AGENDA

RURAL SOCIAL CARE AND HEALTH GROUP

Venue:- City of Westminster Archives Centre, 10 St Ann's Street, London SW1P 2DE

Date: Monday 12th November 2018
Time: 11.00 a.m. to 12.30 p.m.

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

1. **Apologies for Absence**

2. **Minutes: to approve the Minutes of the last Rural Social Care and Health Group held on the 9th April 2018**
(Attachments 1 & 1(a))

3. **Item from Previous Discussions: District Direct – Pilot Review 11th September 2017 – 31st March 2018**
(Attachment 2)

4. **To receive and Consider the Minutes of the North West Regional meeting held on 8th October 2018.**
(Attachment 3)

5. **Presentation by Andy Begley (Director of Adult Services, Shropshire Council and Co-chair West Midlands ADASS): Use of Assisted Technology to help Deliver Services in Shropshire.**

6. **APPG RURAL SERVICES: INQUIRY INTO ADULT SOCIAL CARE FUNDING IN THE RURAL CONTEXT.**

   (a) Update from Graham Biggs

   (b) To consider two reports which have been put to the APPG and to discuss any further points members feel should be referred to the APPG (Attachments 4 & 5)

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

7. **To consider a summary report on "Rural Workforce Issues in Health and Care.** (Attachment 6)

8. **Any Other Business**

The next meeting of this Group is scheduled for the 8th April 2019.

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

Note of last SPARSE Rural Special Interest Group meeting

Title:	**Rural Services Network Special Interest Group** • **Rural Social Care & Health Group Meeting**
Date:	Monday 9 April 2018
Venue:	Smith Square 1&2, Ground Floor, 18 Smith Square, London, SW1P 3HZ

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

Rural Social Care & Health Group Meeting 11am – 12pm

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 20.11.17

The minutes of the previous meeting were approved.

3 Long Term funding of Adult Social Care Inquiry

Graham Biggs, RSN, outlined the current situation with regard to long term funding of Adult Social Care. Members noted the response from RSN on the consultation and specifically on what it considers is currently wrong with the regime – especially from the rural perspective. Members comments on the proposed government green paper included:

- The response was good and concentrated on rural areas and their particular challenges;
- The potential for employment opportunities for working age adults and their careers with disabilities living in rural environments should be included in future papers and members were invited to submit any evidence to RSN to be included in further responses;
- Members were concerned about what the green paper would include and whether it would just refer to funding, therefore all avenues need to be prepared for;
- Realistic expectations of what can be achieved in extreme rural areas need to be addressed and radical thinking is necessary;
- Money needs to be used constructively. Thought has to be given as to the management of issues and would be best done at a local level;
- It is vital that early intervention and prevention is stressed as a key to enable better and more efficient use of resources and improvements in the lives of

residents;

- Members referred to local interventions used within their own areas and agreed that sharing of best practice and ideas would be most useful;
- Members agreed that empowering communities to take responsibility for caring in their own environments should be considered, although some felt that is was not a viable option without appropriate government funding;
- Members felt that communities were best placed to input on housing and planning issues such as where care homes etc. be placed – central government must address this issue and consider allowing them to make decisions;

Members were concerned about urbanisation of funding formulas but were assured that rural MPs were determined to keep these issues on the agenda to ensure a fair distribution of funding. They noted future meetings planned between RSN and the Rural Fair Share Group of MPs to further discuss these points.

The group compared how fair funding for rural communities is achieved in other countries. Members suggested creation of a care package model specific for Rural Services might be a way forward in the future, however agreed that this might be a way off. They agreed opportunities to come up with a radical idea for self-caring of relations and neighbours and to make it cost effective.

The group agreed that there is currently a lack of awareness among the rural community. Mr Biggs notified members that points raised in the response would be publicised via various channels in due course. The focus at the moment must be on the fair distribution of funding although members felt that planning and sustainability need to be included in any response at a later point.

4 To consider the results of the RSN internal consultation - priorities for the group

The group agreed that the responses to the questions posed were in determining the issues to be prioritised in future RSN work

5 Regional Meetings / Seminars

David Inman updated members on the outcome of the two Regional Meetings/Seminars held to date. On a practical level, members noted the need for evidence – one way of doing this is to provide evidence on the amount of miles carers and medical staff - as well as patients – need to travel.

Mr Biggs suggested that members put forward case studies of examples of these difficulties and include additional cost and incidents of trauma related to the difficulties.

6 Any other business

There was no other business and the meeting was closed.

Appendix A

Name	Organisation
Graham Biggs	RSN
David Inman	RSN
Cllr Cecilia Motley, Chair	RSN
Andy Dean	RSN
Chris Cowcher, Community Manager	ACRE
Cllr Neil Butters	Bath & North East Somerset Council
Cllr Roger Phillips	Herefordshire Council
Cllr Mark Whittington	Lincolnshire Council
Heidi Turnbull, Economic Development Officer	Maldon District Council
Cllr Robert Heseltine	North Yorkshire County Council
Revd Richard Kirlew	Sherborne Deanery Rural Chaplaincy
Cllr Gwilym Butler	Shropshire Council
Cllr Peter Thornton	South Lakeland District Council
Cllr Gill Heath	Staffordshire County Council
Cllr Peter Stevens	St Edmundsbury Borough Council
Cllr Owen Bierley	West Lindsey District Council
Frances Bolding	Suffolk County Council
Malcolm Leeding	Oxfordshire Association of Local Councils
Cllr Peter Wild	Chichester District Council
Cllr Cameron Clark	Sevenoaks District Council
Sue Sanderson	Cumbria County Council

Apologies for Rural Social Care & Health Group

9th April 2018

Organisation	**Name**
Arthur Charvonia, Chief Executive	Babergh & Mid Suffolk Councils
Cllr Yvonne Peacock	Richmondshire District Council
Alice Wiseman FFPH, Director of Public Health	Gateshead Council
Rod Hammerton, Chief Fire Officer	Shropshire Fire & Rescue Service
Gary Powell, Community Projects Officer	Teignbridge District Council
Cllr Alan Whittaker	Chorley Council
Kate Kennally, Chief Executive	Cornwall Council
Ian Knowles, Director of Resources	West Lindsey District Council
Ian Cross, Transformation Design and Implementation Manager	Hampshire Council
Cllr Lee Chapman,	Shropshire Council
Karen Wright, Direct of Public Health	Herefordshire Council
Cllr Rob Waltham	North Lincolnshire Council
Cllr Sue Woolley	Lincolnshire County Council
Homira Javadi, Chief Finance Officer	Suffolk Coastal District Council
Mark Sturgess, Chief Executive	West Lindsey District Council
Cllr Colin Morgan	Daventry District Council
John Birtwistle, Head of Policy	UK Bus
Cllr Roy Miller	Barnsley MBC
Cllr Samantha Dixon	Cheshire West & Cheshire Council
Rita Lawson, Chief Executive	Tees Valley Rural Community Council
Paul Blacklock, Head of Strategy & Corporate Affairs	Calor Ltd
Suzanne Clear, Senior Advisor	NFU
Cllr David Godfrey	Shepway District Council
David Heywood, Chief Executive	South Staffordshire Council
Cllr Brian Long	King's Lynn & West Norfolk
Gill Chapman, Principal Community Support Manager	Borough Council of Wellingborough
Jane Parfremont, Director of Children's Services	Derbyshire County Council
William Benson, Chief Executive	Tunbridge Wells Borough Council
Cllr Matthew Lee	South Kesteven District Council
Karen Bradshaw, Director of Children's Services	Shropshire Council
Keith Hinckley, Director of Adult Social Care & Health	East Sussex County Council
Marc Reddy, Managing Director	First Group
Chris Baird, Director for Children's Wellbeing	Herefordshire Council
Christine Marshall, Executive Director	Breckland & South Holland District Council

Homira Javadi, Chief Finance Officer	Suffolk Coastal District Council
Richard Bates, Head of Finance	Dorset County Council
Cllr Liz Redfern	North Lincolnshire Council
Sharon Stoltz, Director of Public Health	City of York Council
Cllr Anthony Trollope-Bellew	West Somerset Council
Cllr Michael Hicks	South Hams District Council
Cllr Janet Duncton	West Sussex County Council
Kathryn Boulton, Deputy Strategic Director (Children's Services)	Derbyshire County Council
Cllr Hugh McCarthy	Wycombe District Council
Cllr Alan White	Staffordshire County Council
Cllr Lindsey Cawrey	North Kesteven District Council
James Howse, S 151 Officer	South Staffordshire Council
Steve Healey, Chief Fire Officer	Cumbria County Council
Anna Graves, Chief Executive	Breckland & South Holland Councils
Cllr Graham Bull	Huntingdonshire District Council
Kath Hemmings, Neighbourhood Manager	Solihull MBC
Cllr Peter Jackson	Northumberland Council
Chris Fleetham, Corporate Director	Braintree District Council
Martin Reohorn, Director of Finance (Treasurer)	Hereford & Worcester Fire & Rescue
Darren Peters, Staff Officers	Devon & Somerset Fire & Rescue
Cllr Stephen Hillier	West Sussex County Council
Cllr Mark McEvilly	Herefordshire Council
Cllr John Williams	Taunton Deane BC
Cllr Richard Sherras	Ribble Valley BC
Lynn Eccles, Director of Communications & Strategy	National Federation of Sub-Postmasters
Cllr Rebecca Knox	Dorset County Council

DISTRICT DIRECT - PILOT REVIEW 11th September 2017 – 31st March 2018

District Direct supports patients and hospital staff to identify and overcome barriers to discharge via a dedicated district council resource within the integrated hospital discharge hub. The aim is to identify housing related barriers to returning home at the earliest opportunity and support residents to return home in a timely manner from hospital to an environment that meets their needs with the necessary support in place.

District Direct provided:

A dedicated District Direct officer based within the integrated hospital discharge hub to;

- Support DISCOs to identify at an early stage patient vulnerable to delayed discharge, developing and promoting the referral process and gaining patient consent
- Assess and create an action plan to remove the barriers preventing patients from returning home
- Patient follow up to support sustainable independent living at home and prevent re-admission

Eligibility criteria

Patient identified as at risk of delayed discharge and/or re-admission due to the home environment, financial situation, homelessness, energy issues etc. and patient's needs not covered by other statutory organisations e.g. personal care.

Referral pathway

DISCOs are prompted at point of admission to ask 5 questions to highlight any indicators of heightened risk of delayed discharge. A simple referral form is completed and the District Direct Officer will visit the patient, assess and create an action plan to support the patient to return home to live independently. The District Direct Officer will then coordinate handover to the home authority.

Resource to date

District Direct was resourced by District Councils between 11th September 2017 and 31st December 2017 as proof of concept.

NNUH extended the pilot by, A&E delivery board agreement, on 6th December 2017. It was agreed to use winter pressure money to support the scheme until 31st March 2018 with the intention of identifying longer term sustainable funding.

Pilot review & outcomes (further analysis appendix 1)

The pilot supported 184 patients, has undertaken 290 interventions and provided wider information and advice to patients and NNUH staff. Patients have ranged from 31 to 96, with an average age of 71 years of age.

A comparative sample of patients, who had had a housing intervention in the previous six-months, was reviewed and it was found that their average length of stay (ALOS) from the point of being medically fit was 11 days. This reduced by 36% to 7 days ALOS for the 184 patients managed via District Direct. There were 725 bed days saved over a 29-week pilot which equates to a saving of £181,250 (based on £250 cost per bed day). Going forward there are plans being developed for a robust evaluation which will be able to include more qualitative elements and a longer-term view of value in respect of 90 day readmission rates. Primarily the focus for the pilot has been on reduction in LOS and improved patient flow. There are some case study examples of the kind of complex cases which the service has been able to support in the supporting evidence. Individual patient experience is a bit harder to capture due to the sensitive nature of some of the problems faced by patients e.g. debt issues, homelessness, domestic abuse.

Future funding & promotion

The initiative has now been extended for 12-months through partnership funding. Adult Social care have contributed £40k, the 3 central CCGs have contributed £39k and Broadland, Breckland, North Norfolk and South Norfolk District Councils have each contributed £8k, Norwich City Council have not contributed. The project will support any patient being discharged from NNUH.

The initiative has attracted national attention:-

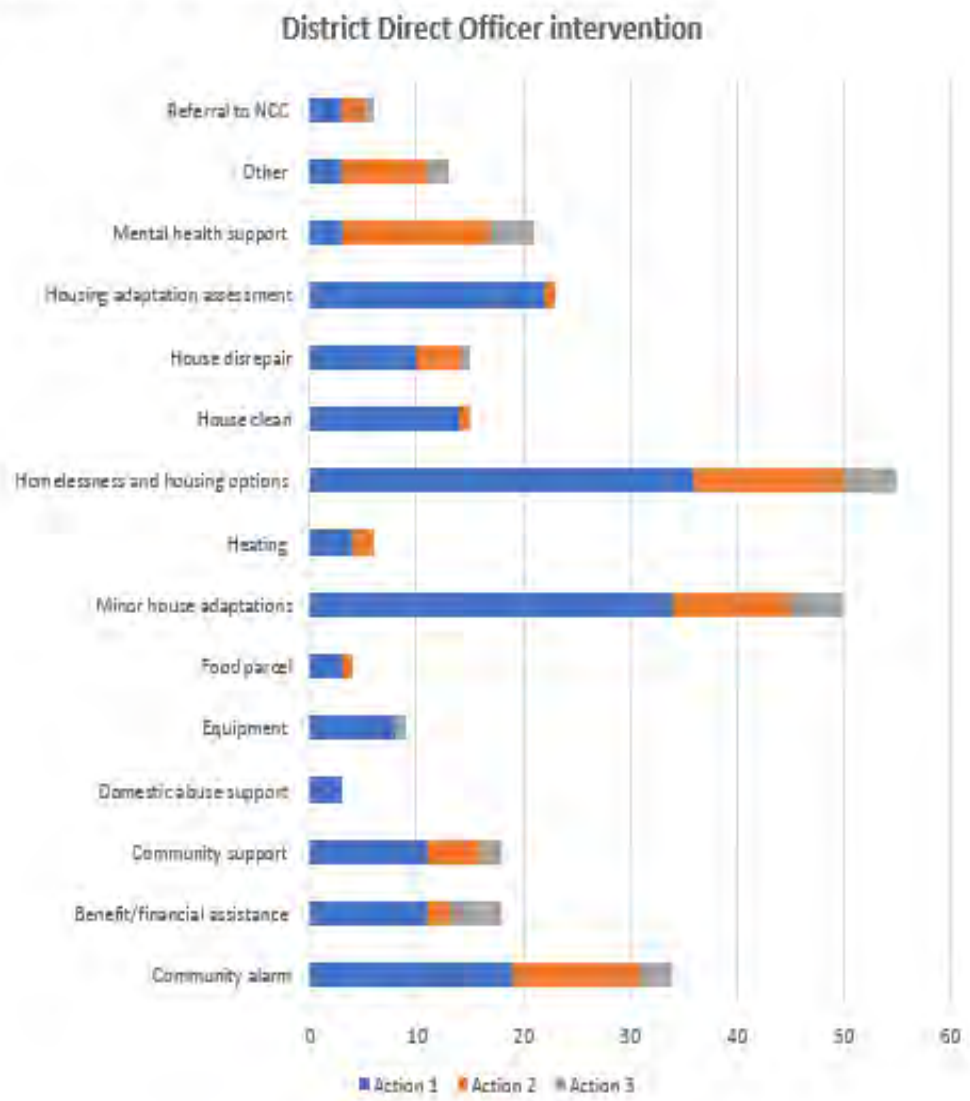
- In June 2018 District Direct was selected as Roy Lilley's 'Pick of the Week' on the Academy of Fabulous NHS Stuff website https://fabnhsstuff.net/2018/06/19/supperandsix-district-direct/ following a 'Supper with Six' event in Sheffield. (Roy Lilley is an NHS writer, broadcaster and commentator and founder of the Academy of Fabulous NHS Stuff). There have been over 5000 views of the streamed live video of the event and further national interest is expected.

- Sam Cayford and Robert Fuller have been invited to speak about the service at a national King's Fund conference as it is considered an example of excellent innovative partnership working.

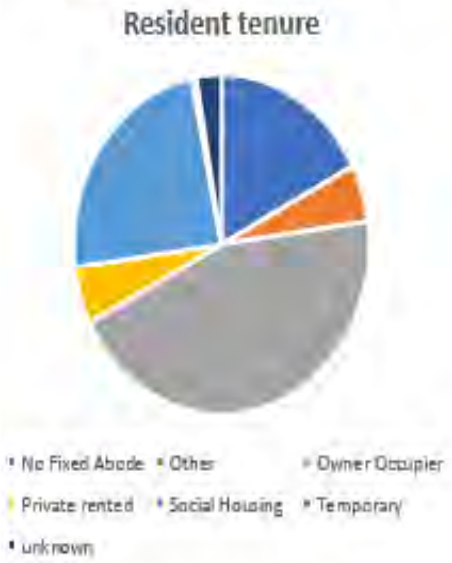
For more information, please contact:-

Sam Cayford, Healthy Living Manager, SNC, 01508 533694 or 07876713641

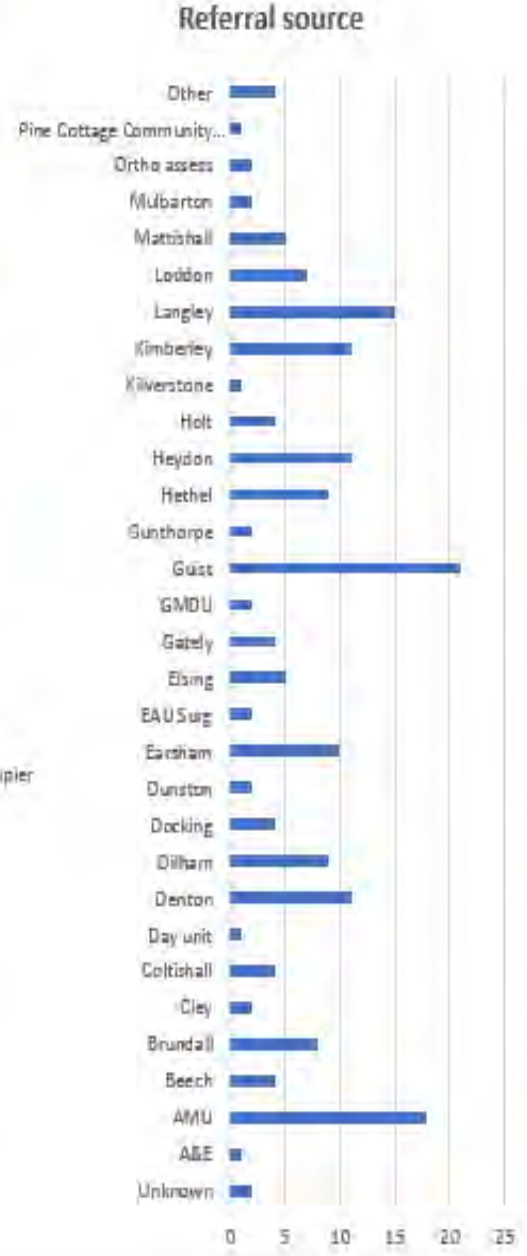
Appendix 1: Pilot analysis



Presenting barrier	
Access and adaptation	94
Housing Quality	20
Housing Status	52
Other	14
Support Networks	4



District	No.
Breckland	27
Broadland	36
Kingslynn	2
North Norfolk	26
Norwich	54
Out of Area	4
South Norfolk	35



ATTACHMENT 3

Notes from the Rural Services Network
North West Regional Seminar/Meeting
Kindly hosted by Lancashire County Council
8th October 2018

Present

Cllr Peter Thornton - South Lakeland District Council
Cllr Alan Smith, Leader - Allerdale Borough Council
Cllr Matthew Salter - Lancashire County Council
Andrea Hines, Policy Manager (Economic Growth) - Allerdale Borough Council
Cllr Aaron Beaver- Chorley Council
Sean McGrath, External Investment & Funding - Lancashire County Council
Cllr Richard Sherras - Ribble Valley Borough Council
Cllr Janet Clowes - Cheshire East Council
Cllr Stella Brunskill - Ribble Valley Borough Council
Gemma Johnson, Project Manager – Superfast Broadband, Lancashire County Council
Cllr Alan Whittaker - Chorley Council
Daniel Herbert, Group Manager – Highways, Lancashire County Council
Cllr Cosima Towneley - Lancashire County Council
Debbie King, Senior Public Health Practitioner - Lancashire County Council
Cllr Gill Gardner - South Lakeland District Council
Cllr Bridget Hilton - Ribble Valley Borough Council
Cllr Alan Schofield - Lancashire County Council
Cllr Lizzi Collinge – Lancashire County Council
Daniel Heery – Charge My Street
Ivan Annibal – Rose Regeneration
Jessica Selleck – Rose Regeneration
Andy Dean – RSN

1. **Apologies:** Due to the amount of apologies, these are included at the end of the notes of the meeting.

2. **Introduction**
   Peter Thornton welcomed everyone, setting out the context for the meeting. Each attendee then introduced themselves and outlined their key rural service concerns.

3. **Andy Dean, Assistant Director RSN**
   Andy set out the background to the operation of RSN and the purpose of the regional meetings.

4. **Daniel Heerey – "Charge My Street" innovation and electric vehicles in rural areas**
   Daniel outlined the background to the establishment of the 'Charge My Street' initiative which was a response to growing congestion and pollution, low take up of electric vehicles and the prevalence of terraced housing in many rural communities in

the Lancashire area where the provision of off-street, home-based charging points was problematic.

The initiative has been established as a Community Benefit Society which managed to raise £39,000 in its first round of installations through a combination of government grant and community finance. Four sites were included in the first round with 3 successfully installed to date.

40% of homes don't have off street parking in major cities and northern towns, meaning that the provision of shared charging points is required to enable more widespread take up of electric vehicles.

The successful use of community shares as part of the finance for the scheme has served to demonstrate the strength of local interest, especially to the public sector.
An App is used to enable members to book time slots at each charging point and monthly bills are issued for the power used.

The scheme provides an income stream. For example, in Broughton-in-Furness electricity is generated from photo-voltaic panels mounted on the village hall roof. The village hall sells electricity to Charge my Street who sell this on to the users.
Charge My Street has recently received a grant from Innovate UK to help roll the scheme out nationally.

5. **Ivan Annibal – "Lost in Space" the challenges of accessing rural health services**

Ivan summarised some of the key issues facing health provision in rural areas including the increasingly ageing population, house price affordability, declining services across the public and private sectors, fuel poverty and poor transport provision.

In addition, health services are extremely urban focused. Smaller hospitals find it more difficult to attract staff than urban centres and rural GPs are often difficult to replace when they move on.

Ivan summarised the challenges facing health provision on rural areas as:

- Public transport (distance, time, cost and frequency)
- Online services and mobile connectivity (poor broadband/weak signal)
- Demographic profile (inward migration of older people and outward migration of younger generation)
- Reduction in buses, banks, local shops, post offices, pharmacies and public services
- Workforce recruitment and retention
- Access to determinants of health

A new 'National Centre for Health & Social Care' will be launched in parliament shortly. The focus for this Centre will be:

- Data and insight
- Research and development
- Technology
- Workforce

6. Issues raised through discussion:

Specific points raised included the following:

- The average installation cost of an electric charging point varies from around £5000 to £12,000 for a fast charger. Rapid chargers cost around £35,000.
- Charging points need to be checked once per annum and require data connection via either broadband or mobile signal.
- A key issue in relation to expanding the charging point network is the winning of hearts and minds. This has been achieved through the Charge My Street initiative simply through talking to people.
- Parking issues were raised in relation to the location of charge points. Daniel confirmed that parking issues are avoided through using community premises, pubs and other accessible locations. A local authority officer added that local traffic regulations were being put in place to ensure cars only remained at charging point locations for a fixed period.
- Local authorities were encouraged to seek to utilise central government funds designed for this purpose to establish electric vehicle charging networks in rural areas.
- Fleetwood was suggested as an excellent example of greater community engagement in health provision.
- It is clear that specialist health equipment is getting focussed into fewer bigger centres.
- Private health and care providers often cherry pick urban areas as this is where efficiencies and profits are greater.
- There is a feeling that people have lost the idea of how to care for themselves, families and friends. There may be a need for a national programme to promote more self help.

7. Suggested actions for RSN

- RSN should promote the need for carers to come out to rural communities. The model pioneered by Community Catalysts in Somerset is definitely worth exploring in more detail more widely.
- RSN provide secretariat to the All Party Parliamentary Group on Rural Services which is very interested in the challenges of delivering adult social care in deep rural areas. The North West is keen to maintain a dialogue on this topic.
- There are service models being re-modelled now, for example pooling and sharing information across organisations in Ribble Valley, and joint working at a corporate level focussing on wellness rather than medical treatment. Good practice and success should be promoted by RSN.
- RSN should work to ensure that some of the government funds for charging infrastructure are directed to rural areas.
- Rural areas will need a voice if and when ‘road pricing’ is introduced (as a potential response to decreased revenues from fuel tax). This is clearly linked to climate change. RSN should maintain a watching brief on this topic.
- Many local authorities lack staff capacity to put bids together for opportunities such as the government funds for electric vehicle charging infrastructure. Is it possible to

widen availability of these funds to other community organisations who may have this capacity?

- RSN could have a role in promoting successful examples of the co-location of services and other projects: for example the ‘Emotional Schools’ project in Cheshire East.
- Reductions in rural policing and the closure of related facilities is a significant issue and could be a useful topic for a future meeting.

Lancashire County Council were thanked for hosting the meeting and all members for their attendance and positive contributions.

ATTACHMENT 3

North West Regional Seminar/Meeting Apologies

Name	**Organisation**
Cllr Kevin Ellard	Lancashire County Council
Cllr Robert Redfern	Lancaster City Council
Cllr Margaret France	Chorley Council
Cllr Dave Brookes	Lancaster City Council
Cllr Neil Hughes	Cumbria County Council
Cllr Gordon France	Chorley Council
Cllr Erica Lewis	Lancashire County Council
Cllr Gwynneth Everett	Copeland Borough Council
Cllr Ian Brown	Ribble Valley Borough Council
Cllr Liz Scott	Lancaster City Council
Cllr Jonathan Brook	South Lakeland District Council
Alison Marland, Principal Planning Officer	Chorley Council
Paul Mountford, Principal Performance & Intelligence Officer	South Lakeland District Council
Cllr Anne Hall MBE	South Lakeland District Council
Suzanne Clear, Senior Planning & Rural Affairs Advisor	National Farmers Union (NFU)

ATTACHMENT 4

All Party Parliamentary Group on Rural Services

3rd July 2018

Rural Services Network and National Centre for Rural Health and Care supported inquiry into the issues surrounding the publication of the Green Paper on Older People (England)

PART 1 – CONTEXT FOR THE INQUIRY

Background

In March 2018 the process set out below was agreed for the development of an APPG review into the issues surrounding the proposed Green Paper on older people's services. This paper reports on progress. It consists principally of a detailed 10-page analysis of the outcomes of a detailed survey of rural upper tier authorities and a brief summation of secondary information by way of context. This second aspect of the report will be updated in the form of a more substantive rapid evidence assessment in due course.

Introduction

During the 2017 General Election campaign, the Conservative Party made a manifesto commitment to introduce a Green Paper on older people and has since said that it will be published before the 2018 Parliamentary summer recess, which is expected to start on 25 July – it was originally due to be published during the summer of 2017.

The Government has said that the proposals in Green Paper will "ensure that the care and support system is sustainable in the long term". During the General Election campaign, the Prime Minister said that the proposals in the Green Paper would include a lifetime "absolute limit" (i.e. cap) on what people pay for social care, and the Conservative Party's manifesto also proposed changes to the means-test. The Health and Social Care Secretary has since confirmed that the Government will implement a cap on lifetime social care charges, according to reports.

Other topics that the Government have said will be included for consultation include integration with health and other services, carers, workforce, and technological developments among others. The Government will also consider domestic and international comparisons as part of the preparation for the Green Paper.

The Minister responsible is the Health and Social Care Secretary, Jeremy Hunt, who in March 2018 set out the 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

Care for younger adults, which accounts for almost half of all council spending on adult social care and includes the fastest growing element, learning disability, is to be excluded from the green paper. Instead, it will be reviewed by "a parallel programme of work" led jointly by the departments of health and communities and local government.

Rural Services Network (RSN) and National Centre for Rural Health and Care (NCRHC)

The RSN is well known to the APPG as its secretariat. The NCRHC is a new body which has been formed to address the challenges of providing Health and Social Care across Rural Settings in the UK. It is a Community Interest Company with representatives on its board drawn from: The Academic Health Science Network, Local Government, Public Health England, the Rural Services Network and the Voluntary and Community Sector. It has a lead Academic Partner – the University of Lincoln and has received funding from a number of bodies including Health Education England. The organisation has four themes associated with its mission: workforce, technology, data/insight and research. The two organisations have agreed to work together to support the APPG.

Proposed Activities

The main focus of the review will be the seven principles referenced above

It is proposed to provide an evidence base for the APPG drawn from both primary and secondary data.

The secondary data analysis will be based on a Rapid Evidence Assessment of published data. The aim of the review will be to draw together key evidence from academics, policy makers and practitioners. It will involve the collation of a range of journal articles, reports, discussion papers and think pieces from organisations and professionals involved in issues relating to the above themes. It will use a search string approach based on key words pertinent to the subject. It will include exclusion criteria, inclusion criteria and limitation criteria to enable us to hone the search as effectively as possible. A number of data sources will be used: (i) Academic databases and search engines (e.g. Web of Science, Interscience, CABI) – all subscription

based (ii) Internet search engines (i.e., Google). (iii) Relevant businesses and consultancies (iv) Relevant professional and technical bodies.

The primary data review will follow the form of a call for evidence distributed amongst all first-tier authorities with a significant rural component. The call for evidence will be distributed to Directors and Portfolio Holders with responsibility for Adult Social Care by the RSN. It will also be distributed to key stakeholders involved in other aspects of rural social care by the NCRHC. The theme of the call will be their views on the how the seven principles referenced for the review manifest themselves in their operational settings.

On 23 March 2018 a Cross Party Grouping of 98 MPs prepared an appeal to the Prime Minister to set up a health and social care parliamentary commission. It identified that a "whole system" review of the issues concerning the provision of social care rather than a narrower focus on adult social care costs. Both data collection approaches will include this issue in their terms of reference.

We will particularly seek views on issues which cause significant rural disadvantage including:

- The range, availability and affordability of housing stock
- Distance/travel times to care
- Technology, e-medicine and access to broadband
- The rural premium in terms of the additional cost of living in rural areas
- Workforce issues in terms of the availability of care staff

We will also seek examples of innovation and good practice including:

- The reduction of rural health inequalities through technology
- Flexible and multi-disciplinary approaches to the provision of support through initiatives such as nurse practitioners and physician associates
- Community pharmacies

We will also have specific regard to profiled population, workforce and health trends in rural areas.

Prevention services are also important, including those provided by upper tier councils under their Public Health duties and those provided by District Councils. Specific regard will also be given to these issues and to their funding.

Finally, we will also consider the manifestation of these issues in the context of the current cost challenges facing local authorities and other providers of adult social care and their longer terms projected impacts.

Report Preparation

A report, will be prepared for consideration, setting out the findings of the above research by APPG members. It will be circulated in advance of the meeting to maximise the opportunities for engagement.

The APPG may chose to hold a hearing inviting witness to give evidence and answer questions from members.

Following the completion of the report the key findings will be prepared for publication and dissemination.

APPG on Rural Services 3 July 2018

PART 2 - Research in relation to forthcoming Adult Service Green Paper

– Survey Results

Introduction

The 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. The results are set out below.

Respondents

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

Respondents completed the questionnaire in different levels of detail. A summary of the key replies is set out below.

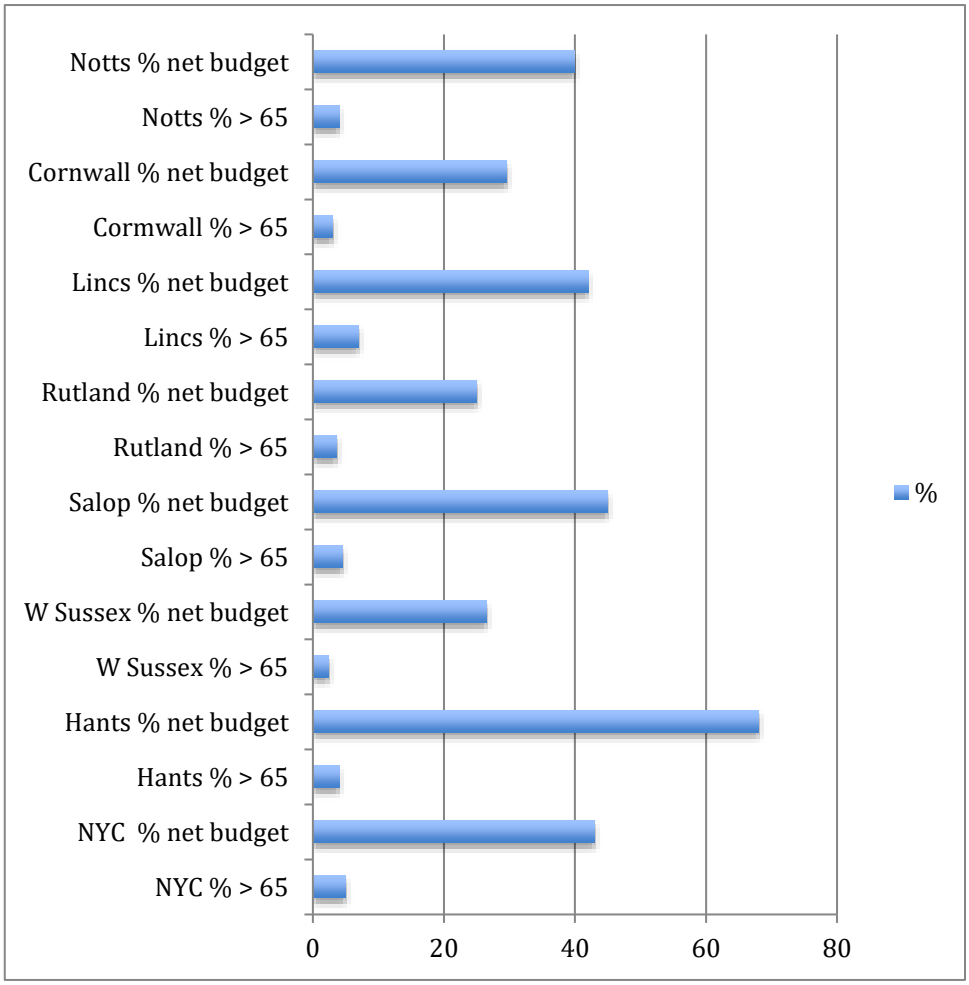
Scale

The scale of adult social care funding as a percentage of all expenditure is interestingly juxtaposed with the proportion of the over 65 funding it represents, in relation to the 8 authorities who answered this question below:

NYC % > 65	5
NYC % net budget	43
Hants % > 65	4
Hants % net budget	68
W Sussex % > 65	2.4
W Sussex % net budget	26.5
Shropshire % > 65	4.5

Shropshire % net budget	45
Rutland % > 65	3.6
Rutland % net budget	25
Lincs % > 65	7
Lincs % net budget	42
Cornwall % > 65	3
Cornwall % net budget	29.5
Notts % > 65	4
Notts % net budget	40%

This is shown in the chart below:



This demonstrates, with some modest variations meriting further analysis (West Sussex, Rutland and Cornwall) that a very significant amount of overall council funds are being spent on a relatively small proportion of the over 65 population of the authorities concerned.

Authorities reported the following increase in spending over the last 5 years:

Cornwall - 16%
Hampshire – 3%
Herefordshire – 2%
Lincolnshire – 13%
North Yorkshire – 5%
Nottinghamshire 1.5%
Rutland – 1%
Shropshire – 45%
Somerset -5%
West Sussex – 11%

Whilst there is very wide variation in these results which merits further analysis, against a background of significantly reducing budgets spending in all relevant respondents has increased and in a number of cases significantly.

7 Principles

The authorities identified their response to the deliverability and challenges of the 7 principles identified for the Green Paper as follows:

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. Other major order 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 in a number of authorities 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.

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 organizational 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 “connectivities” to their maximum in addressing the challenge of greater integration. 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.

The Highest Possible Control Given to Those Receiving Support

The personalization 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. The scope to increase personal support by developing volunteer based services in rural settings was identified. 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.

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. 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 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 problem.

Better Practical Support for Families and Carers

All respondents recognized the very important role this had to play. A number of respondents cited examples of facilitated and manage 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.

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.

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) was referenced as a key innovation making care more local and more affordable in some rural areas. 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.

Key Rural Challenges

Housing - The range of the housing stock was cited as a challenge by most respondents, with a view that the lack of suitable and affordable housing was definitely more acute in the most rural settings. The importance of the provision of extra-care housing as a solution in part to this challenge was referenced by a number of respondents. The desirability of increasing the amount of extra-care housing available in rural areas was identified as an important challenge.

Distance/Travel Times to Care – Seasonal issues in terms of travel to care – particularly accessibility challenges in the winter were cited alongside the

broader acknowledgement that this was a real challenge in rural areas. Providing a very local contracting infrastructure was identified as one (but not easy to achieve) solution to this problem. IT connectivity was seen to be compromised in many rural areas, which limited the applicability of "e-solutions" to this challenge. This was cited as a major factor deterring many people from seeking to work in the adult care sector. The challenges this puts on the availability of home care were cited as a major factor in delayed hospital discharges.

Technology, e-medicine and access to broadband – There was a strong consensus that the opportunities offered by technology had not been fully recognized in rural settings. Mobile and broadband connectivity were both cited as being real challenges in rural settings in the provision of adult social care. Technology was cited as a key factor in enabling vulnerable old people to remain independent in their own homes. This is particularly effective in relation to dementia. Local GPs as the starting point for technology solutions were identified as a key element of this agenda. The shrinking number of rural GPs is a challenge in this context. Technological innovations in being able to complete assessments in client's homes were cited as an important opportunity.

The Rural Premium – most respondents identified that they did provide an enhanced level of funding to take account of the additional costs of providing services in rural areas. None of the respondents saw this as an issue outside of a relatively narrow focus on additional travel times. This is interesting as issues such as a more limited workforce, a low level of good housing options for the elderly and the bigger challenges of multi-agency working are all additional cost factors in rural areas.

Workforce Issues in Terms of Staff Availability – retaining as well as recruiting staff was identified as a key issue. The challenge of coordinating staff training in rural settings was identified as a key factor. Replacement demand, i.e. finding new recruits to replace the care workers due to retire over the next 5 years was identified as a major issue, particularly in rural settings where the pool of young people is smaller and where care is often not seen as an attractive profession. The projected rise in the number of older people in many rural areas was identified as a major factor, which could make this challenge worse.

Relative Challenges

Authorities were asked to rate the relative scale of the following challenges/opportunities and their comments are summarized in the table below:

	SEVERE	SIGNIFICANT	MODERATE	INSIGNIFICANT	TOTAL
The range,	0.00% 0	75.00% 6	25.00% 2	0.00% 0	8

	SEVERE	SIGNIFICANT	MODERATE	INSIGNIFICANT	TOTAL
availability and affordability of housing stock					
Distance/travel times to care	37.50% 3	62.50% 5	0.00% 0	0.00% 0	8
Technology, e-medicine and access to broadband	0.00% 0	75.00% 6	25.00% 2	0.00% 0	8
The rural premium in terms of the additional cost of living in rural areas	12.50% 1	62.50% 5	25.00% 2	0.00% 0	8
Workforce issues in terms of the availability of care staff	62.50% 5	25.00% 2	12.50% 1	0.00% 0	8

The vast majority of respondents found all four challenges severe or significant. 6 of the 8 felt that technology offered a significant opportunity to enhance their service offer.

Innovation and Good Practice

Technology – the following examples were identified by some of the respondents:

Lincolnshire – investment in mobile working for social care assessment staff. Investment in remote access to GP/Medical support for care homes.

West Sussex - tele support for carers. Risk stratification tool (Docobo) which reduces the need for customers and their carers having to travel for support.

Rutland – GP video consultations. Self care toolkit – helping people to manage their own care more effectively.

Nottinghamshire – Florence Telehealth – which enables people to monitor their own conditions and liaise with clinicians.

Flexible and Multi-Disciplinary Approaches – the following examples were identified:

West Sussex – development of a multi-agency approach to supporting hospital bed discharge called “home first”.

North Yorkshire – an extra care facility in Bainbridge, which provides services to the local community in addition to residents.

Lincolnshire – multi-disciplinary neighbourhood teams – facilitating a person-centred approach to prevention and enabling more effective hospital discharges.

Cornwall – the use of health and social care data to enable a predictive analysis of the likelihood of frailty.

Somerset – Village Agents (older person befriending and support) – provide care support and navigations for vulnerable older people.

Other Examples of Innovation – the following examples were identified:

Rutland – preventive model of support for “pre-eligible” adults.

Hampshire – Connect to Support – directory of support and assistance for clients online.

Shropshire – Modular housing pilot to address the challenges of living in inappropriate housing for vulnerable older people. Use of “off the shelf” technology – e.g. “Alexa” to support people living in their homes for longer.

Lincolnshire – HomeFirst – an initiative to develop shared objectives across council and NHS providers to prioritizing home based care.

West Sussex – Shared Lives provides an opportunity for individuals to receive care in a more local setting rather than relocating to a residential care placement if they live within a more isolated rural area.

Costs

Predictions of Future Cost Increases – the impact of the living wage was identified as a key cost driver. Increasing life expectancy, with relatively higher proportions of older people in rural areas was identified as a cost risk particularly when these individuals become frail. The impact of growing costs to support people with disabilities was cited as a major challenge impacting on the availability of adult social care funding. There were major concerns that increasing costs were running alongside an ongoing decline in the overall amount of funding available to respondents. Increasing levels of dementia demands on budgets were cited by some respondents.

Resources to Meet Additional Costs – most authorities identified that they did not have the scope to meet the additional costs, which they anticipated over the next five years. There was an acknowledgment that investment in preventive strategies was part of the solution. A number of respondents identified that other council services would have to be reduced on an ongoing basis to support these rising costs.

The Comparable of Children's Services – The cost of children's services was universally recognized as a challenge and something which should be considered alongside the adult social care agenda. One evocative and representative quote from a respondent is as follows:

"2017/18 saw significant cost pressures arising in children's safeguarding as a result of increased placement costs and agency expenditure and also in areas of Learning and Skills in particular, where Government funding has been reduced. These pressures are expected to be ongoing."

Summary/Overview

This survey reveals a number of rural specific issues, which arise in relation to the issues trailed in relation to the anticipated Green Paper. They are as follows:

The rural authorities that responded have a high proportion of their population as over 65 residents.

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.

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.

Clients with complex support needs in rural areas are harder to support because of the distance between the agencies involved in providing care.

The overall demography of rural areas means there is a smaller stock of workers to support those needing adult social care.

Low wages and high housing costs make it difficult to recruit and retain care workers in rural areas.

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.

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.

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.

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.

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

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.

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. The lack of a suitable housing stock puts pressure on smaller rural care homes and leads to the danger of a two-tier system in terms of care choices between local authority and self-funded clients.

The declining number of rural GPs has a knock on effective 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.

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.

There is a strong feeling amongst respondents that the challenge of supporting people is getting worse. Very few 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.

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.

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 adult social care and these costs are rapidly eroding the financial viability of many local authorities.

APPG on Rural Services 3 July 2018

PART 3 - Research in relation to forthcoming Adult Service Green Paper – Broader Context

Introduction

Upper tier local authorities are responsible for the provision of adult social care. They spend a high proportion of their net budget on providing that care for a very small proportion of their population. The recent figures published by the County Council network give a stark overview of the situation.

- Adult Social Care represents 45% of all county council expenditure 2018/19 excluding education
- County Councils anticipate a £950 million funding gap by 2021in terms of the cost of providing adult social care
- County Councils are home to 55% of the country's over 65s so have a disproportionately higher level of demand than urban areas.

In most first-tier authority areas the adult social care budget supports less than 10% of over 65s.

Looking at adult social care across the whole of England the Local Government Association has reported that an additional £1.3 billion is required immediately to stabilise the social care provider market and that adult social care services will face a funding gap of £1 billion by 2019/20.

RSN Research 2017/18

A Rural England C I C research project looking at challenges facing older people in rural areas highlighted the following issues:

Demographics and Demand

People are living longer but increases in life expectancy are not matched by increases in disability free life expectancy so there is an increasing care need. Rural areas, on average, have a higher percentage of their populations in the older age brackets. Also, those age groups are set to increase disproportionately.

Aged over 85 population as a proportion of total population (all ages)

	2015	2035
Predominantly Rural	3.0%	6.3%
Predominantly Urban	2.1%	3.7%
England	2.4%	4.5%

In predominantly rural areas there is a projected 132% increase in the number of 85+ between 2015 and 2035; the comparable figure for predominantly urban is 102% increase in numbers in the same age category.

The ageing population presents a number of care challenges. For example:

In terms of the incidence of dementia where there is a lower dementia diagnosis rate for people aged 65+ at 63.4% in Predominantly Rural (PR) and 70.8% in Predominantly Urban (PU) areas.

In terms of decreasing numbers of people in receipt of supported social care leading to increasing unmet need amongst the elderly.

In terms of the challenges of a greater reliance on family support which is increasingly unrealistic. Family sizes are smaller so there are fewer potential next generation carers. Geographical mobility means even if there is family they may be a long way away from the individual requiring support.

In terms of demography where many of these issues are more acute in rural areas as young people move away for education/ work and pensioners retire to rural settings.

Home Care Service provision in rural areas

In rural areas lower density impedes economies of scale for care providers and commissioners. Many rural areas suffer from a “penalty of distance” involving: travel costs; unproductive time; and opportunity costs arising from both factors.

Issues Facing Rural Local Authorities

There is only limited scope for shaping the care market- the private sector will only provide service where it makes a profit.

Many external provider businesses are small and localised. Remoter rural clients are the most difficult to serve and often at a premium cost.

The handing back of contracts by social care providers is believed to be widespread especially in rural areas.

Unit costs for externally provided home care in 2016/17 were £16.43 per hour in predominantly rural local authority areas compared to £14.81 in predominantly urban areas with rural costs £1.62 per hour or 10.94% more expensive than urban areas on average.

Problems also manifest themselves in delayed transfers of care. Comparison figures for 2015/16 and 2016/17 in delayed transfer of care (Average number of acute and non-acute delayed transfers of care (18+) per day) per 100,000 population (attributable to Social Care and to both social care and NHS) are set out below:

	2015/16	2016/17
Predominantly Rural	6.1	8.4
Predominantly Urban	4.1	5.5

The NHS data from which the above figures were calculated was not collected in 2017/18. However, a different NHS data set shows that during 2017/18 there has been a very significant reduction in the number of days of delayed transfer of care (DToC) due solely to Social Care. A comparison of April 2017 and March 2018 figures indicates a reduction of some 32% across England as a whole. Preliminary analysis suggests that predominantly rural local authorities achieved, on average, somewhat greater percentage reductions than did predominantly urban authorities. Nonetheless, the rural rates of DToC per head of population remain significantly higher than urban.

Issues Facing Commercial Care -Provider Businesses

In rural areas providers are mostly small and often localised. These providers face difficulties in competing with other employment sectors in both recruitment and retention. In rural settings providers face increased costs associated with travel to rural clients particularly where there is a lack of clustering and clients have complex needs.

Issues Facing Carer Workers

Care workers have low status and limited opportunities to upskill/progress in terms of a career. They have low pay. They face opportunity costs associated with travel. Many have zero hours contracts with little security.

Issues Facing Those in Need of Care

Many people in need of care are often unprepared for the need to pay for their care, which may arise suddenly and unexpectedly. Individuals often face higher costs in rural areas for both local authority supported and private clients. Many of those who pay privately, pay a premium compared to local authority rates.
Accessibility to health care and to advice is a challenge for many individuals in rural areas.

Other Issues

The number of hospital beds has halved in 3 decades. The UK is now the 4th lowest of 22 European countries in this context. Clients face real problems with the rural housing stock in terms of the physical suitability and availability of supported homes. This has knock-on issues for the third sector as well as local authorities and the NHS, which are all put under severe pressure in seeking to provide services for this client group.

ATTCHMENT 5

APPG Follow up responses – 4 detailed follow ups with some reflections linked to a telephone discussion with Cornwall

Overview

a) Percentage of Older People in rural - Variability in the understanding of the detailed distribution of health and care recipients below the district level – this covers all 4 authorities who reported back and Cornwall who gave some telephone testimony.

b) Pinchpoints – West Sussex list is definitive and covers the other 4 respondents namely:

i) **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.
ii) **Costs to ensure viable and sustainable services**. With increased travel and consequently less direct time spent with customers, this means lower income and higher costs.
iii) **Economic factors**. 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.
iv) **Large volumes of 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.
v) **Nursing**. The ability of voluntary and community sector organisations and private sector providers to recruit nurses is a challenge and for the reasons above this is also heightened in rural areas.

C) Prevention – This involves being more flexible with care providers in terms of service specifications, paying higher rates in rural settings, looking at outcomes based contracting models, experimentation with ICT solutions. The work Sian Lockwood will cover about community enterprise solutions in Somerset is also inspirational.

More detailed responses.

(a) the percentage of older people in rural areas with health and care needs and what local authority strategies are for projecting this forward [how does this compare to urban areas?]

Northumbria

We certainly have a higher proportion of older people, and of people in the oldest cohorts of older people, in some of our most rural areas (though there are various complications – commuter villages along the Tyne Valley different from remote hamlets in North Northumberland). But we basically use ONS stats when we want to understand that, rather than cooking our own. We've not tried very hard to estimate comparative age-specific rates of care needs, which would raise further complications about the different social and economic histories of different communities – for instance in South East Northumberland, which we think of as urban, long-term ill-health is commoner among people in their fifties and sixties, and more of the population are at income levels where they are likely to look to us for help rather than making private arrangements.

West Sussex

West Sussex has two districts classed as 'largely rural' by the ONS; Horsham and Chichester. 30-year population projections used by the council segment district/borough populations into the following groups based on need:

- Retain – people who are in good health, with day-to-day activities limited a little or not at all
- Regain – People who have some problem with daily activities and are in fair or bad health
- Long-term support – people who have significant problems with daily activities are in bad or very bad health

Rural districts have a slightly lower percentage of older people with high care needs (in the 'long-term support' segment) than urban districts/boroughs. This is projected to remain similar in the future, with every district showing a 2-4% increase in the proportion of older people in the 'long-term support' segment and a 1-2% increase in the 'retain' segment. The population segmentation model is derived from census data combined with ONS population projections.

Hampshire

The response we gave to your earlier questionnaire gave our figures for the percentage of people we support who live in rural areas: they were 19% of over 65s we support are in rural areas, 20% of the over 85s we support. You're obviously aware of the preventative work we are doing in the technology enabled care (TEC) field, as I understand our TEC partner Argenti are presenting some of their work in Hampshire at the APPG. TEC has huge potential to benefit clients in rural – as well as urban – areas now and in the future as technology develops, and we look beyond traditional telecare solutions towards robotics and cobotics.

Lincolnshire

Don't have a precise breakdown. Overall know that the rate of ageing is slowing within the population and this will be a key factor over the longer term making the growth in demand more manageable.

(b) where the rural pinch points are in terms of those people who put the greatest pressure on local authority budgets and how these are distinctive from urban areas

Northumbria

Our biggest difficulties are certainly in the most remote rural areas, with travel time being a major reason for that.

West Sussex (these also echo Cornwall who briefed me on the phone but didn't send an e-response as promised)

Recruitment and retention of a workforce sufficient to meet the demand for services is one of the biggest challenges. Whilst this is equally an issue in urban areas, it is perhaps more pronounced in rural areas for the following reasons:

vi) **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. This means travel between customers is greater within domiciliary care provision, which increases costs and is regularly cited as an issue in recruiting care workers to cover these areas. In addition, in residential and nursing care the distances travelled to work may be greater than when working in

urban areas, leading to a greater challenge in recruiting to cover services in these areas.

vii) **Costs to ensure viable and sustainable services**. With increased travel and consequently less direct time spent with customers, this means lower income and higher costs. In addition, with limited numbers in the populations in rural areas when compared to urban, services could be less stable as volumes are not as high to ensure regular and consistent ongoing income.

viii) **Economic factors**. 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.

ix) **Large volumes of 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.

x) **Nursing**. The ability of voluntary and community sector organisations and private sector providers to recruit nurses is a challenge and for the reasons above this is also heightened in rural areas.

Hampshire

No response to this question

Lincolnshire

Increasing number of younger adults with ageing carers which may have social care needs

Younger adults getting less NHS care with longer life expectancy – a bill for life

Volume care can be provided for older people acute care needs for others are far more challenging

Common elements linked to rurality, workforce as an issue, 180-degree hinterland, poor communications links prohibit commuting

(c) If/how Local Authorities are planning for these health and care needs – in terms of examples of prevention and/or new approaches to managing funding

Northumbria Response

We're doing fairly obvious things – paying higher rates to home care providers in the most rural areas, encouraging the use of direct payments, and making the most of community resources. We're also looking at ways to help older people

move into market towns when it becomes harder for them to manage life in remote villages and hamlets – there's plenty of anecdotal and small-scale survey evidence of older people wanting to do that, and finding it difficult – and in individual cases, we have made a big difference to older people's lives, and substantially reduced their care needs, by enabling them to move from remote and unsuitable houses into well-designed accommodation in a rural town. But we've never managed to get anyone to produce robust statistical evidence. If there's a single thing that it would be useful to us to get out of this exercise, it would be some national encouragement for serious academic research into the choices older people make, or would like to be able to make, about where they live in rural areas (including both migration to rural areas on retirement or later, and movements between settlements and housing types – both issues need to be considered together; for instance many of the older people who moved into a McCarthy and Stone scheme in Alnwick were moving from Tyneside rather than moving out of unsuitable former family homes in the local area

West Sussex Response

The council has developed a number of initiatives to meet the challenges of providing care in rural communities including:

i) Providing a block of funding for a 3-4-month period to establish domiciliary care providers in areas which have been challenging to source sufficient care to meet demand. This enables providers a guaranteed income in the area in response for establishing a round which can then operate as the start of a viable service from which to grow.
ii) Working in partnership with health colleagues on bed-based services by commissioning blocks of beds to support residents being discharged from hospital.
iii) Rates for service provision including enhancements for rural areas to support covering of additional costs incurred in providing services in rural communities.
iv) A pilot for an outcomes-based service in a specific community to encourage recruitment through payment for shifts and flexible delivery to customers.
v) Focus on provision of technology enabled care and meals to people in their own home in order to support customers through alternative sources of support where it meets their needs.
vi) Working on best practice in moving and handling to support people with updated equipment and techniques which can be provided by one care worker where it is appropriate to do so.

Hampshire Response

Our new Strategy document may be useful to give a flavour of the work we are doing, for example around demand management and prevention.
http://documents.hants.gov.uk/adultservices/publications/AdultsHealthandCareFiveYearStrategy.pdf

Another key area where we should be able to support people better in rural areas in the future is our new Help to Live at Home framework for care at home. We have moved away from standard pricing across the county to a more tailored approach to ensure that we can get the care we need in more rural areas, which of course often costs more and can be less attractive to providers because of the time/travel costs.

Lincolnshire Response

Lincs Care Assoc (Linca) seeking to tackle some of this – in a dialogue with the Council about commissioning strategies, longer planning horizons and more certainty, review of rates for carers overall is ongoing.

Other initiatives –direct payments eligibility increasing, co-design discussions. Direct payment support provider setting up groups of carers who can support each other.

Individual service fund offers – working with small providers. New flexible approach but cost neutral – home care providers are being more flexible with their workforce – rather than 4 calls a day as routinely specified they are being enabled to deliver a person centred approach to care.

Rural Workforce Issues in Health and Care

October 2018

This report has been prepared by Anne Green and George Bramley, University of Birmingham, and Ivan Annibal and Jessica Sellick, Rose Regeneration

Summary

Aim

This report aims to apply 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.

Context

The general context for the study is challenges facing rural areas. Although there are important differences socio-economically and in terms of sparseness of population and access to major urban centres in aggregate rural areas are characterised by disproportionate out-migration of young adults and in-migration of families and older adults. This means that the population is older than average in rural areas - this has implications for demand for health and care services and for labour supply. Relatively high employment rates and low rates of unemployment and economic inactivity (in aggregate) mean that (at least at the current time) the labour market in rural areas is relatively tight.

The specific context for the study is the draft NHS Workforce Strategy to 2027 Consultation *Facing the Facts, Shaping the Future.* The study is stimulated by, but does not directly respond to, this draft Strategy.

Methodology

The study entailed:

- setting out the spatial framework.
- analyses of selected economic and labour market data.
- an evidence review addressing the key questions and issues raised in the strategy.
- primary research entailing interviews and workshops with stakeholders to draw out specific perspectives on challenges and opportunities faced by rural areas nationally and in six rural areas.
- synthesis across the different elements of the research.

Spatial framework

The spatial framework for the study is the 44 Sustainability and Transformation Partnerships in England, of which 22 have a rural population greater than or equal to the national average.

Analysis of Sustainability and Transformation Plans reveals **that connections between 'rural' issues and 'workforce planning' are lacking** : Overall, there is scant mention of 'rural' in Sustainability and Transformation Plans. Of the Plans from the ten areas with the highest shares of rural population, five do not have a rural frame of reference and in the other five analysis of 'rural' tends not to be linked to workforce planning issues.

Findings

In summary, 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 inmigration 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 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 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.

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.

Study findings in the body of the report are organised according to the six principles set out in the Draft Workforce Strategy. There are some overlaps between these principles and cross-references are made between them. In reporting the study's findings a distinction is made between: (i) relevant features of rural labour market dynamics, and (ii) findings from primary research.

Principle 1: Securing the supply of staff

This priority is about securing the staff that the health and care system needs to deliver high quality care in the future. It lies at the heart of this study. The Draft Workforce Strategy acknowledges that the NHS has always recruited staff from outside the UK, but emphasises that there is a need to maximise 'self-supply' from the UK.

Relevant features of rural labour market dynamics:

- *Demographics and population mobility*: rural areas tend to be characterised by an older than average population and by selective out-migration of the most academically gifted young people.
- *Employment and unemployment rates*: in aggregate there are higher than average employment rates and lower than average unemployment rates in rural than in urban areas. This suggests that here is a 'seller's market' for labour at the time of writing (in Summer 2018).
- *Quantity of labour*: a limited labour pool in rural areas means that there is a smaller potential workforce on which to draw; this feature is exacerbated in remote locations.
- *Skills*: a situation of 'low skills equilibrium' (where there is a relatively low supply and demand for skills) has negative implications for expectations about skills acquisition and progression.
- *International migrants*: have become an increasingly important source of labour supply in rural areas over the last fifteen years, so enhancing vulnerability to changes in migrant flows and in immigration rules.
- *A challenging market place*: taken together these features mean that securing the supply of labour and workforce development issues are challenging in rural areas. This means it is necessary to address the question of 'how best to shift the employment model' to best meet the needs of residents and (potential) workers.

Key points from primary research:

- *Variations between rural areas*: rural areas are heterogeneous – geographically and socioeconomically, and their attractiveness for rural living varies. The precise complexion of labour supply circumstances varies between rural areas.
- *Recruitment and retention*: recruitment poses a greater challenge than retention in many (but not all) rural areas. Achieving an optimal balance between mobility and immobility is important – some churn is valuable in stimulating new ideas, but too much churn is problematic. A segmented approach to recruitment is needed to focus on what makes rural areas attractive to different groups. An 'earn, learn and return' approach to attracting workers from outside the UK for a fixed period is one means of addressing the recruitment challenge.
- *Features of rural labour markets*: recruitment and retention policies need to take account of the demographic characteristics of rural labour markets, notably disproportionate outmigration of young adults and in-migration of families and older adults. Relatively high employment rates and low rates of unemployment and economic inactivity (in aggregate) place a premium on widening participation and inclusive modern model employers. It is necessary to work in partnership across policy domains (e.g. transport, the voluntary sector) to help address workforce issues in rural areas. There is scope to address challenges posed by 'thin' (as opposed to 'thick') labour markets in rural areas by highlighting the opportunities for individual empowerment and the varied roles in the NHS. Advantage can also be taken of the opportunity to capitalise on the status and attractiveness of the NHS as a large employer in rural areas.

- *Trade-offs in addressing key dilemmas in service level provision and workforce implications*: rural (and urban) residents tend to want high quality locally accessible services. Resource constraints mean that it is not possible to provide fully-staffed specialist services in all locations. Rather there is a pyramid of services with fully-staffed specialist services in central (generally major urban) locations. This means major urban locations are attractive to staff who wish to advance their careers through access to a range of high level specialist roles. Ensuring rural residents can access a range of general services locally and take advantage of specialist services at central locations as required in order to provide the best health and care outcomes is crucial.
- *Enhancing attractiveness is important in addressing workforce issues*: from a non-work viewpoint there is scope to market the attributes of rural areas as places to live, while from a work perspective creating and sustaining 'centres of excellence' in particular specialisms is a possible way of attracting and retaining staff in rural areas, while at the same time also promoting 'expert generalist' roles.

Principle 2: Enabling a flexible and adaptable workforce through our investment in educating and training new and current staff.

This priority is about the scope to blend clinical responsibilities in an environment which is rewarding to staff and provides the NHS with more choices about how it delivers services.

Relevant features of rural labour market dynamics:

- *There are fewer NHS workers per head in rural areas than in urban areas, and training is more expensive to deliver in rural than in urban areas*: so generating particular challenges for skills development in rural areas.
- *A greater emphasis on informal training* as opposed to formal training is evident in rural areas vis-à-vis urban areas.
- *Rural areas are more likely to either do nothing in response to hard-to-fill vacancies or to innovate or redefine existing jobs*: so raising the question of whether rural areas are, or can be in the vanguard of job redesign in the NHS and social care? This suggests a need for encouragement of different ways of 'innovating out' of current challenges in staffing of health and care services in rural areas – for example, working closely with volunteers.

Key points from primary research:

- *Public attitudes*: were reported as constraining the acceptance of flexible and innovative working practices and new models of delivery in rural areas.
- *Sparsity can stimulate innovation:* generating radical approaches to challenges of service delivery in rural areas (e.g. rotating workforces, getting the community and voluntary sector and local people more involved in health and social care delivery).
- *Technology can be an enabler:* in roles being performed more flexibly and insightfully, with examples including E-medical applications which reduce the number of face-to-face interactions between patients and health professionals and use of technologies to enable individuals to live independently at home.

- *Urban bias:* is apparent in the application of the universal service and standards approach of the NHS; a one-size-fits-all tendency tends to disadvantage rural areas, which is manifest in a lack of training and learning environments in rural areas, increasingly challenging vacancy levels for rural GPs and other roles.
- *House prices in some rural areas:* serve to limit the pool of available workers with a knock on effect for workforce flexibility.

Principle 3: Providing broad pathways for career in the NHS.

This priority is about enabling staff to contribute more (and earn more) by developing their skills and experience through structured progression opportunities within and between professions, so enhancing retention and helping the NHS become the employer of choice.

Relevant features of rural labour market dynamics:

- *A smaller quantity and reduced range and scope of job opportunities in rural areas constrains career opportunities in-situ relative to urban areas* and this has implications for providing broad pathways for structured progression and opportunities for specialisation.
- *In the absence of relatively few large employers in rural areas* those that do exist have a potential advantage of providing a greater range of opportunities in their internal labour market, but progression opportunities need to be visible to employees.
- *In rural and urban areas alike there is a need to think of workforce development in terms of an employment pathway* – from employment entry to in-work progression – with training and support along the way.

Key points from primary research:

- *Grow your own ('get on') approaches*: mean finding ways to recruit, develop, cultivate and retain individuals from the local community to enter healthcare careers to help provide a long-term solution to addressing workforce challenges.
- *Health and care careers need to be conceptualised in terms of a 'climbing frame' rather than a 'ladder' ('get on', 'go further')*: because in practice a health career could include side-steps, changes in direction, entry into related or new specialisms and roles and working for longer.
- *Confident "expert generalists":* are needed in rural areas. Indeed, rural locations may be particularly attractive for those individuals who prefer to pursue such roles and there is scope to promote rural areas as such.

Principle 4: Widening participation in NHS jobs so that people from all backgrounds have the opportunity to contribute and benefit from public investment in our healthcare

This priority is about enabling staff to contribute more (and earn more) by developing their skills and experience through structured progression opportunities within and between professions, so enhancing retention and helping the NHS become the employer of choice.

Relevant features of rural labour market dynamics:

- *Rural areas tend to be less ethnically diverse than urban areas* so widening participation needs to pay particular attention to other dimensions such as gender and age, as well as ethnicity.
- *Developing existing roles/ creating new roles* - as in the case of Nursing Associates in the NHS - may be a particularly pertinent means for widening participation in rural areas.

Key points from primary research:

- *People with disabilities and long-term health conditions*: could undertake a range of roles in the NHS and social care in rural areas with appropriate adaptions and support.
- *The NHS is one organisation in rural areas that can support social mobility and provide a second chance for adults 'failed by the education system'*: and so there is an opportunity for the NHS to sponsor courses that develop adult basic skills and prepare individuals to apply for opportunities available.
- *The third sector can provide alternative routes into employment in health and social care:* which may be particularly appealing for some individuals and sub-groups.
- *Capturing the imagination of young people*: about the range of opportunities in the NHS is important and the need to start early with this means that there is an opportunity for rural NHS Trusts to work more closely with schools and careers services.

Principle 5: Ensuring the NHS and other employers in the system are inclusive modern model employers.

This principle is about employment models that sustain the values which drive health professionals every day whilst protecting against burnout, disillusionment or impossible choices between work and home. The Draft Workforce Strategy emphasises flexible working patterns, career structures and rewards that support staff now as well as changing expectations of all generations who work in the NHS.

Relevant features of rural labour market dynamics:

- *Recruitment to high level roles may be challenging in rural areas* because they are not perceived as being able to offer fulfilling and rewarding roles, with the full range of opportunities for specialisation – even within the larger urban centres.
- *Utilising all workers in dual career households resident in rural areas* is important; this might involve adjusting working times to fit in with non-work roles of individuals who can contribute to the workforce in rural areas but whose partners are working elsewhere part of the week.

In rural and urban areas alike:

- *Becoming an 'employer of choice'* where people want to work, with good employee engagement and shared values and goals, is important for recruitment and retention in contexts where staff resources are finite, but at the same time it is important that employees have values and behaviours that accord with those of the organisation.
- *Being an employer of choice involves providing opportunities for co-design* in order that staff are supported in their professional lives (job satisfaction) in ways that are beneficial to their wellbeing.

- *Providing quality work and opportunities for flexible working* are especially important in understanding career determinants across different generations and these determinants – and the ability to meet them – may be influenced (at least to some extent) by geographical location. However, it needs to be recognised that to some extent there is a trade-of between being employee-friendly and having sufficient staff available at certain times to fill a rota: the 'limits to flexibility' need to be acknowledged.
- *Comprehensive rewards and benefits* associated with large employers can make such workplaces particularly attractive in rural areas.

Key points from primary research:

- *Flexible career structures and working patterns*: take various forms including, for example, team-based rostering, recognising the expectations of different generations of workers.
- *Recognising and nurturing the significant social capital in the voluntary and community sector and local communities* is important for future health and care delivery.
- *Monetary rewards:* can play a role in targeted recruitment to specific roles (e.g. GPs).
- *For health and well-being of staff in rural areas*: building a team ethos across multiple sites rather individualistic silo based working can benefit personal well-being and professional development of staff.

Principle 6: Ensuring that service, financial and workforce planning are intertwined so that every significant policy change has workforce implications thought through and tested.

This principle is about maximising the impact of resources through alignment of services and workforce planning and spans many of the key points covered under previous principles.

This principle is *pertinent in both rural and urban labour markets*, but nuanced features of rural labour market dynamics of particular pertinence include:

- *A limited labour pool in rural areas*, exacerbated by remote location, reducing the range of talent available and the scope for career development and dynamic workforce planning.
- The *higher costs of delivering training in rural areas*, so reducing scope for maximising the use of resources.
- There is a particular issue of *how to provide broad pathways without losing workers from rural areas.*

Key points from primary research pertinent to the alignment of services and workforce planning to maximise the impact of resources:

- *The lack of a spatial component in workforce planning*: means that the generic characteristics of rural labour markets are not taken into account.
- *Local pragmatism:* means that in the absence of discrete strategic planning taking account of the importance of the spatial characteristics of different rural settings and circumstances there are local examples of 'bottom up' innovation and 'joining up' between health and care services.
- *The biggest single structural challenge* in terms of workforce and services alignment in rural areas is the significantly smaller number of NHS staff per head of population in rural areas.

- There is *scope for technology* (including for example, artificial intelligence, robotics, monitoring devices) to play a role in supporting health and care staff in rural (and urban) areas, especially in terms of monitoring and prevention. The primary research revealed limited emphasis on technology – especially where it would replace face-to-face care – but it is important that how technology can help staff and residents in performing different functions is important from both care and staff development perspectives. Where technology was mentioned in primary research the emphasis on urban areas tending to be prioritised for cutting edge investments.
- *Institutionally* the 'one size fits all' universal entitlement strategy of the NHS can have negative implications for the provision of adequate, but different, provision in rural areas.

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 taken into account 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.

Recommendations following from these findings and conclusions:

- *Introducing 'rural proofing'* into health service planning and delivery in rural areas. A recommended way of doing this would be to *introduce an additional 'spatial' component to Health Education England's (HEE) workforce planning STAR tool*.
- *Investing in disseminating good practice* and this could include developing *centres of excellence* in specific aspects of rural health and care delivery.
- *Adopting a more segmented approach to workforce recruitment, retention and development* based on a better understanding of the demographics of rural areas (e.g. age cohorts and sub-groups of the current and future workforce).
- *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.

Next Steps

The National Centre for Rural Health and Care (NCRHC) would like Health Education England to consider the findings of the research, and the development of an additional spatial dimension for the Star tool.

The NCRHC will seek to develop an evidence base on innovation and good practice in rural workforce planning. The NCRHC will act as a coordination point and provide a dissemination facility to share findings and practice.

A foresight study on rural demographic trends could inform long-term thinking, tools and techniques on the supply and demand of a rural health and care workforce.