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.

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6 Any other business

There was no other business and the meeting was closed.