RURAL SERVICES NETWORK

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

Venue: The LGA, Smith Square, London SW1P 3HZ
Date: Monday 8th April 2019
Time: 11.00 am – 1.00 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.**

Visitor information and a link to the map for the venue can be found below:

LGA Map

The building is located nearest to Westminster, Pimlico, Vauxhall and St James's Park Underground stations and also Victoria, Vauxhall and Charing Cross railway stations.

1. **Apologies for Absence**

2. **Minutes: to approve the Minutes of the last Rural Social Care and Health Group held on the 12th November 2018**
(Attachment 1 - Page 3)

3. **Mark Allen, Commissioning Hampshire County Council – Presentation on RSN Health & Social Care Group**

4. **Jeremy Leggatt, ACRE – Presentation on the NHS 10 Year Plan and Adult Social Care Issues as ACRE see them**
(Attachment 2 - Page 7)

5. **APPG RURAL SERVICES: INQUIRY INTO ADULT SOCIAL CARE FUNDING IN THE RURAL CONTEXT**
(Attachment 3 - Page 20)

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RURAL SERVICES NETWORK

6. Any Other Business

The next meeting of this Group is scheduled for the 18th November 2019.

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Note of last RURAL SERVICES NETWORK Special Interest Group meeting

Title:	**Rural Services Network Special Interest Group** • **Rural Social Care & Health Group Meeting**
Date:	Monday 12th November 2018
Venue:	City of Westminster Archives Centre, 10 St Ann's Street, London SW1P 2DE

Attendance
An attendance list is attached as **Appendix A** to this note.

Rural Social Care & Health Group Meeting 11am – 12.30pm

Item	Decisions and actions

1 **Apologies for Absence**

Members noted apologies for the meeting. A full list can be found at the back of the minutes.

2 Minutes of the last Rural Social Care and Health Group 9th April 2018

The minutes of the previous meeting were agreed and noted.

It was reported that on the 16th October at Westminster the National Launch of the National Centre for Rural Health and Care had taken place together with the launch of its accompanying Rural Health and Care Alliance (RHCA).

The RHCA was a partnership between the National Centre and the RSN. Due to its involvement in this new initiative, the RSN had achieved free membership of this Alliance for SPARSE Rural members of RSN with Rural Assembly categorised members only having to contribute an additional £150 (+ VAT) per annum instead of the usual £500 per annum fee. Existing RSP members also get this free if they are non- commercial organisations but full members who have a specific interest in a rural health issues,

3 Items from various discussions – District Direct Pilot Scheme Review 11th September 2017 – 31st March 2018.

There was continuing work which had arisen from this pilot review and the Districts in East Anglia had been very pleased with it.

It was regarded as a strong case study and those involved recommended the work

done and the outcomes achieved.

4 The Minutes of the North West Regional Meeting held on the 8th October were noted.

It was felt by members that the Regional Meetings, all of which had reasonable attendances had been very successful.

5 Presentation by Cllr Lee Chapman, Cabinet Member for Health, Adult Social Care and Housing – Shropshire Council on the Use of Assisted Health and Social Care Technology to help deliver services in Shropshire.

(Cllr Chapman presented in place of Andy Begley, Director of Adult Services, Shropshire Council and Co Chair of the West Midlands ADASS)

Cllr Chapman gave a comprehensive and particularly useful presentation on initiatives which were being taken in Shropshire. He also answered a range of questions very fully. The presentation slides are attached to these Minutes.

The meeting felt the presentation was a very informative one and asked that it be recorded that they felt that for Authorities not able to be in attendance, going through these presentation notes would be very useful.

Particular points of interest were as follows:

1. Special discretionary payment allowing early action had proved to save the Authority money in the longer term.
2. Shropshire had been a Hospital Discharge Telecare Pilot which had been used originally in Eastbourne. They had adapted this scheme and now employed it across the whole of Shropshire. It involved a telecare alarm from the point of hospital discharge aiding in preventing bed blocking and the higher costs of other schemes.
3. The Broseley Project, trialling the use of 'consumer technology' such as Amazon Echo, had been employed and it had produced interesting and useful outcomes. It seemed to establish a good recipe for social inclusion of older people suffering from isolation.
4. A Nursing & Residential Beds commissioning project had been developed for mapping of the anticipated demand of domicilliary care. It allowed a system of tracking and monitoring of provider vacancies and was able to be linked to billing software.
5. The system Shropshire had employed linked Fire Service routine inspection work and lists from G.P. Practices. The Authority now used three pieces of relevant data.

- The age of people in certain areas
- The number of potential cases
- The thermal efficiency of property

6. There was a need to link the vulnerable, the needs of Health and Social Care and the availability of voluntary community care.
7. The Authority wherever possible looked for joint commissioning. It had found benefits by the establishment of a trade Organisation SPIC.
8. The Authority had won awards for its two carers in a car scheme which had allowed for more flexibility in care to be achieved than normal more rigid

arrangements through the traditional sleeping nights' arrangements dedicated night care.

On average the twosome team covered some 5 to 10 visits in a night. It was now in place over 5 market towns and it was known that 24 placements with the ensuing dependency had been avoided.

9. A scheme incentivising providers had proved successful. Delays occasioned by rurality had been reduced. Providers serving urban areas had also been given special parking permits to assist their visit patterns**.**
10. **Independent Care Assessors.**
    The Council had introduced a system of Independent Care Assessors to support discharge from hospital to care homes. It had been so successful it was now being extended to the neighbouring Telford & Wrekin area as well. It would soon be applicable to 100% of the homes across Shropshire. Working with Westminster University it was based on measuring provision and the persons specific needs and and avoiding unnecessary vacancies. Shropshire was also setting up a system of GP Champions seeking to get ahead of medical conditions. It was hoped more additional money would become available for Social Prescribing.

6. APPG Rural Services Inquiry into Adult Social Care Funding in the Rural Context.

Graham Biggs gave a full presentation on developments to date. The proceedings had involved the new National Centre for Rural Health and Care as a joint secretariat for this project. Papers from the APPGs meetings were attached to the Agenda and hopefully these give member Authorities a detailed insight into proceedings to date. The work on this would be ongoing with further meetings on this topic planned as the Governments promised Green Paper emerged.

Members were asked to furnish RSN with case studies from any aspect on this topic. Even if there was a query as to the relevance of these case studies members were asked to provide them in any event.

Some members present did feel that the one Nurse per Nursing Home role created a disadvantageous cost to the running of Nursing Homes in rural areas which because of the sparse population could be relatively small in any event. This it was felt constituted a threat to the continuance of many rural Nursing Homes, threatening their closure. It was felt special arrangements for rural areas needed to be considered.

7. Summary Report on 'Rural Workforce Issues in Health Care'.

This Agenda item (Appendix 6) was considered. It would form part of the jigsaw of evidence going to the APPG informing its intended report.

8.Any Other Business

The next meeting of this Group would take place on Monday 8th April 2019.

Appendix A

Name	Organisation
Cllr Cecilia Motley, Chair	Chair, RSN
Graham Biggs	Chief Executive, RSN
David Inman	Corporate Director, RSN
Kerry Booth	Assistant Chief Executive, RSN
Cllr Robert Heseltine	North Yorkshire County Council
Richard Quallington,	Chief Executive
Cllr Rupert Reichhold	East Northamptonshire Council
Cllr Mark Whittington	Lincolnshire County Council
Cllr Sue Woolley	Lincolnshire County Council
Odhran Jennings, Trusts Fundraiser	Bipolar UK
Cllr Malcolm Leading MBE	OALC (Oxfordshire Association of Local Councils)
Cllr Trevor Thorne	Northumberland County Council
Cllr Owen Bierley	West Lindsey District Council
Cllr Cameron Clark	Sevenoaks District Council
Cllr Les Kew	Bath & North East Somerset Council

Health and care in rural areas

Summary

1. Health service provision for rural communities is strongly influenced by some wider pressures acting on the health service that lead to centralisation, clustering of health specialisms and thus make access for rural people more challenging.
2. Non-health service challenges for rural communities, such as access to affordable housing, digital connectivity and public transport also have an impact on the deliverability of health and social care. A joined-up strategy for rural would add value and enable all these challenges to be properly tackled.
3. Technological and practice developments can either be harnessed to benefit health provision to rural areas or, if this is not done, could quickly make provision much more difficult for rural people.
4. The best interests of rural areas may not be found in retaining a relatively local DGH. The relationships between regional centres of excellence, local 'health hubs', general practice and social care may need to be explored and organised differently in rural areas if the best outcomes are to be achieved for rural people.
5. Health and Social Care need to be thought about together but with a strong awareness of the differences especially in relation to resources, capacity and control/organisation and therefore with differing solutions.
6. The bulk of resources for social care, including the important preventative, wellbeing and health promotion activities operated by voluntary organisations come from social care recipients, their families and the local community. This must be reflected in local control and organisation.
7. Partnership and co-design with rural communities and rural organisations is essential if the resource provided by communities, volunteers and families are to be sustained into the future.
8. Micro-providers / social enterprises in rural areas should become the default approach in rural areas over and above the procurement practices that tend to favour large scale social care commercial providers.

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1. Introduction

It is possible to make the assumption that the issues that have the most impact on the delivery of health and care to rural populations arise predominantly from the nature of the rural areas themselves. We believe that the nature of the services that are being delivered, their organisation, management and funding are just as big a factor in accessibility of these services to rural people. It has also become a commonplace to assume tht health care and social care must be addressed together. Whilst an integrated approach to these is very important, there are some very different pressures and drivers acting on each, not least the requirement for one to be free at the point of delivery whilst the second is a means tested service. This submission therefore covers each separately.

The ACRE Network covers all of England through its 38-member charities. Our focus is on the wellbeing of all people living in all rural areas of England, especially those who are at risk of isolation and disadvantage and for whom rurality brings an additional challenge and cost to their daily lives. In the context of health and care services we believe that nobody

should be unreasonably disadvantaged in their access to public services by the rural location in which they live.

2. The rural challenge for the Health 'system'

2.1 Drivers of change

There are drivers for change within the whole of the health system that are having, and will have, a greater impact on delivery in rural areas than the 'rural specific' ones on which the APPG, and others, could be drawn to focus. They are not labelled 'rural' as they are characteristics of the whole system. Some key drivers are:

- The required **population catchment area** both for a District General Hospital, or equivalent (DGH), for specific treatments/procedures and for regional centres of excellence continues to rise inexorably.
- Local **political pressure** to keep all existing DGHs open appears to be irresistible. There is no lobby group so powerful as the one to keep a hospital open, irrespective of the quality of its services.
- Despite all efforts to the contrary NHS England management is still heavily focused on a single/group hospital and its catchment area, not on achieving ideal **health outcomes of a whole administrative area**. Some local NHS/CCGs in rural areas, however, are starting to break this hospital catchment area way of thinking. It is a distinction that can easily be seen as meaningless in a large urban area with multiple acute hospitals, but takes on a much greater significance in a large rural area that falls under a patchwork of CCGs and Health Trusts where relationships can vary widely.
- **Technological improvements** in treatments/procedures continue apace placing great pressure on training of clinicians in ever increasing specialisations and leads to a requirement for ever larger teams of clinicians.
- Although nothing close to the level in the USA, a **litigious approach by patients** to any failings in their care is growing, making clinical teams more defensive and also tending to a trend for larger sized clinical teams in order to ensure adequate supervision and oversight.
- Technological and practice development increasingly wants all major **specialisms clustered around major accident and emergency provision**. The additional, apparent, need for maternity services to be consultant led, and also to have access to other specialisms on hand, lends further weight to clustering and centralisation. An 'adult' conversation with women in rural areas about both their needs and preferences has been difficult in many areas due to the strong political weight behind DGHs.
- For the above reasons, and also for more intuitively obvious personal ones, **doctor training and junior doctor placement** in anything other than major urban centres with large clinical teams is relatively unattractive. For the remainder of the NHS workforce there is also a considerable personal cost and limited incentive to working for the NHS in high house price rural areas.
- Changes in technology and practice in emergency response is resulting in increasing emphasis being placed on the **first few minutes of intervention wherever this might occur**. Specialisation in this as, almost, a new hybrid medical/paramedical

field of expertise is developing. Despite the implication of these developments even reduced 'blue light time' targets in rural areas remain stubbornly hard to achieve in some areas.

- Small GP practices face constant **pressure to merge and rationalise**, ending up with rural areas having increasingly distant access to primary care and, as a result, making inappropriate use of A and E.
- Economic pressures have resulted in **revenue savings needing to be made and estate to be rationalised**. However, this has tended always to protect the District General Hospital (DGH) or equivalent at the expense of more local community facilities serving rural areas. Figures are not easily available for the numbers of 'cottage hospitals' that have closed in the last twenty years, but it must be considerable.

2.2 Fragmentation and organisation

Fragmentation between health and social care is a well-understood issue. What receives less attention is the fragmentation and poor communication within the health system between Clinical Commissioning Groups, Acute Trusts, Community Trusts, GPs and their staff and Mental Health Trusts. This is not high level, management communication; it is day to day, patient specific, failure to align the actions of all of these 'players' in the system. In a compact catchment area, ie an urban one, all of these management units may have sufficient critical mass of patients to enable them to have an efficient, centre based, approach specific to their service. The management and clinical staff also may have frequent contact with each other and with their counterparts in other parts of the system. For rural areas this is much more difficult to achieve within an alphabet soup of organisations. The NHS Long Term Plan is setting out to achieve greater integration, but the descriptions lead one to think that most of the thinking over this relates to urban scenarios.

So, before even addressing very specific rural issues, such as the preponderance of older people, relatively high housing costs, relatively high suicide rates etc., what might all this mean for rural areas?

Major towns will always fight to protect/retain 'their' DGH, even when continued investment in it is clearly not going to be the best use of resources given the centralising pressures on the whole system. If resources are used in this way, they will not be available to improve community services but, crucially, neither will every DGH be able, in the long term, to keep pace with new technology/practice developments. Rural areas could be left with barely adequate proximity/access to their local, traditional, large town DGH but this hospital will itself be gradually falling into a second tier of practice.

2.3 Re-thinking health services for rural communities

For the reasons outlined above centralisation in the provision of health services, especially acute services, is not going to go away. It is important, therefore, to ask some fundamental questions about how the best possible provision can be organised for people living in rural areas. We raise these questions in the context of the new NHS Long Term Plan and have appended a short paper about some of the specific issues that it raises:

1. Would people living in large rural areas be better served by **Regional / Tertiary centres** than by a relatively local DGH even if this meant longer journey times? Is

there a better way of structuring acute, community and general practice services in rural areas than is currently possible under the NHS commissioner/provider split? By planning services with the access of people from large rural areas in mind (rather than as an afterthought to urban populations) it might be possible to make access easier even if distances are longer. To achieve this the priority for investment would be on accessible out of town locations, not on legacy town/city centre sites.

2. If major acute services were to be located in regional centres (and possibly freeing up scope for investment) what combination of minor injury, acute, maternity and recuperation services would rural areas require at a relatively close proximity? How can these then be best integrated with General Practice, community services and social care? Should we be more ambitious for new **"Health Hubs"** serving rural areas that integrate services locally whilst also drawing on the expertise held in Regional Centres but enable the creation **of 'step up/step down' beds** for very local communities. The NHS Long Term plan is seeking better integration between elements of the NHS, but does the clustering of services need to be different for rural areas if technological and practice change is tending to centralise major acute functions.
3. Is there scope more fully to draw into planning health services in rural areas an **'advanced' ambulance service**, including where necessary air ambulance. It has often not been possible to achieve blue light time targets in very rural areas and, rather than adjusting the targets downwards for these areas, there may scope to re-think the ambulance service's place in the provision of acute services in rural areas and have different, but achievable targets.
4. People active in their communities will become and remain so if motivating factors outweigh de-motivating factors. The latter are often heavy-handed regulation, 'marketing speak' communications and crude attempts to co-opt voluntary activity into providing statutory services. Engagement with the community will be essential for some initiatives e.g. social prescribing. However, different skills will be needed by NHS management if these are to be implemented in rural areas where a 50,000 locality covers multiple communities and GP practices. What training or wider cultural change is needed in **senior health service management** if they are to understand better the community sector and how to work with it.
5. **Technological change**, and practice-change facilitated by technology, is clearly playing a major role in the evolution of the health system. Rural people and rural communities could either be disadvantaged by the unintended consequences of this, or their access to health (and social) care could be dramatically improved. **It would be very helpful if research were carried out, from a rural perspective, into both sides of these developments.** It is easy to focus just on the possibilities of telemedicine without taking account of any disadvantages to patients. Equally, the pressure for improved procedures facilitated by technology, but requiring greater centralisation, could be chased by senior clinicians without considering the risks to rural people of greater centralisation of capacity in the system.

6. The NHS Long Term Plan promotes integration between NHS organisation and starts to break down some of the 'commissioner/provider' received wisdom of the past thirty years. In order to make this work, for rural areas, it would be worth exploring in detail whether **integrated Health Trusts** incorporating CCGs, Minor Acute services, Community and Mental Health Trusts would be more satisfactory than the current fragmented arrangements. This would minimise management

duplication and duplication of patient contact and assessment. It would also make the most effective use of resources without having to staff multiple interfaces between purchasers and providers.

The concept of an internal market that drives up quality and performance simply cannot exist in some rural areas because there are not enough patients in the system to create choice amongst NHS providers. Instead management effort should be reserved for planning and delivering good care and forging effective links with regional centres of excellence.

7. The commitment of the NHS to **social prescribing** is very welcome. In rural areas there have been many VCS and ACRE Network initiatives to establish this approach. It is essential that a 'top down' commitment to funding 'social prescribers' in GP practices is delivered in rural areas through the development of existing initiatives to create Village and Community Agents. This will ensure that the practice that has grown up in an organic, local way is not sacrificed in favour of a nationally defined approach that will not be sustainable in rural areas.

3. The Social Care 'system' in rural areas

3.1 The rural community

It must be stated clearly at the outset that social care encompasses a wide range of non-medical care to people of all ages and whose need for such care arises from an equally wide range of medical conditions, disabilities etc.. The age profile and pressures on the social care system in rural areas, however, means that emphasis here is bound to fall on social care needs of a **disproportionately ageing population** and one with a **historically high incidence of mental health issues** and **isolation leading to poor self-care**.

3.2 The health and social care conundrum

The second important issue to note is the underlying statutory requirement for **health services to be free at the point of delivery but for social care to be means tested**. The second issue is generally seen as a crude accountability 'mis-match' when fine distinctions are being made over an individual's needs. Indeed, the term 'accountable care' has been coined for initiatives that attempt to bring these two strands of funding and service together. Irrespective of this difference, there are other distinctions of particular importance in rural areas where people may live a long way from centralised health provision or the increasingly contracted out and administratively centralised/call centre-organised statutory social care services. These are to do with where capacity and control over services exist, rather than their statutory basis

In the health service resources, and thus control over the purchase of capacity to deliver services, flow from the centre. The channels down which they flow are complex and convoluted, there are purchaser/provider interfaces (each of which have to be staffed on both sides) along the way but, essentially, it is a flow from the tax raised centre to local points of delivery.

3.3 Resources for social care

The definition of social care, especially in rural areas, must encompass preventative activity, health promotion, social prescribing, community activity that promotes well-being and a panoply of other activities. These are all important if recourse to the ultimate cost of 'heavy' domiciliary and residential care is to be kept to an affordable minimum. For social care to be effective, however, capacity must be available in or close to the recipient's home. The involvement of neighbours, family, community and local carers means that, in the most part, this is also where the bulk of the resource and capacity to provide care is being found anyway.

Resources used to deliver social care, especially in rural areas, are not, therefore just the limited budgets now available to County Council Adult Care departments but:

- Care recipients own means, until they are spent down to a defined maximum
- Care recipients' families, either financially or through their own caring activity
- Housing organisations – usually the charitable ones – adding value to their housing offer.
- Voluntary work contributed by active citizens to a wide range of services
- Charitable resources derived from a wide range of large-scale grant making organisations to local village fundraising for local services
- Hospices and related services raising money from a mix of voluntary and statutory services.

It is worth reflecting that the time input alone from carers to the care system in the UK is estimated to be around £132b, the other areas listed above are harder to quantify. Management of Adult Social care must, therefore, see one of its prime functions, especially in rural areas, to be making sure that those providing all of this extra resource do not either break down or walk away. Budgeting to support voluntary sector groups who, in turn, help to keep all this in place has to be seen as an investment not a cost.

Those in need of social care services are often also recipients/beneficiaries of a wide range of other public and voluntary sector services aimed at vulnerable people. All of these share the same challenges when it comes to delivering to people in relatively remote settings. The following list is not exclusive:

- Benefits and Job Centre Plus services
- Citizens Advice
- Housing advice and support
- Fire Service, fire prevention services
- Support from energy network and other utility providers
- Fraud and scam prevention initiatives – PCC and Police initiatives

What many of these sources of resource to provide support to vulnerable people, have in common is that control is in very local hands, they cannot be 'controlled' either by the statutory health or statutory social care organisations. Indeed, to try to do so can make much of the voluntary elements evaporate away. Attempts to co-opt informal voluntary services into the delivery of statutory social care provision has already had this effect in some places.

The process of **assessment** for social care, and also assessment by health services for ongoing medical care, has become the point of 'passive conflict' between the health service, statutory social care, voluntary social care organisations and the family/carers. In rural areas there is a clear danger that assessment is coloured by what can easily be found and affordably provided in a rural location rather than by the individual's needs.

3.4 Control and organisation

Especially in rural areas, then, the distinction between health and social care is not just one of the statutory basis on which they are delivered and paid for, it is also one of resource control and organisation of capacity. **Health services are resourced and controlled from the top down; the bulk of social care is resourced, controlled, and capacity needs to be found, from the bottom up.**

Part of the answer for delivery of sustainable social care to rural populations has to be found by the statutory sector using its limited resources in such a way as to motivate the resources, control and capacity that arises from within rural communities to meet their local needs. In addition, they then need to operate in partnership with other organisations seeking to meet the other needs of those benefiting from social care.

This means organising integration between statutory health and care services requires a strong initial commitment to fully engaging the voluntary and community sector. In rural areas this also requires an understanding that the strength of the sector is at its most local level. Integration at a catchment area of 30k to 50k population in rural areas is meaningless unless a method of working with the voluntary sector at a community level is included. At this geographical level the lead is best taken by the voluntary and community sector itself and often the local ACRE Network member will well placed to provide this lead.

3.5 Re-thinking social care in rural areas and for rural people

Unlike the previous section on rural health care where we pose questions, here we propose particular actions that arise from our experience working with communities throughout rural England. From the perspective of rural communities, it is helpful to look at resources, capacity and control/organisation separately:

Resources:

- Statutory Social Care organisations **must factor distance into all their costings for domiciliary care**, this will give them a financial incentive to work with local communities to unlock local capacity for the 'heavy' care for which they remain responsible. Care workers employed by large contractors based at a distance from rural areas cannot be a sustainable long-term proposition.
- The resources available for health promotion, preventative social care intervention, social prescribing etc must be integrated together and, for rural areas, the default way of using these budgets should be through **partnership and co-design with local village and rural organisations**.
- The resources available from other organisations who are also seeking to reach out to vulnerable people in very dispersed areas need to be clustered with resources

from the social care system in order to make the **most efficient operational use of all these budgets**.

Capacity

- There will not be capacity to provide social care within villages if there is no workforce to provide it. If the **cost of housing** is beyond the reach of those employed in this sector. An age and socially balanced community will be more able to viably and sustainably provide for its own needs including social care. The requirements of social care need to drive policy in other areas, especially housing, planning and regeneration to support achievement of this.
- **People active in their communities will become and remain engaged if motivating factors outweigh de-motivating factors**. The latter are often heavy-handed regulation, poor communication and crude attempts to co-opt voluntary activity into providing statutory services. Senior public service management needs to be trained to better understand the community sector and how to work with it.
- Rural villages almost all own their own assets such as community buildings, minibuses, recreation grounds etc all of which can be used both to provide social care and access to it. They should be viewed as essential capacity in themselves, but they are also a way of focusing voluntary activity in support of social care in local areas. For this reason, **investment in community owned assets should, in rural areas, be the subject of public sector capital investment on the same terms as investment in statutory owned estate** and plant in urban areas. However, the emphasis has to be on supporting those who own and run these facilities, rather than on their capital transfer as might be the case in urban areas.
- There are good examples of micro-enterprises and community enterprises being developed in rural areas and, thereby, growing the capacity to meet local needs. This needs to be actively pursued and received wisdom on **County Council procurement** overturned if this is what is required to make this development possible.

Control/organisation

- Whilst there is a **market for the delivery of social care in rural communities** it is not one that lends itself to large-scale procurement practices by local government. The default for delivery of care to those assessed by statutory local social care organisations as eligible for their intervention should be through local social enterprise, micro-providers, care co-operatives or voluntary organisations.
- Where services are not defined through individual assessed interventions (ie health promotion, preventative activities and wellbeing initiatives) **statutory social care funds should be used through co-design with local village and rural organisations** to build local capacity and control to promote good health and informal care.
- In order to use their resources efficiently in rural areas, **statutory social care organisations must work in partnership with other organisations** seeking to reach the same vulnerable people. Together they can co-design networks of

Village/Community Agents who will connect local village organisations into a broad range of statutory and voluntary sector services.

- In rural areas, very local voluntary sector resources can be critical to the quality of outcomes for vulnerable. **Localities of 30k to 50k population are too large in rural areas** for this to be accomplished. Engagement and support must happen at a more local, community, level especially for initiatives under the NHS' 'social prescribing' banner.

Jeremy Leggett

ACRE Policy Advisor, September 2018

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Health and care issues for rural areasv4.0.docx

Appendix to ACRE Health and Care position statement

NHS Long term plan, January 2019

1. Introduction

The ACRE Network covers all of England through its 38-member charities. Our members are known locally by their local names eg Action with Communities in Rural Kent, West of England Rural Network, Community First etc.. Our focus is on the wellbeing of all people living in all rural areas of England, especially those who are at risk of isolation and disadvantage and for whom rurality brings an additional challenge and cost to their daily lives. In the context of health and care services we believe that nobody should be unreasonably disadvantaged in their access to public services by the rural location in which they live.

This initial set of comments on the NHS Long Term Plan take a national perspective and do not seek to go too far into operational detail. Many of our members are engaged in Sustainable Transformation Plans and in local partnerships that are seeking to put in place Integrated Care Systems. This is the best place at which to address rural people's access to health care in the local area or region.

Overall, ACRE welcomes the focus that the Long Term Plan places on integration between NHS organisations, on leavening the effects of competition and internal markets and on placing the user of the health service at the centre of all decisions. We can see the scope for digital advances to improve some aspects of healthcare for rural people and look forward to a time when these services are both technologically possible and affordable for all people in rural areas. With the age profile in rural areas rising faster than in the rest of the UK we also welcome the urgent intent to take pressure off emergency services by improving community services, especially for older people and their carers.

However, we have some serious reservations about some assumptions that underpin the Plan. One, at least, of these is also very urgent due to its potential impact in the 2019/20 financial year. These reservations are set out below.

2. Access, equity and equivalence

From a rural perspective the most striking element of the NHS Long Term Plan is an error of omission, rather than commission. There is no clear commitment to making NHS services fairly accessible to the whole population, especially those living in rural areas.

Rural people are realistic and practical, they know that it will never be possible to have the services of a major teaching hospital available in every market town. However, a truly **national** health service must have a commitment, at the core of its planning, to ensure that nobody will be unreasonably disadvantaged in their access to its services by where they live. As there is no commitment to geographic accessibility there will be no drive to monitor it and, consequently, no pressure to achieve, report or improve on it.

The Plan mentions the NHS' Public Sector Equality Duty under the Equality Act 2010, but this is narrowly defined solely in terms of specific 'protected characteristics'. One approach that the NHS could choose to take – and one that has been implemented by some local NHS organisations – would be to treat rurality as if it were a protected characteristic under this legislation.

Accessibility for rural communities may be difficult, and the few mentions in the plan suggest an awareness of this difficulty, but simply failing to address it is not the answer. At the very least the cost to an individual of accessing any service must be included within the true resource cost of providing that service. If this is not done there will little incentive for NHS Trusts to seek the most accessible and efficient ways of delivering to their rural populations. The consequences of rural people is either limited or no care being received and this will lead to even greater calls on emergency services, more acute episodes and worse ultimate outcomes for these members of the population. There are clearly financial and performance implications for both rural Trusts and CCGs that include rural populations.

ACRE calls on the Department of Health and NHS England to treat potential limitations of access to NHS and Social Care services as a result of an individual's rurality as a form of discrimination. They must put in place the same monitoring and mitigation measures that are used to prevent discrimination resulting from other protected characteristics.

ACRE further calls on NHS England to include in the calculation of Weighted Activity Units (WAU) for all procedures the cost to an individual of gaining access to the location where a procedure is carried out and include this as a cost to the Trust. The 'Model Hospital' management tool should, thereby, be amended in order to reflect the full opportunity cost of gaining access to a service; the cost that is currently passed on to the patient.

3. Targeting health inequalities

It is worth reflecting at the outset that the NHS Long Term Plan is a ten year strategy for one of the largest organisations in the world. Despite all efforts to break the NHS up into manageable units the whole is centrally funded from the Treasury, has the highest possible national political profile and is resource managed by a complex and largely invisible national management structure.

It is understandable that the 'fine grain' of the NHS Long Term Plan is defined by population localities of around 50,000 people, roughly the size of an urban GP practice. It is at this level of population that improved integration between social care, primary health care and community health care is being sought. Unfortunately, much of the policy set out in the Plan gives the very clear impression that the authors had in mind relatively compact areas with this size of population. In the rural context a population of 50,000 will be geographically much larger, consist of many communities and could easily be a considerable distance from an acute hospital that it shares with ten similar 'localities'.

The Plan continues the historic practice of the NHS and the Joint Strategic Needs Assessments (JSNA) of directing resources on disadvantaged people primarily through geographic targeting. This approach consistently misunderstands the nature of disadvantage in rural areas, allowing it become 'lost' in the averages.

As a result, rural health inequalities are not targeted and therefore some rural people are left to become multiply disadvantaged ie disadvantaged by poor health, disadvantaged by their rurality and also disadvantaged by the crude, pro-active, targeting of resources by the NHS into primarily urban 'hot-spots' of disadvantage. The plan leaves little doubt that this is central to its policy and is chilling for its likely effect on disadvantaged people dispersed throughout apparently affluent and healthy rural areas:

> NHS Long Term Plan "2.25. **NHS England will continue to target a higher share of funding towards geographies with high health inequalities** than

> would have been allocated using solely the core needs formulae. This funding is estimated to be worth over £1 billion by 2023/24. For the five-year CCG allocations that underpin this Long Term Plan, NHS England will introduce from April 2019 more accurate assessment of need for community health and mental health services, as well as ensuring the allocations formulae are more responsive to the greatest health inequalities and unmet need in areas such as Blackpool. Furthermore, no area will be more than 5% below its new target funding share effective from April 2019, with additional funding growth going to areas between 5% and 2.5% below their target share. NHS England will also commission the Advisory Committee on Resource Allocation to conduct and publish a review of the inequalities adjustment to the funding formulae." (Page 40)

The very rapid implementation of a shift in resources arising from the part of the Plan make this an urgent issue that needs equally urgent correction. The JSNA and Index of Multiple Deprivation assist in the targeting of small geographies by ranking them. Most disadvantaged people do **not** live in the small number of disadvantaged areas that relative ranking is used to target ie the most deprived 10% or 20%.

ACRE calls on the Department of Health and NHS England to review urgently the approach taken in the Long Term Plan to targeting resources intended to tackle health inequalities. The current methodology risks making an assumption that most, if not all, people at risk of disadvantage and poor health live in locations where the average level of health inequality is relatively high. This is not true and leaves the Plan silent over dispersed disadvantage and poor health across all of rural England.

4. Small acute hospitals

Prior to the publication of the Plan, NHS England commissioned the Nuffield Trust to carry out research into smaller acute hospitals serving, in the main, rural areas. The population catchment area for these hospitals can be in the region of 150,000 population compared to the current trend of acute general hospitals serving populations of around 500,000 and tertiary centres / regional centres of excellence requiring a population of over 1m. The Nuffield Trust's report carried many sensible, pragmatic and important recommendations, few of which seem to have made it into the Long Term Plan. It is hoped that this is an omission that NHS England intends to correct over time and at a more local level.

The sole mention in the whole Plan of rural areas, and the particular operational differences in delivering services to them, comes in section 1.32 . This in, turn, is focused just on emergency and same day care in smaller acute hospitals. This paragraph, whilst carefully written, is a serious indictment of the failure of the rest of the NHS' planning to take account of the need to operate differently if the stated objectives of the plan are to be met for rural people. It carefully avoids reflecting that it is these hospitals that are often in 'special measures', are most challenged by the NHS' wider workforce issues and do not, on the face of it, perform well in the current internal competition regime.

> NHS Long Term Plan "1.32. We will develop a **standard model of delivery in smaller acute hospitals who serve rural populations.** Smaller hospitals have significant challenges around a number of areas including workforce and many of the national standards and policies were not appropriately tailored to meet their needs. We will work with trusts to develop a new operating model for these sorts of organisations, and how they work more effectively with other parts of the local healthcare system." (Page 21)

This very brief mention, however, opens the door to a new approach to the place of smaller acute hospitals within a planned and managed NHS as opposed to one driven by internal competition and activity costing. This is welcome, but if it is not accompanied by an understanding of growing centralisation throughout secondary health care, and how its effects can be mitigated, will make only a limited difference to these rural hospitals.

We would welcome national standards specific to care and promotion of well-being in rural areas. This would be a more effective long term way of promoting quality standards in locations where internal markets will not do so.

ACRE welcomes the Plan's commitment to work with smaller acute hospitals to find new operating models and urges NHS England to recognise that market mechanisms – internal or external – often fail to drive standards in rural areas. We hope that NHS England will move to a planned approach to delivering acute services in rural areas that places equity of access to services ahead of competition and fully engages rural communities in service decisions. ACRE stands ready to help and support through its network of Rural Community Councils.

Our Network has a unique involvement and understanding of a wide range of rural issues from housing and transport to supporting village community care groups. There would seem to be a great deal of sense in the ACRE Network being represented on any cross-sector taskforces addressing both rural delivery of services and planning/retention of a rural workforce for the NHS and Social Care.

Jeremy Leggett

ACRE Policy Advisor

January 2019

Attachment 3

INTERIM REPORT OF THE RURAL SERVICES ALL PARTY PARLIAMENTARY GROUP (APPG) INQUIRY INTO THE LONG -TERM FUNDING OF ADULT SOCIAL CARE IN THE RURAL CONTEXT

1.0 INTRODUCTION

1.1 The Rural Services APPG has for some months been carrying out an Inquiry into the future funding of Adult Social Care in the rural context. The Inquiry was limited to England.

1.2 The Inquiry has been conducted to enable the APPG to submit evidence to, and to respond to the specific issues contained in, the Government's Proposed Green Paper on the subject to be published later in 2018.

1.3 The APPG's work on this subject is on-going and this report should, therefore, be regarded as an Interim Report.

1.4 The APPG has not limited itself to issues directly related to the financing of Adult Social Care. It has also considered matters such as staffing and skills, resource distribution, the challenges to the sustainability of the care market in rural areas and has sought examples of best practice.

2.0 BACKGROUND

2.1 The Seven Guiding Principles for the Proposed Green Paper

In March 2018 the then Minister responsible for Health and Social Care Secretary, set out seven principles, which will "guide the Government's thinking ahead of the social care green paper". These are:

- quality and safety embedded in service provision
- whole-person, integrated care with the NHS and social care systems operating as one
- the highest possible control given to those receiving support
- a valued workforce
- better practical support for families and carers
- a sustainable funding model for social care supported by a diverse, vibrant and stable market
- greater security for all – for those born or developing a care need early in life and for those entering old age who do not know what their future care needs may be.

As far as practicable the APPG is presenting its findings against these Seven Guiding Principles as set out in Section 4 of this Report. The Rural Context is explored in Section 5.0 of this Report.

Resource Distributional Issues are not referred to in the 7 Guiding Principles but the APPG's Analysis and Views on that subject are set out in Part 1 of this Report (with the evidence in that regard set out in Appendix A).

2.1 In Part 1 of this Interim Report we set out our recommendations from our work to date. In Part 2 we set out the conduct of the APPG's Inquiry and its findings from which our recommendations flow

PART 1: RECOMMENDATIONS

A. OVER-ARCHING RECOMMENDATIONS

1.The present system of funding both Adult and Children's Social Care Services needs to be changed urgently and ahead of new legislation flowing from the Green Paper's wider considerations. The present system is unsustainable and, moreover, is very unfair and inequitable for providers operating across rural areas (and the Council Tax payers in those areas) when compared to their urban counterparts. There needs to be a substantial re -balancing to those areas which have the oldest populations in both the 65+ and 85+ age categories
2. Social Care is a national issue – and at present is in crisis nationally. It should be 100% funded by central government in terms of a national core level(s) of service available (at the same cost if personal financial contributions are to be required) to all, irrespective of where they live. The Service should continue to be delivered at the present level of County/Unitary local authorities with sufficient discretion to determine how that core level(s) of services should be provided in their local context. Council Tax is not a suitable taxation vehicle for demand responsive services and produces a postcode lottery of supply which is able to be funded.
3. Council Tax should only be used to fund any exercise of discretion by the local authority to provide a service above the national core level(s).
4. A future system of dealing with care needs must address, and properly fund, the "prevention" services" provided by County and Unitary Councils through Public Health funding and also those services provided by District/Borough Councils which are aimed at enabling people to live healthily and safely in their own homes (if necessary, with support) as long as possible.

We set out in APPENDIX A our evidence as to the inequalities in funding currently faced by rural councils and their council tax payers as well as other core data relevant to the issues being considered.

B RESOURCE DISTRIBUTIONAL ISSUE RECOMMENDATIONS

5. The way in which resources from taxation are distributed/ re-distributed and the proportion of the total costs to be funded by local Council Tax payers must be fair across both urban and rural areas and fully reflect the costs of providing the care needed in different geographical contexts. This demonstrably is not the case at present as we set out in Appendix A. This applies to government distribution/re-

distribution of funding for both Adult and Children's Care and Pubic Health duties
6. In taking account of the amount to be funded by local council tax payers a notional amount of council tax should be applied across all councils. This would remove any perverse incentives for Councils to keep council tax low to generate more government grant.
7. Formulae to fund the delivery of the national core levels of service must fully reflect the different costs of delivery imposed by the geographical conditions and population dispersal patterns of each area. Such costs inevitably impose service delivery impacts on rural councils, which are compounded by issues such as poor broadband and mobile phone connectivity, lack of economies of scale and poorer external markets for delivery.
8. It should not be the case that because it costs substantially more to provide Adult (and Children's) Social Care in rural areas than it does in urban -and there is higher demand for services - the necessary prioritisation of these (statutory) services, comes at the expense of other services such as rural transport support, for example.

C. WORKFORCE PLANNING RECOMMENDATIONS
9. Introducing 'rural proofing **into health service planning and delivery in rural areas is strongly recommended. A good way of doing this would be to *introduce an additional 'spatial' component to Health Education England's (HEE) workforce planning STAR tool*.**
10.There should be investment into disseminating good practice **and this could include developing *centres of excellence*** **in specific aspects of rural health and care delivery.**
11. A more segmented approach to workforce recruitment, retention and development **should be developed based on a better understanding of the demographics of rural areas (e.g. age cohorts and sub-groups of the current and future workforce).**
12. There should be a detailed mapping of programmes and initiatives that have funded innovative approaches to workforce development **in the past 15 years and identify projects located in rural areas.**

PART 2: THE CONDUCT OF THE APPG's INQUIRY AND ITS FINDINGS

3.0 RESEARCH FOR THE APPG

On behalf of the APPG its Secretariat for the purpose of this Inquiry (The Rural Services Network (RSN) in partnership with the new National Centre for Rural Health and Care) commissioned a survey of rural upper tier authorities in RSN membership to ascertain their views and experiences of the issues trailed in the build up to the Green Paper on Adult Social Care. The survey also asked a number of additional contextual questions.

On receipt of replies to the initial survey some additional questions were subsequently put to the respondents. The results of these two surveys are set out below under the relevant guiding principle together with details from presentations made to the APPG and evidence from literature review and other research conducted for, or on behalf of the APPG.

12 responses were received from a good cross section of RSN members. They were:

- Cornwall
- Hampshire
- Herefordshire
- Lincolnshire
- North Yorkshire
- Northumberland
- Nottinghamshire
- Rutland
- Shropshire
- Somerset
- West Sussex
- Worcestershire

4.0 THE DELIVERABILITIES AND CHALLENGES OF THE 7 PRINCIPLES IN THE RURAL CONTEXT

4.1 GUIDING PRINCIPLE 1: Quality and Safety Embedded in Service Provision

- A lack of transport options and the distance between individuals needing care in rural settings were highlighted as the main challenges in this context.
- Ever reducing rural transport is reported to be leading to some older people not seeking medical support early enough, potentially leading to more severe health conditions and earlier need for support
- Other major risk factors were cited as a lack of workforce choices and limited funds to underpin the cost of an increasingly expensive service. There was a recognition amongst respondents that they needed to meet a rural premium cost in terms of attracting a quality workforce.
- Supporting sustainability and choice were referenced as key challenges exacerbated by rurality. The challenge of facilitating good quality provision for self-funders was acknowledged as a general principle first and then as an issue exacerbated by rurality. Contractual approaches to setting quality and safety standards and quality assurance approaches were cited as factors underpinning quality and safety.

- Particular “pinch points” referenced by respondents to the APPG’s survey were:

- **Increased travel**. Rural areas by nature of their population have lower numbers of customers requiring care than in built-up urban areas and customers are geographically more widely spread.
- **Costs to ensure viable and sustainable services**. With increased travel and consequently less direct time spent with customers, this means lower income for providers and higher costs.

4.2 GUIDING PRINCIPLE 2: Whole Person Integrated Care with the NHS and Social Care Systems Operating as One

- There were some examples of progress but broad unanimity that this was not in place in any of the areas we received feedback from. The complexity of the organisational framework for supporting people was cited as being exacerbated by the physical sparsity of counties such as North Yorkshire and Lincolnshire.
- Poor broadband was referenced as a rural challenge in using IT connectivity to its maximum in addressing the challenge of greater integration.
- Despite the massive investment made by rural councils to make super-fast broadband available in their areas (a cost which their urban counterparts have not had to face) there is still not anything like 100% coverage. The deployment of modern technology to assist service delivery is, therefore, not an option at present in many parts of rural England - thus the cost savings from Assistive Technology cannot be realised in such areas. Realistically, rural areas are always going to fall behind urban areas in the roll-out of enhanced technology by the market.
- Integration in a rural area was identified as being hardest for those with the most complex needs due to the dispersion of specialist providers of services. The difference in terms of funding constraints on each sector was referenced with a view from some areas that the lack of a need for a balanced budget within the NHS side of the equation led to an unbalanced set of expectations amongst providers in terms of the affordability of care.

4.3 GUIDING PRINCIPLE 3: The Highest Possible Control Given to Those Receiving Support

- The personalisation agenda and the provision of direct payments were referenced as a core element of this. A lack of local options in terms of the use of personal budgets was referenced as a challenge in rural settings. Some areas also identified a non-rural specific lack of enthusiasm amongst some individuals to take on the responsibility of personal budgets.
- The principle of taking a person - centred approach to planning provision was referenced along with the caveat that in rural settings limited provision and choice made this more difficult. Managing increasing expectations of choice and opportunity for clients was referenced as being more challenging because of the limits on what is available in rural areas.
- The scope to increase personal support by developing volunteer - based services in rural settings was identified – although “volunteer overload” in rural areas is acknowledged.

4.4 GUIDING PRINCIPLE 4: A Valued Workforce

- The environment within which the workforce operate was cited as a common challenge, particularly in respect of the housing options available to low paid workers in rural settings.
- Recruitment and retention of staff is also a growing problem. Many providers lose staff during the summer time as they take up other seasonal employment opportunities even where they are receiving the National Living Wage levels. Both Health and Care sectors need support to offer lasting career opportunities and the ability to gain socially rewarded qualifications.
- Two recent authoritative studies of recruitment and retention problems within adult social care by the National Audit Office and the Social Care Workforce Research Unit both concluded the sector was facing a staffing crisis exacerbated by continued uncertainty over financial sustainability.
- The role of good quality and well adapted housing for older people were cited as factors which ameliorated the pressure on care workers in relation to the intensity of personal support required by clients.
- The need to provide wage enhancements particularly in relation to retaining a stable workforce was referenced as a key challenge in rural settings. Working on a third -party basis with the intermediary organisations providing carers was also identified as a challenge.
- Setting minimum expectations, particularly in terms of workforce training and development was referenced as a key challenge. An ongoing lack of recognition of the value of adult social care as a profession was identified as a significant issue.
- A recent report published by the National Centre for Rural Health and Care applied a rural lens to the workforce challenges facing the NHS and social care in England in recognition that *securing the supply of staff* that the health and care system needs to deliver high quality care now and in the future is crucial.

  This report entitled 'Rural Workforce Issues', sets out a number of findings, conclusions and recommendations which are detailed below.

'Rural Workforce Issues' Findings

- In summary, the report found that the main ***challenges*** facing rural areas face in securing the supply of staff that the health and care service needs are that:

  1. "Rural areas are characterised by disproportionate out-migration of young adults and immigration of families and older adults.
  2. This means that the population is older than averag***e*** in rural areas - this has implications for demand for health and care services and for labour supply
  3. Relatively high employment rates and low rates of unemployment and economic inactivity mean that the labour market in rural areas is relatively tight
  4. There are fewer NHS staff per head in rural areas than in urban areas.
  5. A rural component in workforce planning is lacking.

6. The universalism at the heart of the NHS can have negative implications for provision of adequate, but different, services in rural areas and also means that rural residents can be reluctant to accept that some services cannot be provided locally.
7. The conventional service delivery model is one of a pyramid of services with fully-staffed specialist services in central (generally major urban) locations – which are particularly attractive to workers who wish to specialise and advance their careers.
8. Rural residents need access to general services locally and to specialist services in central locations to provide best health and care outcomes.
9. Examples of innovation and good practice are not routinely mapped and analysed, so hindering sharing and learning across areas.

- The main ***opportunities*** for securing workforce supply and maximising impact identified in the report are

1. Realising the status and attractiveness of the NHS as a large employer in rural areas (especially in areas where there are few other large employers)
2. This means highlighting the varied job roles and opportunities for career development available and that rural areas are attractive locations for clinical staff with generalist skills.
3. This means developing 'centres of excellence' in particular specialities or ways of working in rural areas that are attractive to workers.
4. This requires developing innovative solutions to service delivery and recruitment, retention and workforce development challenges.
5. This may provide opportunities for people who need or want a 'second chance' – perhaps because the educational system has failed them, or because they want to change direction; their 'life experiences' should be seen as an asset.
6. Finding new ways to inspire young people about possible job roles and careers in health and care.
7. Drawing on the voluntary and community sector, including local groups, to play a role in the design and delivery of services, as well as achieving good health outcomes for rural residents.
8. Promoting local solutions can foster prevention and early intervention and enhance service delivery.
9. Using technology so face-to-face staff resources are concentrated where they are most effective.

- The report suggests that inherent in these challenges and opportunities are a number of *trade-offs* concerning:

- Achieving an optimal balance from staff and service user perspectives on centralisation versus localisation of services.
- Providing the flexibility that health and care workers increasingly desire while achieving required safety standards in health and care delivery.
- Attaining an appropriate mix of specialist and expert generalist staff in situ in rural areas to provide high quality health and care services for residents.

- Appropriate use of technology and face-to-face provision of health and care services.

➢ **'Rural Workforce Issues' Conclusions:**

- There is *systemic lack of 'thinking rurally' in workforce planning in health and care*. This poses challenges both for staff development and for access to health services in rural areas. It points to rural disadvantage that remains unacknowledged.
- Sparser and smaller populations, higher employment rates, lower unemployment rates, an older population and relatively fewer younger people *pose challenges for recruitment, retention and workforce development in rural areas*.
- Despite having common features *rural areas are diverse*. There is increasing awareness and recognition amongst policy makers and the general public that 'place matters' in terms of healthy life expectancy. The importance of *sensitivity to local circumstances* also needs to be considered in workforce planning in rural areas.
- Establishing and, as far as possible, fostering consensus on what *health and care service delivery should look like in rural (and urban) areas,* and what staffing models are most appropriate to achieve this lies at the heart of workforce supply and development issues.
- *Urban bias* is apparent in the application of the universal service and standards approach of the NHS. This tends to further disadvantage rural areas which can face enhanced challenges relative to urban areas in meeting nationally imposed minimum threshold standards associated with health-related and non-health-related aspects of service delivery.
- There are examples of *good practice* and there has been *innovation in rural areas,* yet there has been no detailed mapping of programmes and funding streams, or an analysis of the extent they have supported innovation in rural areas - including workforce development".

4.5 GUIDING PRINCIPLE 5: Better Practical Support for Families and Carers

➢ All respondents recognised the very important role this had to play. A number of respondents cited examples of facilitated and managed networks for families and carers. In a number of cases IT approaches were being used to seek to overcome the challenges of sparsity. The development of flourishing communities in rural settings through indirect investment (i.e. in activities which weren't directly care related) was cited as an activity likely to underpin a better environment for families and carers to operate in.

➢ The provision of respite care in rural settings was referenced as a key challenge for families and carers in rural settings. The importance of providing good quality information services to promote resilience amongst rural carers was identified as an area of good practice.

- Profiling potential developments amongst those with the greatest likelihood of need to support preventive strategies and tailor the support available to individuals were cited as examples of good practice. This was referenced by one respondent as being about “pre-eligibility” awareness.

4.6 GUIDING PRINCIPLE 6: A Sustainable Funding Model for Social Care Supported by a Diverse, Vibrant and Stable Market

- All respondents identified this as an aspiration rather than a reality. The use of preventive funding strategies to reduce the scale and growth of the level of adult care need was referenced as a general point applying in both urban and rural settings.

- A lack of providers, a lack of suitable housing, exacerbated by a complex operational framework, with significant distances between agencies and poor IT connectivity were all cited as severe challenges in rural settings.

- Identifying local and “place” specific contracting approaches to the challenge of providing services in rural settings were identified as key factors in seeking to address the problems arising from rurality.

- The sustainability of the Care Home and the Care Provider Sectors in rural areas is a real concern. Many rural councils are facing problems with care contracts being “handed-back”.

- Once the issue of funding is resolved the Care Home and Care Provider Sectors in rural areas will become regarded, as they should be, as a significant and essential part of the rural economy in general.

4.7 GUIDING PRINCIPLE 7: Greater Security for All

- Managing expectations about what is practical in terms of budgets, particularly in view of the additional costs of providing services in rural settings was cited as a key element of addressing this principle.

- The burgeoning costs of supporting people with disabilities was identified as a challenge which was as severe and as exacerbated by rurality as adult social care. The patchy operation of the direct payment system was identified as an area requiring further attention.

- The development of a two-tier system in terms of the quality and range of residential care choices was identified as being more starkly split between local authority and self - funded clients in some rural areas. This was put down to the limited range of residential care options in some rural settings.

- The development of micro-providers of care (based on examples of the work of organisations such as “Community Catalysts” in Somerset who presented evidence directly to the APPG) was referenced as a key innovation making care more local and more affordable in some rural areas, and also creating opportunities for entrepreneurship and employment.

- The challenge of predicting and therefore planning for the likely demands of older residents was identified as a general point, which is exacerbated by sparsity. The factors which made this more of a challenge in rural areas were cited as: limited choice of providers, greater distances between clients, poor IT provision in some rural areas and in many cases a lack of co-terminosity in terms of geography amongst the agencies concerned. Overall there was a strong degree of pessimism about being able to deliver this aspiration under current funding conditions.

CONCLUSIONS IN RESPECT OF THE SEVEN PRINCIPLES
1. The rural authorities that responded have a high proportion of their population as over 65 residents.
2. Dispersed population patterns lead to higher service provision costs in terms travel to care distances and reduce the contact time that can be allocated to clients. This can be exacerbated by seasonal weather fluctuations.
3. In many rural areas there are very few providers of social care to choose from due to the relatively high cost of providing services and the small number of clients.
4. Clients with complex support needs in rural areas are harder to support because of the distance between the agencies involved in providing care. Some residents require two care workers to provide their care in their own home. The workforce challenge increases the difficulty in accessing care for these rural residents, as to access two people to provide care and arrive at the same time increases the practical challenge of delivering services.
5. The ability of voluntary and community sector organisations and private sector providers to recruit nurses is a challenge and for the reasons stated in this report this is also heightened in rural areas.
6. The overall demography of rural areas means there is a smaller stock of workers to

support those needing adult social care.

7. **Low wages and high housing costs make it difficult to recruit and retain care workers in rural areas. As an example, house prices can be significantly higher in some rural communities, meaning that care workers are less likely to be able to live within these communities. This can subsequently increase their travel to work in rural areas and create difficulties recruiting and retaining staff in these areas.**

8. **The high level of replacement demand, linked to a higher proportion of care workers retiring compared to new ones entering the profession is a significant challenge in rural areas.**

9. **All the authorities responding have a high proportion of their net budgets allocated to supporting a very small proportion of their overall population. This is an issue, which is common to both rural and urban authorities.**

10. **Poor broadband and mobile connectivity limit the scope to deploy technological innovations to support people in their own homes for longer. They also limit the potential to deliver cost efficiencies in the management of health conditions by both older people and their support workers accessing/providing services remotely.**

11. **Notwithstanding the practical challenges facing rural areas in terms of connectivity there is a strong consensus that technological solutions provide real, but largely unfilled potential to improve outcomes for adult social care clients. The presentation to the APPG by Hampshire County Council on its use of Assisted Technology in its Social Care Services shows what can be achieved including examples where Broadband "efficiency" is not a totally limiting factor**

12. **Carers in remote settings find it more difficult and expensive to network and support each other in rural settings.**

13. **Direct payments have the potential to help stimulate very local enterprises providing care, but are not effectively rolled out, the people eligible for them are often not well supported in their use. In cases where vouchers are used, rather than direct financial payments, innovation and choice is further limited due to the limitations placed on the use of the vouchers.**

14. **The housing stock in rural areas often fails to match the needs of the vulnerable older population. There is an acknowledgement of the need for, but a lack of, adequate provision of extra care housing in many rural settings.**

15. The declining number of rural GPs has a knock-on effect in terms of support for vulnerable older people in rural settings and where they have a key role in preventive strategies limits their potential impact.
16. Whilst preventive strategies based on mutli-agency working and early intervention offer the potential to reduce rising costs they are more difficult to deliver in rural areas. This is because of the wide distribution of clients and the greater distances, which agencies seeking to work collectively have to overcome in pursuit of integrated care approaches.
17. The challenge of supporting people is getting worse. Very few providers appear to have a long-term plan for overcoming the scale of challenge they face under the current system of providing adult social care. There is a wide acknowledgement that not only does the funding regime for providing adult social care need to change but so do attitudes about what is expected.
18. Respite care is more difficult to provide in rural settings due to sparsity in terms of the number of eligible clients within manageable geographical bounds.
19. There is a very acute cost linked to providing support for younger and disabled local authority clients, which is equally as severe as the pressures put on local authority finances by adult social care. Taken together with adult social care and these costs are rapidly eroding the financial viability of many local authorities.

5.0 THE RURAL CONTEXT EXPLORED

5.1 HEALTH AND WELL-BEING IN RURAL AREAS

In a joint report issued last year the Local Government Association and Public Health England considered a whole host of issues impacting on “Health and Wellbeing in Rural Areas”. That report commented –

- “But for a number of years, there has been a growing realisation by national and local government that broad-brush indicators measuring the largely positive health, wealth and wellbeing in rural area can mask small pockets of significant deprivation and poor health outcomes”
- “Both sparsity and rurality appear to affect poverty levels and consequently the health of people in rural areas”.
- “One of the difficulties in writing this document is the absence of statistical information on health outcomes in rural areas as they are usually sub-divisions of the larger areas for which statistics are available”

- "Financial poverty in rural areas is also highly concentrated amongst older people, with around one-quarter of those in poverty in pensioner households"

- "Along with reductions in central government grant to local authorities, expenditure on adult social care services has declined and this has led to provision focusing on those assessed as having either critical or substantial needs"
- While the 'personal budgets' awarded to people in rural areas are lower, charges for social care are, on average, higher in rural areas, significantly so with respect to home care charges"
- "Reductions in resources for social care are compounded by the fact that population sparsity leads to higher delivery costs and makes it more difficult for commercial providers to keep their staff"
- "Overall, around one sixth of areas with the worse health and deprivation indicators are located in rural or significantly rural areas"
- "It cannot be assumed that the health and social care needs amongst older people are or will be evident, Research for Defra in 2013 identified evidence of significant unmet needs from health services but found that these were often hidden"
- Service users themselves tend not to identify unmet need, and are also reluctant to discuss challenges around getting the health care that they require. Also, many older residents do not seek out preventative health care or even acute treatment, and in some cases avoid seeking care even in moments of emergency and health crisis"

5.2 THE DEMOGRAHICS AND HIGHER DEMAND IN RURAL AREAS

The Demographics

- 23% of England's rural population (of 9.3 million – 19% of the overall population and more people than live in Greater London) are aged over 65 compared to 16% in urban areas.
- In the ten years between 2005 and 2015 the number of people living in rural areas and aged over 85 years increased by 36.4%. The comparative figure for urban areas was 27.6%
- The ONS predictions for local authorities show that by 2039 1 in 3 rural residents will be aged 65+ and of those 11% (currently 6%) will be aged 80+
- It is the population aged over 85 where there is the most likely need for Social Care Support together with more complex, more intense and wider ranging (and hence more expensive) support.

Examples of Higher Demand for Services in Rural Areas

- Recently published "Local Area Performance Metrics" showed that delayed discharges from hospital per 100,000 of the 18+ population were 15.4 in Predominantly Rural Areas compared to 10.9 in Predominantly Urban areas. Those are very telling statistics

- The following statistics are taken from HHS Digital, Summary figures regarding Adult Social Care Activity and Finance (2016-17 – the latest data currently available)

  - Number of requests for support received from new clients (18 and over)
    Predominantly Rural = 4615 requests per 100,000 resident population in age group
    16.5% greater than Predominantly Urban (3960 requests per 100,000)

  - Admissions to long term nursing or residential care
    Predominantly Rural = 141 admissions per 100,000 resident population
    31.0% greater than Predominantly Urban (107 admissions per 100,000)

  - Support provided to carers during the year
    Predominantly Rural = 753 cases per 100,000 resident population
    15.9% greater than Predominantly Urban (650 cases per 100,000)

  - Number of Clients aged 64 and over Accessing Long Term Support for Social Isolation/Other
    Predominantly Rural = 92 per 100,000 resident population in age group
    10.1% greater than Predominantly Urban (83 clients per 100,000)

  - Gross Current Expenditure on Support for Social Isolation/Other
    Predominantly Rural = £210,982 per 100,000 adult population
    20.0% greater than Predominantly Urban (£175,877 per 100,000 adult population)

  - Average weighted standard hourly rate for external provision of home care (unit costs)
    Predominantly Rural = £16.43 per hour
    11.0% greater than Predominantly Urban (£14.81)

  - Number and Value of Deferred Payment Agreements
    Predominantly Rural = 12.4 DPAs per 100,000 resident population, £342,918 per 100,000 resident population
    10.4% and 18.8% respectively, greater than Predominantly Urban (11.2 DPAs, £288,620 per 100,000 resident population)

APPENDIX A

EVIDENCE OF INEQUITIES IN THE CURRENT SYSTEM AFFECTING RURAL SERVICE PROVIDERS AND RURAL COUNCIL TAX PAYERS

(a) Generally, and Adult Social Care Specific

- As a consequence of the fact that rural areas have, over decades, received substantially less government funding per head of population for their local government services compared to urban areas rural local authorities had increasingly to rely more heavily on Council Tax income than their urban counterparts, whilst still struggling with considerably lower Spending Power overall. This has inevitably impacted on the level and range of services they could provide.

- Thus, rural residents, who on average earn less than their urban counterparts, pay more in Council Tax but get less government grant and receive fewer services which cost those residents more to access. In addition, according to recent research, rural residents pay some £3000 more per annum for 'essentials' than their urban counterparts.

- Whilst increased funding for Adult Social Care is much needed, the amounts provided through the Final Local Government Finance Settlement for 2019/20 and those announced in recent months, will do relatively little to address the overall underlying funding crisis that these services face across England. Furthermore, the fact that much of this increase has to come from Council Tax is very unfair to rural residents. The Council Tax precept for Adult Social Care is only covering, at most, 50% of the required budget growth due to demand and increased expenditure on things such as the National Living Wage.

- The Government's introduction of the Improved Better Care Fund (IBCF), whilst insufficient to meet the Adult Social Care needs is, in principle, a step in the right direction. However, the Government's policy has built inequity into the system. The inclusion of Council Tax flexibility in the IBCF calculations means that, in practice, rural residents are forced to contribute more in council tax levies to fund pressures which the Government is funding in urban areas. The use of the Social Care Relative Needs Formula, frozen in 2013/14, in the Better Care Fund means that social care authorities serving rural areas are not being recompensed for the significant growth in their older population -or indeed the greater costs of meeting those needs.

- Taking these things together, it is not surprising that, more government grant per head goes to urban areas. In 2019/20, the average predominantly urban resident will attract £37.74 per head in Improved Better Care Funding, £8.20 per head more than rural residents per head (of £29.54). In 2017/18 Adult Social Care Core Funding is met by Council Tax to the tune of 76% in rural areas compared to just 53% in urban.

- There is no relationship between the numbers of people requiring social care and either Council Tax or Business Rates. Growth in business rates or council tax income is in no way correlated to the service needs of care services It is obvious that the rising costs of caring for the growing elderly population cannot be met by local taxation and must be funded per capita by central government. In rural areas there are significantly more residents aged 65+ (and 85+), fewer businesses required to pay business rates and Council Tax levels are already much higher than in urban areas. Thus, there is created a 'perfect storm' of rising costs and limited income in the rural areas across England.

- In 2015/16, Settlement Funding Assessment (SFA) per head of population for all services in predominantly urban areas at circa £428 was already some 43% higher than in predominantly rural areas of circa £299. By the end of the settlement period, SFA per head in predominantly urban areas will reduce by just 30.79% compared to a reduction of 41.25% in predominantly rural areas. The cost pressures in Social Care Services mean that County and Unitary Councils serving rural areas are having to cut other budgets to the detriment of the well-being of rural residents and businesses

- Council Tax per head, in 2018/19 is reflected in the Final Settlement at £541.46 for Predominantly Rural Areas compared to £450.58 in Predominantly Urban Areas. The gap, at circa £91 per head, is indefensible.

- The 2018/19 Settlement re-enforces the view that it is acceptable to the Government that in rural areas Spending Power will be increasingly funded by council - taxpayers. In other words, the Government is prepared to see people in rural areas pay more Council Tax from lower incomes and yet receive fewer services than their urban counterparts**.**

- The table below shows the relative gearing between Government Funded Spending Power and Council Tax between predominantly rural and predominantly urban areas over the four-year settlement period as a result of the inequitable changes to the calculation of Revenue Support Grant cuts.

Percentage of Spending Power funded by Council Tax over the four-year settlement period					
	2015/16	2016/17	2017/18	2018/19	2019/20
Predominantly Rural	58%	62%	66%	69%	71%
Predominantly Urban	45%	49%	53%	55%	57%

- The role of preventative services in respect of adult social care is not formally recognised by government and district councils are not funded for public health. With increasing pressures on district council budgets, there remains uncertainty as to how public health interventions delivered at a local level will be funded in the future.

(b) <u>Prevention Services</u>

- Looking at the Public Health Grant Allocations shows –

For the year 2018/19,

Predominantly Rural (PR)	£42.97 per head
Predominantly Urban (PU)	£66.91 per head (55.7% greater than PR)

Indicative allocation for year 2019/20,

PR	£41.61 per head
PU	£64.63 per head (55.3% greater than PR)

- With adult social care at a tipping point action is needed to recognise and adequately resource prevention services to reduce demand on primary care.

- To provide a long-term solution to social care it is necessary for any new arrangements to provide separate funding streams and acknowledge the importance of prevention, which is fundamental to driving down the currently unsustainable costs of adult social care and improving people's lives over the long term.

- Housing authorities provide a whole range of services critical to the wider health agenda. Prevention services include leisure and recreational services, tackling homelessness, providing debt advice, supporting troubled families, joined up help services, improving air quality and improving housing as well as services provided through Public Health funding. A recent report by the CLG Select Committee conclude that older people need greater help with housing to enable them to live independently. Both Stephen Dorrell, the Chairman of the NHS Federation and Duncan Selbie, the Chief Executive of Public Health England in recent comments have recognised the important role of housing in reducing demand for care support.

- These services reduce the burden on adult social care and the NHS. They help prevent, or at least delay, residents needing to access services both in the short and long term. The needs of an ageing demographic mean it is more important than ever that funding is spent keeping people well and safe in their own homes and empowered to care for themselves independently. These service areas significantly impact the wider determinants of health and are crucial to addressing the increased pressure on primary care.