural communities. Its research streams included 'healthy ageing', new products and services to support earlier diagnosis, and 'leading-edge healthcare', which would develop new technologies for improving quality of treatment and speed up access to new medicines.

8. It was noted in a range of evidence that social care funding was a particular challenge in rural areas. Age UK informed us that the number of people with social care needs living in rural areas is predicted to reach 930,000 by 2029, requiring an additional £2.7bn a year if these needs are to be met through publicly funded social care. The Rural Services network also argued that there was a case for statutory social care provision being fully funded by central government rather than through Council Tax. It added that "this would address the current unfairness in the system and would make it easier to cope with future demand".

9. Access to services was identified as a particular challenge in evidence to us. For example, during our visit to Herefordshire, we were told that the medical centre in the village of Fownhope had approximately 5,500 registered patients of whom only around 1,000 live in the parish of Fownhope itself, with a large proportion of patients living in isolated locations. While Community Transport Schemes existed, they are not able to respond at short notice to assist all patients in need of transport, meaning many people are dependent on taxis.

10. South Northamptonshire Council called for the "provision of multi-use health centres in accessible locations that enable a potential patient to get the majority of their needs met within one location rather than having to drive to another location for treatment". As an example, it cited wellbeing centres that can be designed as dual use functions with indoor leisure facilities, "undertaking a promotional and educational aspect, encouraging prevention as well as cure".

11. Community Pharmacy Wales and the Pharmaceutical Services negotiating Committee (PSNC) both advocated greater utilisation of community pharmacies to deliver healthcare needs for rural communities. PSNC drew attention to the Essential Small Pharmacies, Local Pharmaceutical Services (ESPLPS) scheme which they said sustained predominantly rural pharmacies for many years in places where they would otherwise would not have been financially viable, though they noted that this scheme closed in March 2017. The PSNC argued that to improve and maintain health services in rural areas, a credible successor to the ESPLPS scheme should be introduced, to safeguard patient access to smaller pharmacies in rural areas, with additional funding.

12. We also heard evidence highlighting possible technological means to address challenges in rural healthcare provision. For example, the District Councils Network stated that "the digitisation of public services offers an important opportunity to support sustainable local services in more remote district council settings and overcome the barriers of sparsity". It added, however, that "this is dependent on the right digital infrastructure" and that "without this, the provision of essential services continues to remain at risk". It also stated that while the government was planning to invest £4.2billion in digital health, these services would be harder to use in rural areas because of poor connectivity.

13. Defra stated that "the government recognises the additional challenges in

providing services in rural areas", and added that "clinical commissioning groups in predominantly rural areas in England receive 17 per cent of funding, which is in line with the proportion of the population that they cover". We note, however, that this does not appear to take account of the additional costs of rural health provision that may require funding of a greater level per head than in urban areas.

14. We welcome the Government's promise that its Industrial Strategy research into the "grand challenge" of ageing will incorporate specific issues identified in rural communities. Nonetheless, the Government's statement that it funds clinical commissioning services to the proportion of the population that they cover indicates that it still does not understand the additional challenges and costs associated with rural service provision.

15. Government must ensure that the challenges and costs of providing health services in rural areas are properly reflected in funding allocations to Clinical Commissioning Groups. This should include proper recognition of sparsity costs as well as a recognition of the ageing population of rural areas.

GOVERNMENT RESPONSE

NHS England is responsible for decisions on the weighted capitation formula used to allocate resources between Clinical Commissioning Groups (CCGs), a process that is independent of Government. NHS England take advice from the independent Advisory Committee on Resource Allocation, a group of academics and other experts. The allocation to each CCG is informed by the estimation of the relative health needs of local areas. Funding is based on a complex assessment of factors such as demography, morbidity, deprivation, and the unavoidable cost of providing services in different areas. Over the past two years, the Advisory Committee on Resource Allocation has been considering the evidence for any additional adjustments relating to the costs of providing healthcare in remote areas. Following this, the Committee has endorsed the introduction of a new community services formula that has the effect of better recognising needs in some rural, coastal and remote areas that on average tend to have much older populations. Further detail on the Advisory Committee's findings and recommendations can be found in the note on this year's allocations to CCGs published by NHS England.

16. The Department of Health and Social Care together with NHS England should also take further steps to improve the availability and accessibility of rural healthcare provision, including support for the development of multi-use health centres or hubs. The Government's investment in digital health is welcome, but the success of this approach will depend on the urgency with which it addresses the rural-urban digital connectivity divide.

GOVERNMENT RESPONSE

The NHS's Long- Term Plan commits to delivering fully integrated community-based health care. This will be supported through the ongoing training and development of multidisciplinary teams in primary and community hubs. In support of Sir Robert Naylor's independent report on NHS property and estates in 2017, the government provided £3.9 billion new capital investment as part of the 2017 Budgets which will deliver over 150 schemes providing new and upgraded facilities across the country. All 42 Sustainability and Transformation Partnerships including those in rural areas, have produced local estates strategies for the first time setting out how they will transform their estate in support of delivering ambitions in the NHS's Long -Term Plan and benefitting patients.

In April 2018 NHS Digital published a digital inclusion guide for health and social care aimed at local health and care organisations to help them to take practical steps to support digital inclusion in their communities, including those in rural areas who are more likely to be digitally excluded. DHSC is working closely with the DCMS to ensure that health and care needs are taken into account in national digital infrastructure policy. Two test beds under DCMS's 5G programme are focused on improving access, and the 5G programme itself will address rural connectivity. A fundamental part of the work of the new joint unit, NHSX, will be ensuring that all digital services are designed around, and are accessible to people that need them the most, wherever they live in the country.

17. Government should also take steps to improve rural pharmaceutical services. This might include reopening the Essential Small Pharmacies and Local Pharmaceutical Services (ESPLPS) scheme, which helped rural pharmacies in places where they would not otherwise have been financially viable.

GOVERNMENT RESPONSE.

Rural pharmacies that are situated at least 1 mile from their next nearest pharmacy and dispensed fewer than 109,012 prescriptions in 2015/16 (when eligibility was determined) are already eligible for the current Pharmacy Access Scheme (PhAS). PhAS which replaces the ESPLPS is better targeted and tops up pharmacy.

Loneliness, isolation and other mental health challenges

18. We also heard evidence on the challenges associated with tackling loneliness, isolation and associated mental health issues in rural areas. As Prof Michael Dower noted in evidence, "social isolation in loneliness … is found in many rural areas, but often overlooked and invisible". He added that "much is already done by village communities, churches and voluntary organisations to alleviate this isolation and loneliness", and that dependence on voluntary effort was likely to become more marked because of financial pressure on local authorities.

Box 27: The Rural Coffee Caravan

The Prince's Countryside Fund cited the example of The Rural Coffee Caravan, a charity set up in 2003 to tackle rural loneliness. Its caravan and campervan travel around rural communities "to act as a meeting place and allow access to life-improving information in a friendly nonthreatening environment".

Examples of its initiatives include MeetUpMondays, in which hospitality businesses are invited to tackle isolation by inviting local communities into their venue on a Monday for free food and drink and to engage in social interaction. The Fund stated that "it's purely social, and it's always in a commercial venue that is open most days. This makes it a very consistent offer and leads to a robust strengthening of the community".

19. Age UK noted that "loneliness is not the same as social isolation, but social isolation is a risk factor for becoming lonely". It added that it was important for solutions to be tailored to individuals in rural environments, where older people already face more obstacles in accessing services and social activities, and "may have greater difficulties in dealing with their loneliness than those in urban environments". It stated that voluntary sector organisations and public services in rural areas should "develop strategic partnerships to identify and reach out to isolated or lonely older people. This should include finding appropriate ways to share information to identify people who may be at risk of becoming lonely".

20. Prof Richard Parish noted that there were well-observed economic consequences to loneliness, including an increased risk of health problems ranging from high blood pressure to Alzheimer's. He also stated that people who are lonely tend to be admitted to residential care on average earlier than others. With regard to solutions, he argued that better provision of sheltered housing was important, but that there was less of this in rural than in urban areas.

21. During our visit to Herefordshire, we were told about the Compassionate Community Scheme in Fownhope, which matches people up with those who need company. The Scheme has 18 companions who make weekly or fortnightly visits based on referrals from the Medical Centre. We were told that these visits also cut down the need to visit the Centre and can reduce hospital stays as it brings people into the community, encouraging sociability and combatting isolation. While it was not difficult to get volunteers in the village, they were mostly retired people and it was much harder to get younger people to volunteer.

22. Locality stressed the role of community organisations in tackling loneliness, noting that "they offer safe and welcoming spaces and provide inclusive services, where people from different backgrounds and with different experiences of life can come together and meet their neighbours. Community organisations are often adept at asset-based approaches, enabling people to see their strengths, contributions, skills and knowledge, and unlocking the potential of this for the individual and the community".

23. Dr Rashmi Shukla of Public Health England stated that PHE was “working to develop a metric for loneliness in our Public Health Outcomes Framework”. She added that “we are beginning to report on it for local areas. Once you start reporting on it, you start measuring it and you then know what you are dealing with” She also cited the example of ‘village agents’, who are used by local authorities to help connect people suffering from isolation.

24. Defra noted that the government would be publishing a loneliness strategy, which was subsequently published in October 2018. This stated that Defra would “support community infrastructure and community action to tackle loneliness in local areas”, and that the department would also convene a rural stakeholder group to advise and support the work of government departments and help with the local communication of initiatives and good practice. Defra also informed us that the government has announced a £20 million loneliness grant fund for charities and community groups to help isolated people and those suffering from loneliness.

25. Prof Richard Parish expressed concern that there was considerable underreporting of mental health challenges in rural areas, in particular because “there is a culture of self-reliance and a more pronounced stigma in rural communities about mental health”. This was compounded by the fact that confidentiality was more easily compromised because of the closer-knit nature of rural communities when compared with their urban counterparts.

26. Prof Parish added that mental health provision was much poorer across the board in rural areas, both with regard to trained personnel and support services such as community mental health teams. This point was echoed by Billy Palmer of the Nuffield Trust, who stated that there is no adjustment for the cost of mental health services in rural England. Professor Parish also called for a programme of mental health first aid training in rural areas to help members of the public recognise the early signs of potential mental health problems and enable early intervention.

27. Isolation among farmers and agricultural workers was also identified as a serious mental health challenge. Dr Rashmi Shukla told us that “the report last year by the Office for national Statistics looking at a five-year period of suicides by occupation does show that agricultural workers have a higher risk of suicide”. She added that Public Health England was developing local real-time surveillance data on suicides, both to support the bereaved and to identify particular hotspots where suicide risks were higher.

28. Isolation, loneliness and associated physical and mental health challenges are key issues in rural communities. In this context, it is particularly important that policy solutions are rurally oriented, taking account of the greater challenges of combatting isolation in sparsely populated locations.

29. The Government’s loneliness strategy is to be welcomed, as is the

commitment to support community infrastructure and community action to tackle loneliness in rural areas. Government must ensure that, as it implements its strategy, it continues to pay close attention to the distinctive challenges of combatting isolation and loneliness in a rural context. Government should promote and spread good practice among rural voluntary and community organisations in this regard.

30. It is of great concern that there is no adjustment for the additional cost of providing rural mental health services in England. Government must remedy this and ensure that sufficient staff and support services are available to tackle rural mental health. It must also take wider steps to address rural mental health, such as supporting mental health first aid training schemes which will enable early intervention.

APPENDIX A

MAIN REFERENCES TO THE ISSUE OF RURAL HEALTH, SOCIAL CARE, MENTAL HEALTH AND LONLINESS IN THE DEBATE ON THE COMMITTEE'S REPORT IN THE HOUSE OF LORDS ON 8TH OCTOBER, 2019

Lord Foster (Select Committee Chair)

The formula that determines health funding currently transfers at least £1.3 billion away from rural areas and does not properly account for the additional costs of rural health provision.

Baroness Pitkeathley (Lab)

I was very pleased to visit my home county of Herefordshire and see some of the innovative work going on there, although my local contacts—especially in my role as patron of Herefordshire Carers Support—give me grave concern about the resources available to the local authority to support the health and care needs of their population.

The ageing population and rural health services were a particular concern to me and to some other members of the committee. Our strong recommendation was that the higher than average age of rural dwellers, which is of course increasing, should be reflected in policy and funding allocations, especially in view of the additional costs associated with things such as transport in rural areas. The availability of staff is an issue too, particularly those on low wages. Very few health and care workers will be able to afford a house in an area of outstanding natural beauty.

Rural people understand that they will never have a major general hospital in every market town, but they should not be further disadvantaged by their rurality and asked to accept inequity of access to facilities by thoughtlessness—simply assuming access, as many agencies do—or deliberate use of resources to service only those in urban areas because these services are easier to plan. Loneliness and isolation must also be taken into account, especially where mental health in rural areas is concerned. I hope the Minister will confirm that the Government will take steps to support rural mental health more widely.

Baroness Humphreys (LD)

One of the major contributary factors to rural social isolation is the worsening situation regarding rural transport. Indeed, in many areas the rural transport system has virtually collapsed. The system in Wales is no exception. Rural areas throughout the UK have similar problems, but devolution allows the devolved Administrations to tackle problems in a different way or at different paces.

As already indicated in this debate, the rural economy has its roots in many interrelated aspects, IT, education, healthcare and transport being four. If we want a strong rural economy, we need to ensure that strong infrastructure is in place. The report comments on the need for strong IT infrastructure. With more people working at home

in our rural communities than in our urban centres, and with the increased need for digital health, the rollout of broadband is essential. Where there should be hot-spots, rural-proofing reveals that there are not-spots. Cornwall is much better for digital access than where I was in Devon. Why? Because of EU funding in Cornwall.

When I was in Devon, I saw the challenge of maintaining quality education and healthcare when the road infrastructure in some areas was so difficult. Ensuring the recruitment and retention of teachers, nurses and doctors depended as much on transport accessibility as it did on the quality of organisations. I have been encouraged over recent months by campaigns to encourage people to train as nurses. Primary school children have access to mini nurses' uniforms. Apprenticeships and cadet schemes have been introduced, but more could be done to tailor these to rural communities. Three avenues that I believe should be explored further are direct entry into community nursing courses, just as we have direct entry into midwifery; increased distance learning for healthcare professionals; and improving the understanding of the nature of rural healthcare within our training organisations.

We must also be honest. In some of our more isolated rural communities, providing healthcare and education will cost more than providing the same service in our urban centres. Yet the report highlights that despite the population in rural areas being older, there is less spending per head of population on healthcare. Yes, this is good investment, because it contributes to our rural economy, but fundamentally it is a mark of our Christian hospitality to seek to include all of society in its flourishing.

Additionally, what is the Minister's response to some of the issues that I have outlined, specifically on the Government's commitment to increasing community-driven digital infrastructure in rural areas to help bridge the digital divide; improving transport links in these areas; and taking into account geographical factors in healthcare funding differentials?

Lord Greaves (LD)

In that debate I quoted some of the things that the noble Lord, Lord Cameron of Dillington, had said slightly earlier in the debate. I thought, "These are very sensible. I will quote them again". Then I discovered that he is to speak immediately after me, which makes it a very dangerous thing to do—he might stand up and say he has changed his mind since then, but I do not think so. I might be making part of his speech for him, I do not know, but what he said was that:

"Any vision for our countryside has to include agriculture, the environment and rural communities. They are all interlinked … what is our countryside for? There are services that society will want to buy from our land managers: landscape, improved access opportunities for leisure and health and greatly improved diversity of habitats and species",

Lord Cameron of Dillington (CB)

However, rural prosperity continues to be important to the prosperity of the UK as a whole and needs the attention of government, and that rural prosperity involves not

only Defra but all departments. As the report recognises, rural prosperity depends on housing, transport, law and order, health, education and training, so it is a multidepartment issue as far as government is concerned. In this speech, I want to make the point that Governments do not treat the countryside with any degree of equality or fairness, and thus we do indeed need some general focus, across government, on how to make things work better.

On health, the situation here is probably best summed up by two facts and one illogical consequence: the most expensive age cohort to treat medically is from 65 to death; and those aged over 65 represent 16% of the urban population compared to 23% of the rural population. In an attractive county like Devon that figure is 26%— nearly twice as high as some of our large cities. People like to retire to the countryside. Therefore illogically, funding for public health services, for instance in the county of Devon, is 40% lower per head than the national average and nearly 80% lower than in London, and that ignores the extra costs of actually running a rural health service.

One of the overall problems—this is a general point—is the lack of proper data collection. The health service does not produce rural datasets.

Earl of Devon (CB)

As the nation sets its world-leading climate mitigation targets and strategies, as well as ambitious, nationwide health and well-being policies, it is to the rural landscape and the rural economy that the nation will look to deliver these policies. It is only the countryside that can offset our carbon emissions; it is only the countryside that can provide locally sourced, ecologically sound and nutritious food; and it is only our rural communities that provide opportunity for well-managed amenity space for leisure and well-being.

The provision of services to rural populations needs renewed focus, and I support the committee's efforts in this regard. The relative underfunding of schools, doctors, transport, social care, police and other essential services in our rural communities is a stain on our public life. It is often only the strength of rural communities, and the generosity of local volunteers, churches and neighbours, that keep these communities functioning, by stepping in where public services fail.

Baroness McIntosh of Pickering (Con)

My father and brother were both dispensing doctors in their time. This is one area that goes to the heart of how those in the Department of Health and Social Care fail to understand the role of dispensing doctors and pharmacies in rural areas, as opposed to those who work in urban areas. We just need to look— as has been rehearsed this afternoon—at how delivering healthcare in rural areas is more expensive: running ambulances is more expensive, and obviously it is more challenging for patients to reach their GP and hospital appointments. If they do not have a car, they have to rely on neighbours or very erratic bus services.

However, what the Government often seek to do is almost cut the money in primary healthcare in favour of secondary healthcare, which is normally delivered in an urban

area. How many times do people now go to hospital as an emergency rather than having a GP appointment because it takes three weeks to get a GP appointment, both in rural and urban areas?

So, I hope that the Government might reverse their priorities and look to give more funds to delivering healthcare in rural areas through dispensing doctors, because they are the first line of patient care. If we fail the dispensing GPs and reduce their resources, it will make life more difficult for hospitals. The number of closures of community hospitals has, again, had an impact on acute hospitals, because there is nowhere else for people to go to recover after an operation or stroke—which is one of the roles of community healthcare.

I have reached the conclusion I have because all rural services are intertwined: access to rural transport, affordable homes, rural schools, the health service, good communications—both broadband and mobile phone coverage, which is woeful and dangerous in parts of North Yorkshire—and, as others have mentioned, access to a post office, bank, community shop and the local church. It is obvious that many across government departments do not understand rural areas. I make this plea: perhaps a three-month period at the start of a new person taking up a role will enable them to understand rural life and the rural economy better.

Lord Dannatt (CB)

Moreover, an effective community is an important element in reducing the sense of loneliness that many people experience in rural areas. Poor local transport services exacerbate a sense of isolation, especially among older people. Furthermore, modern farming methods often mean that individuals spend much time on their own. These circumstances combine to create mental health issues, which place great pressure on the delivery of healthcare services in rural areas.

The report welcomes the Government's loneliness strategy, and it is pleasing to note in the Government's response to the report that last year the Minister for Loneliness co-hosted a round-table discussion on rural loneliness with the Minister for Rural Affairs. But there is only so much the Government can do, and much of the initiative lies more effectively with the charitable sector. In Norwich Cathedral last Sunday, along with the harvest produce processed to the altar at the harvest festival service was a pair of work boots no longer needed by a farm worker who had just taken his own life. This sad sight was a sobering way of highlighting the loneliness issue by a charity called YANA: You Are Not Alone. Again, this illustrates that many of the solutions to pressing problems can best be found when the public, private and charitable sectors work effectively together.

Lor**d Grantchester (Lab)**

Access to affordable homes can enable generations to stay in close proximity, keeping families together and tackling the other scourges of rural living—loneliness and social isolation—as highlighted in the report

GOVERNMENT RESPONSE TO THE DEBATE

The Parliamentary Under-Secretary of State, Department for Environment, Food and Rural Affairs (Lord Gardiner of Kimble) (Con)

Affordable housing is in short supply. People have to travel further to access essential services such as schools, colleges and hospitals. Distance makes many public services more costly to deliver. There is a higher proportion of older people, which places pressure on health and social services. As we know, there are pockets of extreme deprivation.

CONCLUDING REMARKS BY LORD FOSTER

I thank all members of the committee and all other noble Lords for their contributions to what has been a very encouraging debate, in the sense of supporting many of the things that we have said in our report. The disappointing thing is that the majority of Members of your Lordships' House want to see a rural strategy, but the Government currently do not. Prorogation is about to be upon us. It is the ending of something, but it also heralds the beginning of something new: a new Queen's Speech, a new Budget and possibly even a new Government. Let us hope this will bring about new thinking on the importance of having a comprehensive rural strategy, whatever Government we have. I thank all noble Lords for their contributions.