NATIONAL CENTRE FOR RURAL HEALTH AND CARE


# APPG Rural Health & Care

Parliamentary Inquiry | February 2022

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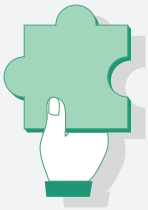



## Part Five: Recommendations

# Introduction

**The events of the last 18 months have led to a large number of people discovering the attraction of rural living and the lifestyle that it offers. Yet for the newcomers and part-time rural residents who have become full time converts, the realities (both good and bad) will have become very apparent. For many, the very idea that there could be a challenge, albeit a well-hidden one, in the appropriateness, adequacy and quality of health and care provision in such idyllic settings seems almost counter intuitive.**

Yet, the reality is it exists and without clear changes in policy direction and decision-making, the situation will move from urgent to critical. As the last 18 months has made clear, undiagnosed and unaddressed health conditions usually end up resulting in higher costs, poorer health outcomes, poorer economic opportunity and, in every sense, a poorer community. And it's an issue that impacts a lot of communities up and down the country.

This isn't a small issue either; 9.7 million people live in rural areas in England, many in very isolated, sparse hamlets and villages. This is less about a leafy part of the London commuter belt and more about a small cottage at the end of a track with no amenities for miles around. Residents are disproportionately older than average, with a higher number of comorbidities, each presenting a different challenge. Rural areas are also more likely to contain hidden areas of significant deprivation, masked in the way that statistics are recorded.

Part of the problem is what we actually mean by the term rural isn't defined particularly well. Currently it's defined as part of the 'rural-urban classification'. Whilst this is useful in that it does provide some level of data classification and is the go-to definition in policy making, the data is collected and reported on at too high a level of granularity, masking problem pockets. So, there is also an issue about data and measurement.

Another problem is a common view in the media that countryside dwellers live longer happier lives, which for a lot of people is entirely true. But the reality is that some residents, often with complex comorbidities, live lonely lives, all without the support that the economies of scale of the services provided to urban counterparts.

> **Levelling up must include health and social care in our rural communities - and the time is now.**

As a group of MPs and Lords representing a huge geographical and social patchwork of areas across the country, we see the reality of rural living and have chosen to lift the stone and shine the light on the problem, based on evidence with the aim of providing actual solutions rather than abstract slogans. This report has been a journey of discovery, hearing examples of good practice across 28 hours of evidence from 89 different witnesses from 8 countries, spread across 6 continents.

Change isn't necessarily easy, but change is required. The solutions are there, you just have to look for them, as we have done. We owe it to our rural communities to build a health and social care provision that para-matches their needs both now and looking to the future. If we are truly serious about 'levelling up' this must include health and social care in our rural communities. The time for change is now.

None of this would have been possible without Professor Richard Parish and the team at the National Centre for Rural Health and Care, based in Lincoln. But for a chance meeting in the House of Commons, with Richard, this report with all its richness and depth of evidence would not have happened. I would also like to take this opportunity to thank all of those who have contributed to this Inquiry, whether it be by giving evidence or providing support.

A meeting of minds and a determination to get this done has, I believe, enabled us to establish clearly what the problems are, what the challenges to resolving them are, and provided a route map to success with real life examples of how to achieve a fair deal for rural communities.

**Anne Marie Morris MP**
Chairman, APPG Rural Health and Care

# Foreword

**For too long people in rural and coastal areas have experienced poorer access to health and social care services than their counterparts in cities and towns. For many, the prospects of a healthy life are also worse, somewhat at odds with the perceived benefits of living the idyllic rural life. Almost 10 million people live in rural areas in England and they deserve better health and social care outcomes than is currently the case. This is not in any way a criticism of the staff or the hard-pressed system in which they work, far from it. They too deserve better.**

Policy-makers all too frequently underestimate the challenges of living in a rural area and the costs of ensuring that services are available equally to all citizens, irrespective of their location. This is in part because the way we collect data distorts the situation in rural and coastal communities. Rural residents often appear to be more affluent than is the case. The mechanisms we use to collect data, although reliable in urban circumstances, are inappropriate for more sparsely populated areas. Put simply, we just don't know enough about the health and wellbeing of people living in rural, remote and coastal settings, but we do know enough to show that all is not as it should be. That disadvantage and inequalities exist is indisputable. Unlike cities and major towns, however, where individual postcodes are associated with poor health and poverty, inequalities and disadvantage are hidden in more dispersed communities.

Moreover, coastal and rural economies are highly seasonal in nature. Tourism, the hospitality industry, agricultural production, and our fishing industry all influence the ebb and flow of rural and coastal populations. The influx of large numbers of visitors and migrant workers at certain times of the year leads to consequential peaks and troughs of demand upon the healthcare system.

When the NHS was launched in 1948, it was founded on three fundamental principles, namely.

- It should meet the needs of everyone.
- It should be free at the point of delivery.
- It should be based on clinical need, not ability to pay.

The more recent NHS Constitution is founded on the principle of equal access to health care. The Constitution states that the NHS is available to all and that it has a 'social duty to promote equality through the services it provides and to pay particular attention to groups or sections of society where improvements in health and life expectancy are not keeping pace with the rest of the population'. It emphasises that people should not be disadvantaged because of where they reside and that nobody should be excluded, discriminated against or left behind.

We acknowledge that it is often more difficult to provide services to dispersed populations or those living in more remote coastal communities. The 2021 Report on 'Health in Coastal Communities' from England's Chief Medical Officer, Professor Chris Whitty, identifies the challenges only too well and I endorse wholeheartedly his conclusions.

The provision of services generally in rural, remote and coastal areas is poorer than in more heavily populated parts of the country. Public transport is often a major impediment to accessing health and social care, not just for patients but also for staff travelling to work. Cars have become essential for most people living in sparsely populated communities. Many more households own a car than in urban areas. Ironically, vehicle ownership is often seen as a measure of affluence, rather than a necessity and cars owned in rural settings are on average older and less energy efficient. Similarly, housing is also more expensive (excluding London), often less well maintained and again less energy efficient. Poorer educational provision and facilities for young people, fewer day centres for those of more advanced years, lack lustre digital connectivity, poor housing stock, and economic uncertainty in agricultural and agrarian industries all influence the health and wellbeing of rural residents. It is not just access to healthcare that is compromised, but the very determinants of health itself.

In essence, rural residents are disadvantaged throughout the life-course compared to their urban counterparts. Access to maternity care is more problematical; the wider community services for children and young people are less accessible; primary and secondary care are less readily available for people of working age, including

preventative and screening services; and the provision of both health and social services for the growing proportion of older citizens is increasingly inadequate. We are not offering equal care for all in England, despite the commitment to do so.

It was against this backcloth that the National Centre for Rural Health and Care (NCRHC) was established in late 2018 to address these challenges. The Centre focusses on practical solutions. Supported by Rose Regeneration Ltd, a specialised rural development consultancy, the NCRHC agreed early in 2019 to work with the All Party Parliamentary Group (APPG) on Rural Health and Care, the intention being to conduct an extensive, research-based and solution-focussed Inquiry into the aforementioned challenges. This report is the result and is based on a multiplicity of evidence from across the United Kingdom and indeed worldwide. In carrying out its work the National Centre collaborates closely with a range of highly credible organisations, including the Rural Services Network (for local government), the NHS Confederation, the Nuffield Trust, and the national Rural Coalition, to name but a few. It has also received funding from two very committed organisations in its home base of Lincolnshire which have underpinned the resourcing for this work Lincolnshire Economic Action Partnership and the University of Lincoln.

I hope that this comprehensive Inquiry will stimulate real action. Numerous reports in recent years have emphasised the growing unmet health and care needs of the rural population. The average age is already higher than in urban and non-urban communities and this will increase significantly over the coming decades. We really cannot afford to delay any longer. We already know what the solutions should be and they cover the full panoply of economic, social and environmental sectors. As such, we need an overarching place-based rural strategy; a piecemeal approach will lack coherence and impact. The concept of 'Health in All Polices' was never needed more than in the rural context. Not only will the solutions be multisectoral, but so too will the benefits. Poor health may be a cost to society, but better health is an economic resource.

'Levelling-up' is not just about the north-south divide; the urban-rural divide must be tackled as well. The time for action is now. The Inquiry into Rural Health and Care provides solutions. A network of organisations stands ready to help, including the National Centre for Rural Health and Care. However, the unresolved question remains: Does the political will exist to capitalise on the opportunities presented in this Report?

**Professor Richard Parish CBE**
Executive Chair, National Centre for Rural Health and Care

# Our Twelve Recommendations For Change

## Build understanding of the distinctive health and care needs of rural areas

**Recommendation 1:**
Rurality and its infrastructure must be redefined to allow a better understanding of how it impinges on health outcomes

**Recommendation 2:**
Identify and measure drivers of health inequalities at a greater level of granularity (1000 head of population should be a denominator)

**Recommendation 3:**
Include specific rural content in every first degree in medicine, nursing and social care. Mandate rural work experience in every general practice course, every geriatrician course, every nursing course and every health care course

## Deliver services that are suited to the specific needs of rural places

**Recommendation 4:**
"Rural health" proof housing, transport and technology policy

**Recommendation 5:**
Develop a rural technology health and care strategy and platform

**Recommendation 6:**
Core health and care pathways for cancer, heart, stroke and emergency and mental health care must be urgently reviewed to better meet the rural need

## Develop a structural and regulatory framework that fosters rural adaptation and innovation

**Recommendation 7:**
Enable and empower local placed based flexibility in the ICS structure

**Recommendation 8:**
With the Royal Colleges and NHS England, review the match between the existing health and care professional structure and the skill needs of today to meet health and care demands with a view to creating a wider variety/diversity of health and care professionals with shorter training courses

**Recommendation 9:**
Hard-wire generalist skills training across the medical professions, in both core and update CPD training

## Develop integrated services that provide holistic, person-centred care

**Recommendation 10:**
Fund research into the nature, connectedness and integrated treatment of complex co-morbidities across primary, secondary health and social care

**Recommendation 11:**
Integrate health and social care budget setting in rural areas as a test pilot of the Health and Care Bill's ambition and measure combined health and care outcomes against that budget

**Recommendation 12:**
Empower the community and voluntary sector to own prevention and wellbeing

# Rationale

**The focus of this Inquiry has been to ensure that health and care will be accessible to all – regardless of whether someone lives in a rural or an urban area. The NHS 10-Year Plan and the Health and Care Bill have signalled clear intentions supporting this view when it comes to the future of health and social care. Likewise, the Defra report on rural proofing in England and the Lord's Committee report on the rural economy signal that ensuring accessibility to services in rural areas is worth taking seriously and provides benefits to the whole country, not just rural areas. But there remains a risk that people in rural communities – almost 10 million people – will continue to be overlooked and left behind in terms of health and social care provision.**

This report offers a suggested blueprint for change at a time when the opportunity to enact change, post-pandemic and through the Health and Care Bill, has never been greater. The evidence is there to show this change is needed; from the experience of individuals navigating the system to health and care sector leaders reporting on continued systemic disadvantage in rural areas.

Providing health and care services that are place-based and patient-focused for rural communities is not an optional extra, it is an absolute necessity. For too long, rural communities have been told that parity of accessibility is unrealistic and too costly. The reality of 'too costly' is that lives have been lost and diagnoses missed in rural communities due to lack of provision. Health and care staff in rural communities go above and beyond with the resources that they have, in a system that often works against them. The time for dithering is over: rural communities need better health and care, and they need it now. The Government has pledged to 'level up'. This must include rural communities and it must include health and social care.

When the issue of rural health provision has been raised with the Government over the last few years, the response has consistently been that their ambition is to ensure that all areas of the country receive the same level of quality and service provision from the NHS, irrespective of their location. In an ideal world this would indeed be the case; after all, parity of accessibility should be the foundation of any public-policy proposal.

The reality, however, is that we do not live in an ideal public-policy world and, therefore, this idea of identical level of service provision, irrespective of location, is both impossible to achieve and, arguably, not the correct direction to be going in. As this report will set out, the whole point of providing place-based, person-focused healthcare is the need to be part of a flexible system of provision that enables locally defined groups (be they Integrated Care Systems, Primary Care Networks or even local volunteering initiatives) to provide the health and care that is needed in their local community.

The generally accepted official metric in order to define rurality in Government policy making is the Rural-Urban Classification. Based on the latest figures from mid-2020, 9.7 million (17.1%) people lived in rural areas and 46.9 million (82.9%) were living in urban areas. In comparing population estimates at lower super output area (LSOA) level, there was an increase in the rural population from 9.1 million in 2011 to 9.7 million in 2020. As the figures indicate, our rural population is growing, and this increase has been given further impetus by the Covid-19 pandemic trend of people leaving urban settings to move to more rural areas.

The Government needs to take notice of how health services are maintained and provided for this growing population in rural areas.

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## Parity of access does not mean identical service provision

When it comes to rurality as a framing device, it is often primarily viewed in a geographical sense, with a simple contrast between rural and urban areas. Indeed, some dictionary definitions of rural still refer to 'underdevelopment', inferring that an absence of something is what makes a place rural. This type of framing ignores the fact that accessibility is not just about geography, it is also about equally important factors such as quality, availability and choice. And blunt rural versus urban contrasts overlook the range and variety of rural places and their needs: Mablethorpe, Malham and Moretonhampstead may all have 'rural' needs but they all also have different needs. As one witness succinctly put it, "If you have seen one rural place, then you have seen one rural place".

As this report highlights, whilst geography is clearly a primary factor that feeds into the other factors, there are some fantastic examples of where rural communities have adapted to work with the geography that they have to ensure there is availability and quality of service to suit the needs of their population.

It is important here to consider the wider placement of accessibility to rural health care in the wider and interlinked discussions and delivery of Government policy. For example, telehealth/e-consultations are a great way to reach those who, for whatever reason, are unable to travel to a GP surgery. However, this relies on there being a stable phone signal or broadband connection in order to hold the call. The fact that the London Underground is likely to see 4G connectivity before some rural communities is a clear example of rural communities being left behind. Similarly, rural transport networks (or lack of them) have been another barrier to healthcare accessibility. The Government has made its mission to 'level up' the country and this is a clear example of where this needs to happen. For all the talk of 'north' vs 'south', there is arguably a far greater need to level up 'rural' areas in order to achieve parity of accessibility in the broadest sense. After all, accessibility is about adaptation not limitations.

It would be impossible to publish a report on any policy area and not mention funding. The funding of health and social care is complex, fragmented and an incredibly divisive issue. How much funding each area receives, from whom and how it is spent are all questions on which there are a multitude of opinions.

Greater funding for health and social care is clearly needed, but there remain questions as to whether the new Health and Social Care Levy, increasing the level of National Insurance paid by individuals, is the correct vehicle for this. For all the talk about fixing the mechanism by which we share the cost between state and individual, this is arguably the wrong priority. If we do not have a social care system that actually delivers, there is nothing to pay for, and there is nothing to debate about how we fund it. This is especially critical when it comes to the provision of health and social care services in rural areas. If individuals are being asked to increase their contribution to the state to pay for services, the very least they deserve is a clear improvement in service provision.

## Understanding distinctive rural health and care needs is vital

Our Inquiry shines a light on the lack of focus on rural needs in health and care policy and service design. This starts with a lack of appropriate information and data. Indices of deprivation aggregate a wide range of factors and do not place sufficient weight on issues that are particularly pertinent to rural health and care, such as distance from services and the proportion of older people in a locality.

Equally, there is insufficient knowledge of the issues that most affect rural communities' health and care: the disproportionate number of older people which leads to higher levels of need; the isolation and loneliness which can heighten mental health issues; the distance from services which means people in rural areas need to travel further to access treatment and have less access to specialist provision; the lack of affordable housing and the prevalence of older properties; and the cultural and attitudinal differences of rural communities which often lead to rural patients seeking medical help late.

It is also key to develop a workforce in health and care that has the right skills and staffing to meet rural needs. This means adapting recruitment and training to develop rural sensitive approaches so that people are recruited from rural areas and that training includes rural experience. It means developing place-based solutions to workforce challenges which understand local community needs. And a key factor is finding ways to overcome the instability in the care sector workforce to meet the needs of rural communities.

## Opportunity to learn

The Inquiry has had the opportunity to learn from a range of innovative rural health and care projects, which are helping to shape national policy approaches. These have included ways to deliver integrated, holistic support through new blended professional roles; approaches to include rural experience in the medical training of GPs; and community micro-enterprise models which are helping to redefine care provision.

As with any public-policy making, it is also useful to see if lessons can be taken from other countries around the world in order to improve systems and service delivery here in England. The inquiry was fortunate to be able to hold evidence sessions focused on international perspectives from across the globe. Interestingly, there is no universal standard for delineating rural and urban and every country will have a different approach to how they define rurality. A good example of this is the fact that, despite the vast difference in size, a smaller percentage of the Australian population lives in 'rural' areas compared to here in the UK.

## Why this matters

At its most basic level, the health care needs of rural communities have been side-lined for far too long. There is clear evidence that a change is required in how we provide a tailored, person-centred, community-based approach to providing health and care services in rural communities. The Government can no longer use the unachievable ambition of equal health provision, irrespective of location, to turn a blind eye to the present needs of rural communities. Any future approach needs to recognise how health is intricately linked with other policy areas such as housing and digital technology and any solution requires different layers of Government and local communities to work together in a place-based approach.

This can be achieved by focusing on how we design, commission and deliver health care in these areas at a place-based level whilst, at the same time, understanding that every rural place is different. Our rural communities deserve better health and care. This report shows how we can make this happen.


> There is clear evidence that a change is required in how we provide a tailored, person-centred, community-based approach to providing health and care services in rural communities.

# Part One: Distinctiveness

In this first part of the report, we examine what makes rural health and social care needs distinct from those in other parts of the country. We look at definitions of rurality and how these definitions affect provision.

Then, we consider the challenges of collecting data on rural health and social care and using this information to improve provision We consider both the differences and some of the commonalities between different rural places. The final, and largest, section of this part of the report then looks at the distinctive health and care needs in rural places.

# 1.1 What is ‘rural’?

## Section Summary

- Almost 10 million people live in rural areas in England and the total rural population continues to grow

**In defining what we mean by ‘rural’, key factors to consider include:**

- The Rural Urban Classification is used for a wide range of analysis and policy development but should not be used as a blunt statistical tool
- In rural areas, the scale, standards, regulations and approaches of health and care provision often need to be adapted to best meet needs
- There is no single, clear definition of rural to inform health and social care provision. This lack of clarity makes it harder to ensure that urban systems of provision are adapted to meet rural needs.

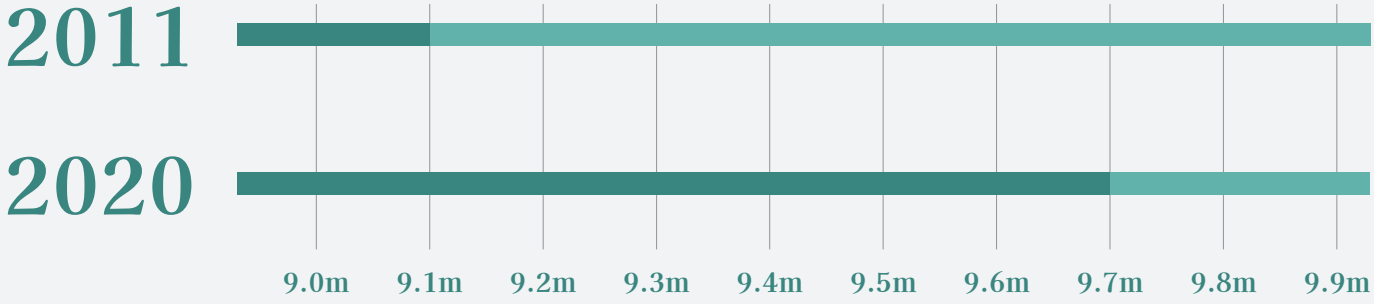
## Almost 10 million people live in rural areas in England and the total rural population continues to grow

The population living in rural areas of England increased from 9.1 million to 9.7 million (17.1% of England’s total population) between 2011 and 2020, as set out in Defra’s Statistical Digest of Rural England:

“In 2020, the mid-year population estimate (based on lower super output areas, LSOAs) for England was 56.6 million, of which 9.7 million (17.1 per cent) lived in rural areas and 46.9 million (82.9 per cent) lived in urban areas... In comparing population estimates at LSOA level, there was an increase in the rural population from 9.1 million in 2011 to 9.7 million in 2020... Within rural areas, 0.5 million people lived in sparse settings in 2020.”

Statistical Digest of Rural England, September 2021

It should be noted that although the absolute population is growing, the Statistical Digest of Rural England states that the proportion of the population living in rural areas has fallen from 17.2 per cent to 17.1 per cent over the period 2011 to 2020, as the urban population has increased at a faster rate.




**The population living in rural areas of England increased from 9.1 million to 9.7 million between 2011 and 2020, as set out in Defra's Statistical Digest of Rural England**

## The Rural Urban Classification is used for a wide range of analysis and policy development, but should not be used as a blunt statistical tool

The Rural Urban Classification, an official statistic developed in 2011, is used to distinguish rural and urban areas. The Classification defines areas as rural if they fall outside of settlements with more than 10,000 resident population. The Classification is based upon a six-fold grouping: (1) major urban, (2) large urban, (3) other urban, (4) significant rural, (5) rural 50 and (6) rural 80. These groupings are then aggregated into three categories: (i) predominantly urban, (ii) significant rural and (iii) predominantly rural. In 2014, the University of Sheffield carried out further analysis to identify hub towns, 'settlements of between 10,000 and 30,000 resident population that have an enduring though not unchanging role as a service hub of some sort for their rural hinterland.'

In his evidence to the inquiry, Stephen Hall (Head of Statistics, Rural Policy Team, Department for Environment, Food & Rural Affairs) outlined how the Rural Urban Classification is used by the Department to undertake statistical analysis.

**This includes:**

- The Statistical Digest of Rural England: a compendium of rural urban statistics on a wide range of social and economic Government policy areas. This includes a chapter on 'health and wellbeing', with data presented on life expectancy, potential years of life lost (PYLL), infant mortality rate and wellbeing.
- The rural economic bulletin: a 'dashboard' of indicators designed to provide evidence on the rural economy. This includes additional analysis to show impacts of COVID-19 on claimant counts.
- Defra is a publisher on the Data.Gov.UK platform – this includes hundreds of Department specific datasets.
- Outside of Defra, Mr Hall noted how the Classification is used to inform analysis by a number of Departments and in particular by the Office for National Statistics (ONS) for use with the Census. However Departments are free to use this or other classifications for policy, funding and analytical purposes as they see fit.

A methodology note describes the importance of the Classification for the identification and characterisation of physical settlements and the context in which they are found. This highlights the significance of the Classification to policy because 'it might indicate the costs of delivering key services such as health.' However, in his evidence Mr Hall underlined how the Classification provides both a useful starting point but should not be used as a blunt statistical tool without context. Witness testimony from Professor (Emeritus) John Shepherd (Birkbeck College, University of London) described how "the link between data interpretation [the Classification] and policy development is often rather weak in the way it is used by many agencies".

## In rural areas, the scale, standards, regulations and approaches of health and care provision often need to be adapted to best meet needs

Within health, the Advisory Committee on Resource Allocation (ACRA) is an independent committee that 'makes recommendations on the preferred, relative, geographical distribution of resources for health services.' ACRA provides information and advice to both the Secretary of State and the Chief Executive of NHS England on the 'weighted capitation formulae' which sets target shares of the national budgets for local areas. ACRA uses the technical term 'unavoidable smallness due to remoteness' to apply to hospitals which serve a population of under 200,000 people [the minimum population required to achieve economies of scale]; and for these hospitals, the proportion of the population they serve for whom the next nearest hospital is more than 60 minutes driving time away [the maximum travel time for clinical safety reasons for emergency care].

**The evidence received by the Inquiry frequently drew attention to the following definitional issues:**

**Scale:** Darren Catell (Director of Finance, Isle of Wight NHS Trust) described scale as a big issue, exacerbated by geography, demographic, economic and deprivation challenges: "geographical dispersion means district nurses spend an inordinate amount of time on inefficient travel. Transport options mean sometimes the Trust needs to deploy a specialist transport supplement. There is no recognition of this within national tariff funding".

**Standards:** Dr Ed Smith (Chair - Service Design and Configuration Committee, Royal College of Emergency Medicine) explained how clinicians delivering health services in rural places are held to the same set of standards as everywhere else which are often based on urban mentalities. The Care Quality Commission standards, for example, do not recognise how hospitals are surrounded by rural populations with health needs. The definitions and standards should not necessarily be the focus suggested Dr Smith, instead the focus should be on measuring the outcomes not the process - with the aim of having the same or better outcomes for rural patients, sometimes delivered differently. Dr Smith expressed how "there is a danger that in setting alternate targets and standards for rural places it looks to the outside observer that you are unable to manage the national standards that cause anxiety amongst clinicians".

**Regulation:** how regulatory bodies work in a national pattern of delivery where rural issues are atypical.

**Efficiency:** Keith Tolley (Health Economist) implied that while a one size fits all model may be good for efficiency (i.e., is the most cost-effective thing to do to maximise health outcomes in a population), for rural places this is not the same – smaller, more patient focused interventions may cost more but it is the price of equity against efficiency.

> "There is a danger that in setting alternate targets and standards for rural places it looks to the outside observer that you are unable to manage the national standards that cause anxiety amongst clinicians"

## There is no single, clear definition of rural to inform health and social care provision; this lack of clarity makes it harder to ensure that urban systems of provision are adapted to rural needs

From witness testimony and evidence submitted to the Inquiry, there is no single or clear definition of rural in guidelines or statute to inform health policy, decision making and funding. We consistently heard from witnesses how the planning model is based on an urban mentality – and that recognising place and locality need to be seen as important dynamics. Professor Helen Stokes-Lampard (Chair of the Academy of Royal Colleges) described how rural "is such a wide, fuzzy space that it needs nailing down so it can be understood and there are objective and subjective strands to this. Should you expect the same standards of care in rural areas – equity, quality, fairness – and we cannot achieve the standards in remote places so they want to close them down and that worsens other inequalities. We need a public discussion about what we should expect in rural".

This point was echoed in the international evidence we received too – with Professor James Rourke (Co-chair Rural Road Map Implementation Committee, Society of Rural Physicians of Canada & Professor Emeritus & Former Dean of Medicine, Memorial University of Newfoundland) illuminating how the urban system does not work in rural areas and we need to look at access and equity. Professor Roger Strasser AM (Professor of Rural Health, The University of Waikato - New Zealand) suggested what people think is rural is a mindset rather than geographic distance or population size. Richard Murray (The King's Fund) queried "if other national models can run smaller units of care rather than massive hospitals then it is perfectly reasonable to ask why not here?"

Professor Martin Green (Chief Executive, Care England) identified that such "structural discussions can divert us from concentrating on people and their needs". The establishment of Primary Care Networks was viewed by Dr Alex Degan (Medical Director for Primary Care, NHS Devon CCG) as "providing a useful systems development for enthusing people at local levels. They are re-balancing a feeling of strategic disempowerment". Simon How (Health and Wellbeing Programme Leader, Public Health England ) also queried if Primary Care Networks could be a solution to overcoming the challenge of rural areas being neither too large nor too small to merit special attention and understanding. In response, Dr John Wynn-Jones (Working Party on Rural Practice, World Organisation for Family Doctors [Wonca]; Senior Lecturer in Rural and Global Health, Keele Medical School) suggested PCNs with mixed urban and rural places will be the real challenge.

# 1.2 What data do [or don't] we collect about health in rural places?

## Section Summary

**Collecting information on health and social care in rural places comes with a range of key challenges:**

- Indicators measuring largely positive health, wealth and wellbeing of rural communities can mask pockets of significant deprivation and poor health outcomes
- The challenges of rural data collection include small sample sizes and the way aggregated indices can mask the specific issues of rural communities
- Evidence-based policy making relies on data collection, but interpretation and understanding of this data is equally important
- It is important to apply a rural lens to data that is already collected, rather than to try to develop completely new ways of identifying rural health inequalities


36% of rural dwellers are on state sponsored health insurance programmes.

## Indicators measuring largely positive health, wealth and wellbeing of rural communities can mask pockets of significant deprivation and poor health outcomes

**Multiple witnesses cited the joint Public Health England (PHE) and Local Government Association (LGA) 'Health and Wellbeing in Rural Areas' case study report. This unpicks a widespread belief that people living in rural places are better off, both in monetary terms and in terms of health and wellbeing, compared to people living in towns and cities. The case study report was prepared against a backdrop of a growing realisation (by national and local government) that broad-brush indicators measuring largely positive health, wealth and wellbeing of rural communities can mask pockets of significant deprivation and poor health outcomes. Evidence collected throughout the Inquiry has sought to illuminate how and why to address the statistical gap in information collected about rural places.**

George Coxon (a care home owner in Devon) described how deprivation leads to discrepancies in life expectancy in a number of rural places in Devon, while those with superficial knowledge of the county assume it is an affluent area.

Darren Catell (Isle of Wight NHS Trust) described how hidden pockets of deprivation are masked by broader data and drive up costs. These issues have been set out in research for the Isle of Wight Council by the University of Portsmouth which explored geographical isolation in respect of mainland authorities (Cornwall, for example) which are similarly isolated, yet benefitting from spill over from neighbouring counties and direct funding from central government with regards to the road network. Issues of deprivation and benefit dependency are not unique to the Isle of Wight but clearly add to the pressure on the provision of public service delivery. Research by the Institute of Fiscal Studies into the way COVID-19 is affecting health, jobs and families across England singled out two areas as being the most vulnerable: Torbay and the Isle of Wight. Many coastal towns have older populations vulnerable to COVID-19 and a lot of low-paid work in the hospitality sector. Many are already deprived, and it has been suggested that COVID-19 could exacerbate this.

Evidence from international witnesses also bore out how in making assumptions that rural residents are wealthier and healthier can mask health inequalities. Alan Morgan (Chief Executive Officer, National Rural Health Association, Washington DC, United States) described how 20% of older people in rural areas are on the Federal Medicare insurance programme and 16% of those on the lowest income are on the State Medicaid programme. This means 36% of rural dwellers are on state sponsored health insurance programmes (excluding veteran care patients or the Indian Health Service for tribal and indigenous populations). Patients in rural areas are older, sicker and poorer compared to their urban counterparts. Professor Ian Couper (Director of the Ukwanda Centre for Rural Health, Department of Global Health, Stellenbosch University, Cape Town, South Africa) reflected on his experiences in South Africa where approximately 20% of the population have private health cover and soak up about 80% of the resources.

**The challenges of rural data collection include small sample sizes and the way aggregated indices can mask the specific issues of rural communities**

Back in 2011 the Scottish Government, Local Authorities and Community Planning Partnerships published a position statement to improve the identification of poverty, income inequality and deprivation in rural Scotland. Under the heading 'our rural numbers are not enough', the statement called for an exploration of differences within rural Scotland rather than risk oversimplification by only providing rural data for Scotland as a whole. The inadequacy of sample size or sampling approaches which means a representative Scottish rural sample is not always attainable and a wider issue around using data as a proxy for rural need and the under-utilisation of what we already have were also raised.

Dr Rashmi Shukla (Regional Director Midlands & East, Public Health England) described how rural-specific issues can be masked in current measures of deprivation and need: if we use existing data they are only available at a certain level of geography (e.g. the English Indices of Deprivation – commonly referred to as the Index of Multiple Deprivation [IMD] – are available at lower super output area level). It is the aggregation of statistics that masks deprivation. IMD is used by PHE to look at challenges within or between communities and to inform policy and practice in health and care. Yet not all the IMD indicators are relevant in rural areas – health outcomes in rural areas are normally, on average, better in rural areas; and housing, access to transport, distance to services (such as the local GP or dentist) can be more important in rural areas. Because IMD aggregates data it masks some rural deprivation.

**Evidence-based policy making relies on data collection, but interpretation and understanding of this data is equally important**

Professor John Shepherd (Birkbeck College) described the scale of the challenge needed to compile a robust rural evidence base: "managing rural data is a sophisticated process if we want to interpret information…the effective development and use of a robust evidence base is important. The use of data at a national level is too generalist. We either need central provision by a purpose built unit to enable the interpretation of rural data at meaningful geographical levels, or to develop the capability to understand rural data at the local level" Professor Shepherd's view resonates with the OECD Rural Policy Review which found England had adopted 'evidence based policy making' where quantitative data was favoured but not readily available at a local level for rural communities to access, understand and use.

Witnesses suggested defining rurality through a first layer (for statistical and data purposes) and a second layer (to take account of people's experiences, needs and issues at a local, place, level). Place became an important lens for the Inquiry. Professor Martin Green (Care England) discussed differences in rural places and people's expectations of the health care they would like to receive. Professor Shepherd indicated while all rural places face common issues (e.g. access to transport, digital exclusion) the demographic and public service delivery challenges may differ from place to place; with different challenges in sparse rural places compared to rural hub towns.

Ensuring health care delivery approaches are appropriate to localities was emphasised. Dr Billy Palmer (Senior Fellow in Health Policy, Nuffield Trust) reflected on how the issue of measurement works inadequately in terms of the allocation of funding. He explained that the key issue is making the distinctive case for addressing rural challenges in the allocation of funding.

> The inquiry findings unpick a widespread belief that people living in rural areas are better off…

## It is important to apply a rural lens to data that is already collected, rather than to try to develop completely new ways of identifying rural health inequalities

The current system of identifying health inequalities does not function adequately or equitably for rural residents. There are 37 indicators and 7 domains in the IMD. Witnesses queried whether some indicators may be more relevant to rural places than other. Jeremy Leggett (Policy Adviser, Action for Communities in Rural England [ACRE]) described how "the NHS Long Term Plan focus on higher health inequalities…[and] is based on an approach focused on concentration not dispersed areas. This will drive resources away from rural areas".

However, the importance of applying a rural lens to the data we already collect – rather than starting again – was seen as important by many of the witnesses who provided evidence. John Wynn-Jones (World Organisation of Family Doctors) drew attention to previous examples of rural proofing. He referenced the value of the Rural Proofing for Health Toolkit developed at the Institute of Rural Health in collaboration with the Countryside Agency and later the Commission for Rural Communities. He emphasised the importance of introducing the principle of Rural Proofing to health and care. The National Centre for Rural Health and Care and Rural England have recently completed the development of a new Rural Proofing for Health Toolkit.

Nigel Edwards (The Nuffield Trust) referenced PHE's Fingertips tool, the NHS Right Care Programme and the PHE Atlas of Variation: these do look at the burden of disease and life expectancy in rural areas linked to lower super output areas level. Mr Edwards said this would help us to "start to get a grip on whether a change in resource allocation is needed". We need to try to unpick the true costs of being in a rural area (e.g. transport, critical mass, hospital discharge). While Councillor Lee Chapman (Portfolio Holder for Adult Services, Health and Housing, Shropshire Council) highlighted how "a change from using the Index of Multiple Deprivation to the number of over 65s as a driver within the funding formula is really important".

Keith Tolley (Health Economist) indicated how we need to understand all of the determinants of health (e.g. how health links to housing, transport, the environment). Mr Tolley recommended using Patient Reported Outcome Measures (PROMs) to begin this process.

# 1.3 Not all rural places are the same

## Section Summary

- There are substantial differences between different rural places, and this often requires adapting health and social care approaches to a specific place
- But, on the other hand, there are also commonalities between rural places. Common place-based issues in rural communities include distance, the small scale of provision and, for coastal and island places, the impact of seasonality

> Bringing together housing, health and employment at the neighbourhood level based on a whole person approach

## There are substantial differences between different rural places, and this often requires adapting health and social care approaches to a specific place

Professor Roger Strasser (Waikato University, New Zealand) began his evidence to the Inquiry by describing how "if you have seen one rural place, then you have seen one rural place". This draws on rural definition work undertaken by the OECD which moves away from the definitions of the previous section – where rural is viewed as non-urban or a distinct variety of places (the six-fold categorisation) – to consider the functionality of different rural places.

What became clear through the Inquiry is how terms such as 'rural', 'coastal' or 'island' are not single entities. Evidence from Professor John Shepherd (Birkbeck College) illuminated how "in England, we have a rural urban system...overlain on this complex settlement pattern is the complexity of demographic change. There is evidence that younger families are moving into, in some senses, deep rural areas. Urban fringe is often an area where demographic change is outstripping public service provision. If you look at data on rural and urban places in terms of sectors of the economy and age groups, a nuanced understanding is required to grasp different needs. The one area of straightforward and generalisable difference between rural and urban places is to do with business productivity – this is interesting in terms of the relationship between health and business success in rural areas". Stephen Hall (Defra) also highlighted demographic trends in remote rural places – and an ageing population which is likely to increase and deepen over time.

Acknowledging how rural places differ from each other requires finding alternative ways of delivering health care in rural places. Tim Goodson (Chief Officer, Dorset Clinical Commissioning Group) shared how Dorset has adopted an approach around a natural community focus covering two Local Authority areas. For Dr Richard West (GP and Chair, Dispensing Doctors Association) a lack of population density means we need to think about a different model, which moves away from seeking to concentrate things in one area. This puts a focus, in part he suggests, on the importance of rural transport systems. And for Councillor Lee Chapman (Shropshire Council) "the Director of Public Health in Shropshire is looking to work on a place plan basis for strategic working across the Council. This will involve bringing together housing, health and employment at the neighbourhood level based on a whole person approach".

Richard Murray (CEO, The King's Fund) explained that by looking at localities and at a place level you can undertake smart design, which best matches resources to local circumstances. The key question to consider is: "what is beneath these big geographies - where are the most important decisions being taken?"

**Common place-based issues in rural communities include distance, the small scale of provision and, for coastal and island places, the impact of seasonality.**

Although individual rural places may be very different, the evidence received by the Inquiry frequently drew attention to the following common place-based issues:

**Distance:** Dr Alex Degan (NHS Devon CCG) highlighted how it is the distance between rural residents and providers that is the real issue. Social isolation, transport challenges and fuel poverty are all important dynamics and compound this. Similarly, workforce and the amount of travel time it takes them to see patients in rural places was underlined - moving clinicians between sites is challenging and expensive.

**Small scale of provision:** The Isle of Wight NHS Trust is an integrated trust covering mental health, community and ambulance services – this integration makes it unique nationally but Maggie Oldham (Chief Executive, Isle of Wight NHS Trust) described how "the joining up benefits of the current state of integration are attractive and there is a desire to retain them but it is very hard to maintain this when everything has to function at a very small scale". Ms Oldman highlighted how the Trust is only able to deploy 4-6 ambulances at any one time, and some of those are sent to the mainland to transfer patients. Similarly, the Trust has a special care baby unit and how "due to the small scale of demand on the island there are some days or even weeks with no babies in this facility".

**Seasonality (island and coastal places):** Darren Catell (Isle of Wight NHS Trust) described how the population swells, doubling with over 2.5 million visitors each year. Similarly, Katherine Nissen (Chief Executive, Cornwall Rural Community Charity) explained how Cornwall has an ageing demography and three hospital sites, which includes one acute centre and a significant travel time for some rural and coastal residents to access. "Cornwall is seen as a holiday destination and there is a real affluent/poor divide in the county...In summer months, the capacity of roads to take emergency or NHS service related transport is very challenged. The seasonal nature of work is also a common factor in many Cornish towns".

## The Big Picture in Cornwall

Katherine Nissen (Cornwall Rural Community Charity) gave a vignette of the perspective of a rural county in relation to wider determinants of health.

Ms Nissen identified that Cornwall is often seen as a holiday destination and there is a real wealth divide in the county. Cornwall has an ageing demography; it only has one hospital and significant travel times challenges for those accessing acute services. In the summer months the capacity of roads to take emergency or NHS service related transport is very challenged. The seasonal nature of work is also a common factor in many towns. Ms Nissen has some local intelligence that the tourism sector in some settings has been very badly affected for the longer term by the Covid pandemic.

There is a feeling in Cornwall that national policy makers don't understand the challenging mix of remoteness, deprivation and ill health, which characterizes a number of communities in Cornwall. Housing is a challenge in the county, in some inland places there is extensive poverty manifested around poor housing. Some significant parcels of land are owned by large estates, which provides a generational challenge for some families, who have a long term experience of variable investment and support by landlords. Cornwall also has distinctive fishing communities where debt is one of the key issues people face. This experience of debt then ripples out to health and social care agenda.

# 1.4 What are the distinctive health and care needs in rural places?

## Section Summary

**Although rural places are often very different, we have identified five common characteristics of rural health and care needs based on the evidence given by witnesses:**

A. Ageing population: rural areas have a disproportionate number of older people leading to higher levels of demand

B. Mental health: isolation and loneliness can heighten mental health issues in rural areas and there is also limited data available on rural mental health

C. Distance from services: people in rural areas need to travel further to access treatment and often have less access to specialist provision and to emergency services

D. Housing: issues in rural communities such as the cost of housing, prevalence of older properties, fuel poverty, older populations and living alone can increase vulnerability to poor health and chronic illness

E. Cultural and attitudinal differences, combined with remoteness from specialist provision, often lead to rural patients seeking medical help late; rural poverty and deprivation is linked to lack of confidence and aspiration

> The disproportionate number of older people living in rural places leads to differentially higher levels of demand.

## A. Ageing population: rural areas have a disproportionate number of older people leading to higher levels of demand

We have an ageing society but ageing is greater in rural areas (by 5.5 years) compared to urban areas. Ursula Bennion (Chief Executive of Trent and Dove Housing Association; Chair of the Rural Housing Alliance) described how rural England has a population ageing faster than the national average - by 2039 over half of rural residents will be over 65 years of age. George Bramley (University of Birmingham, City-REDI [Regional Economic Development Institute]) identified that one of the drivers of this trend is that rural areas are characterised by disproportionate out-migration of young adults and in-migration of families and older adults.

Professor Tahir Masud (President, British Geriatrics Society) highlighted the disproportionate number of older people living in rural places which leads to differentially higher levels of demand. Professor Masud described how only 14% of small hospital trusts have a dedicated frailty team. Dr Debbie Freake (Director of Integration, Northumbria Healthcare NHS Foundation Trust) explained how past a certain age some people move into rural towns as they find it easier to access services, particularly if they have complex comorbidities which can be more challenging to manage in rural places. Sue Bradley (Chief Officer, Age UK North Craven) cited Age UK's painful journeys report as providing a comprehensive overview of why getting to hospital appointments is a major issue for older people.

Research carried out by the Internal Longevity Centre (ILC) for Age UK found 1.45 million people over 65 years of age find it quite difficult or very difficult to get to a hospital. Cuts to bus services, long and uncomfortable transport journeys, and underfunding of community transport services were all cited as particular issues for rural places. Ms Bradley indicated that these issues are not picked up in hospital datasets. Dr Jane Hart (Rural Services Network/Rural England) indicated that there is significant hidden need in rural communities – with family members and carers 'filling the support gap'. Again no routine data is collected on informal carers in rural places.

Dr Gill Garden (Director of Clinical Skills, Lincoln Medical School, University of Lincoln) identified that there are particular pockets of deprivation linked to acute ill-health, often linked to older people migrating to the coast from urban settings. This view was further borne out by Maggie Oldham (Isle of Wight NHS Trust) and Katherine Nissen (Cornwall Rural Community Charity).

## B. Mental health: isolation and loneliness can heighten mental health issues in rural areas and there is also limited data available on rural mental health

The sparsity of population and community services in rural areas can lead to mental issues related to isolation and loneliness. The challenges around mental health in rural settings arising from loneliness were identified in terms of the experience of clients by Dr Debbie Freake (Northumbria Healthcare NHS Foundation Trust) and Jonathon Holmes (Senior Policy Analyst, Healthwatch England). The 'Health and Wellbeing in Rural Areas' case study report describes how social networks are breaking down with a consequent increase in social isolation and loneliness, especially among older people.

Jim Hume (Convenor, National Rural Mental Health Forum) identified the difficulties of obtaining quantitative and qualitative data on mental health in rural areas. In 2016 Support in Mind Scotland and Scotland's Rural College (SRUC) carried out a survey which asked people experiencing mental ill health what it is like living in rural Scotland. This revealed a strong desire to create ways for people to connect with one another before personal crises occur; that these connections need to be 'low level' in non-clinical and informal settings, through trusted people and networks; and that services need to be close to the place of need, designed to include mobile services and outreach. Similar to the evidence from Age UK on older people and ageing, in a mental health context too the need for an approach that recognises the significant stress of travelling to appointments for those with mental ill health was emphasised. The survey also found more work needs to be done to reduce stigma around talking about mental ill health so that people can start to improve their mental health at home and in their communities.

Professor Sheena Asthana (Director, Plymouth Institute of Health & Care Research [PIHR], University of Plymouth) identified that granularity is important in understanding rural mental health challenges: "the scale at which the data is collected makes it hard to pull out distinctive rural characteristics". Professor Asthana linked poor mental health and self-harm to negative factors in the early years, poverty and deprivation, isolation and dementia. The Health and Wellbeing in Rural Areas case study report, for example, found access to mental health services varies from area to area, and there is little statistical or other information about rural areas specifically, making it hard to assess access issues to these services.

Sue Bradley (Age UK North Craven) indicated how it is important to look at people who are self-medicating because they are struggling with their physical or mental health (e.g. alcohol consumption, comfort eating).

In some rural settings the Warwick-Edinburgh Wellbeing Scales is used to measure the personal progression and recovery of people suffering from poor mental health.

## C. Distance from services: people in rural areas need to travel further to access treatment and often have less access to specialist provision and to emergency services

The distribution of services and the availability of treatment facilities within localities is still perceived as a driver of distinctive rural health needs, leading to poorer health outcomes because of the need for rural dwellers to travel relatively long distances to access care.

Dr Simone Yule (Chair, North Dorset GP Locality) was one of many witnesses who identified distance from services as the defining characteristic of rural places. The high level theme in this context is the urban focus and concentration of services which predominates in our service delivery model and provides a significant barrier to rural people accessing services. In his view, travel distances lead to a lack of productivity. This along with poor IT connectivity can limit innovation. IT systems which don't integrate between different health and care providers are an institutional issue which sits alongside poor broadband and connectivity. Transport is a really large determinant of poor quality health provision.

Dr Ed Smith (Royal College of Emergency Medicine) explained that from his point of view we have moved beyond community hospitals and it is difficult to bring this model of care back because of staffing in rural areas and training and generalisation and in some senses clinicians don't have the skills anymore. Nurse practitioners supported by GPs in community hospitals have been withdrawn and in many cases the approach is now based on signposting and is risk averse – this reflects the changing context and governance in which people are working. Another factor militating against small district hospitals is the recognition that social care should happen close to where the patient lives and long convalescence isn't needed anymore.

Sparse settings also have an impact on access to health and care in relation to emergency services. Helen Ray (Chief Executive, North East Ambulance Service) explained that inevitably resources are pulled towards areas with high density populations to meet performance demands and targets. When an emergency occurs in a rural area, this can result in delays in the nearest resource arriving on the scene and the response times in rural areas are considerably longer than in urban areas. This is compounded in winter months when road conditions deteriorate significantly. To counterbalance this from a safety perspective NEAS do have a single point of contact at hospitals to discuss the needs and care for patients, they are trialling initiatives to improve care.

> “It is difficult to bring back older models of emergency care in rural areas because of staffing issues.”

## D. Housing: issues in rural communities such as the cost of housing, prevalence of older properties, fuel overty, older populations and living alone can increase vulnerability to poor health and chronic illness

**Ursula Bennion (Rural Housing Alliance) described the distinctive nature of the challenges in terms of housing in rural areas which condition the character of health and care needs in rural places:**

- It is more expensive to provide homes in rural England
- Rural areas suffer from poor broadband, which affects the use of technology to make rural dwellings more "liveable" and the desirability of rural places as communities to live in.

Ms Bennion also highlighted 'city flight' as a result of the Covid-19 pandemic, with the countryside now seen as a safe haven with an increasing number of people wanting to reside there. A survey of buyers and sellers registered with Savills in May 2020 found 51% of people in London were considering a move outside the city [compared to 42% for the same period of 2019] and 30% were more likely to consider a village or countryside location for their next move.

Councillor Lee Chapman (Shropshire Council) explained that as a large rural county, Shropshire faces a number of challenges relating to fuel poverty; possessing an older housing stock and a high number of properties off the mains gas supply. Poorly heated homes are known to cause increased mortality and poor health in older people; exacerbating chronic conditions, such as arthritis, respiratory diseases, and mental health; and indirectly impact upon quality of life through lack of income for adequate food, clothing and other basic provisions. Shropshire HeatSavers was formed in 2011 by Shropshire Council. It involves the Shropshire Council's private sector housing team, adult services team, and public health team; Age UK; and Marches Energy Agency, working in partnership to aid vulnerable and fuel-poor households. Building on this, Councillor Chapman outlined three data sets being collected by the Local Authority to predict vulnerability: houses below energy efficiency, residents over 65 years of age, and people living alone.


A survey of buyers and sellers registered with Savills in May 2020 found 51% of people in London were considering a move outside the city, compared to 42% for the same period of 2019

## E. Cultural and attitudinal differences, combined with emoteness from specialist provision, often lead to rural patients seeking medical help late; rural poverty and deprivation is linked to lack of confidence and aspiration

Dr Ed Smith (Royal College of Emergency Medicine) indicated how different attitudes to illness mean that often rural patients present late and have more acute support needs. Katherine Nissen (Cornwall Rural Community Charity [CRCC]) identified how this was a characteristic of some people employed in primary industrial settings. She explained that farmers and fishermen, both of whom represent distinctive working groups in Cornwall have particular needs which require more than just a standard approach. In fishing communities, CRCC has facilitated mobile doctor and dentist services working with the Fishermen's Mission. CRCC is also working with primary schools around the development of positive community messaging and lifestyles. She went on to explain that social determinants of population health in terms of disabilities and lifestyle choices are more common in coastal communities in many places in the UK.

Professor Tahir Masud (British Geriatrics Society) suggested older people in rural places often leave it late to seek support. Another issue is that these individuals are often remote from major hospitals with specialisms which makes their treatment more remote and demanding. This point was further amplified by Dr Debbie Freake (Northumbria Health Care Trust). Stephanie Berkeley (Manager, Farm Safety Foundation) described farmers as "by nature and culture reticent and less likely to seek help when experiencing poor mental health". .Ms Berkeley also explained how people with a link to agriculture account for 20% of workplace deaths in England. Agriculture accounts for 1% of the working population but 24% of all workplace deaths in Great Britain (HSE Fatal Injuries in Agriculture, Forestry and Fishing Report 2020/2021)

Dr Mark Spencer (GP and Lead, Healthier Fleetwood) explained how Fleetwood (a peninsula some 10 miles north of Blackpool) has poor transport links. 53% of residents live in the worst quintile of poverty compared to all neighbourhoods in England, and many residents lacking aspiration and low on confidence. Until recently the town had only 50% of its quota of GPs and it is 17 miles to the nearest A&E department. Healthier Fleetwood was inspired by Professor Sir Michael Marmot and his view that you should listen to residents in planning health – enabling residents rather than taking control away from them. The initiative empowers residents to take control of their own wellbeing and take an active role in the decisions that affect them.

### From the Perspective of a Rural GP

Dr Robert Lambourn (Rural Forum, Royal College of GPs) provided a cameo of how the distinctive characteristics of a rural population present themselves:

Rural GPs are typically required to respond to an older demographic arising from retired incomers especially when their health deteriorates as they age, often leading to the development of multiple morbidities. Dr Lambourn's practice in Wooler has highest morbidity for diabetes in Northumberland.

Patients in rural settings are more likely to be discharged early, counselling services by GPs and blood-taking are more frequent due to distance from services. Transfer to emergency care takes longer in relation to rural settings. Rural communities are often more close-knit with many individuals knowing each other, but this can create exacerbate problems associated with stigma and confidentiality, not least in relation to both mental and social health.

Rural patients are less likely to use A&E. Rural areas also have stigma and confidentiality issues, which affect patients in small communities where everyone knows each other seeking health support in relation to sensitive issues.

In terms of economics rural GPs need more equipment, have less opportunities for outside income, higher dependencies on prescribing to supplement their income, have higher

qualification thresholds for staff because of the variety of issues they encounter and find it very difficult to cover absences. They also have to have a wider breadth of expertise.

# Part Two: Landscape

In this part of the report, we consider the landscape in which the rural health and social care sector operates. First, we consider the organisational structures at a local, regional and national level that provide services. Then, we consider the different costs of providing services in rural areas. The largest section of this part of the report looks at the key role of the people delivering health and care services.

Finally, we look at broader external factors that are inter-related to the landscape of health and care provision.

# 2.1 The health and care needs of rural communities from a structural perspective

## Understanding the overall national structure of health and social care is important in interpreting the narratives arising from this inquiry

### Section Summary

The overall structure of health and social care provision in England comprises Government departments, national NDPBs and executive agencies, local clinical commissioning groups, primary care, NHS, local authority and independent provision, and STPs and ICSs working to improve and integrate services. Key issues for these structures in a rural context include:

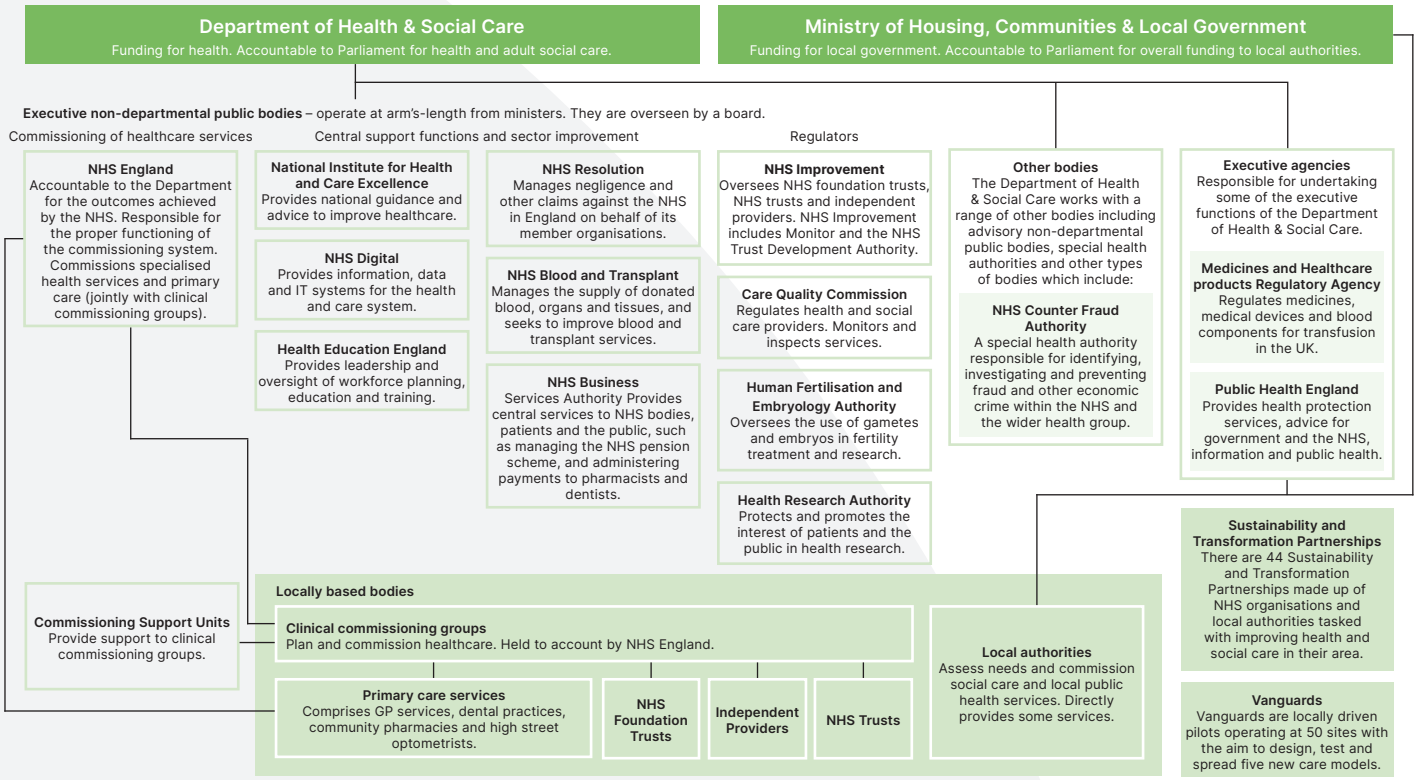
- **Integrated Care Systems (ICSs)** – there are challenges around the scale of ICSs and their ability to engage local people taking account of rural needs
- **Social care provision** – there is often less choice and higher costs for people in the care system in rural areas
- **Primary care** – rural GP practices should have scope for innovation and to play an active role in communities
- **Pharmacies** – a lack of pharmacies in rural areas is the driver for the Dispensing Doctor approach
- **Emergency Services** – there is no real recognition in contractual arrangements of additional costs of providing services in rural areas
- **National regulatory structures** – standardised national regulatory and funding structures can stifle rural adaptation of delivery

To fully understand the narratives arising from the Inquiry it is important to have a clear basis for interpreting the functionality of the NHS. A 2020 House of Commons Library Briefing Paper – "The Structure of the NHS in England" provides a very useful overview. The Department for Health & Social Care Departmental Overview 2019, which is the most contemporary summary of the current structures is set out below.

The overall structure comprises Government departments, national NDPBs and executive agencies, local clinical commissioning groups, primary care, NHS, local authority and independent provision, and STPs and ICSs working to improve and integrate services.

Current changes mean this diagram is being superceded with the realignment of some functions within the NHS such as those of Health Education England, it does however still provide a useful overall summary of the broad structure of the national health and care framework."


**Dr Alex Degan (NHS Devon CCG) drew attention to the new wide distribution of PCNs which will take some time to become fully established – there are 31 in Devon.**




## Integrated Care Systems (ICSs) – there are challenges around the scale of ICSs and their ability to engage local people taking account of rural needs

ICSs bring together local organisations to deliver the 'triple integration' of primary and specialist care, physical and mental health services, and health with social care. Challenges around the scale of ICS boundaries and the ability within them for local people to be properly engaged, taking account of distinctive rural settings and needs, was referenced by a number of speakers. Tim Goodson (Dorset CCG) expressed a view that the principle underpinning ICS geographies ought to be that an ICS should be big enough to be strategic but small enough to implement change. Mr Goodson identified an example of the challenge of integrated delivery in the form of the use of care records across delivery geographies in the care journey of individuals. This agenda is important in joining up the integration between service providers. It is hard to see how very large ICSs can achieve the joining up agenda in this and a number of other contexts. In his view, almost irrespective of rural/urban issues, the bigger discussion is about the pattern of investment between the acute sector and the primary sector. Primary Care Networks (PCNs) have made a useful systems start to driving change in this context. There is, however, likely to be a time lag before these benefits are fully realized. Dr Alex Degan (NHS Devon CCG) drew attention to the new wide distribution of PCNs which will take some time to become fully established – there are 31 in Devon. The standard NHSE contract involves a 30-50,000 population range for PCNs. In Devon the threshold has been lowered to 20,000 recognising the small scale of many localities.

Sheila Childerhouse (Chair, West Suffolk NHS Foundation Trust) identified an alliance working initiative in her West Suffolk footprint incorporating shared activities and better alignment of budgets through reaching out to social care. In her view, future legislation around joint working may be too prescriptive if it sets nationally uniform approaches to this issue, although it could unblock some of the more insuperable challenges through a centrally directed approach. Trust and confidence is really important as an underpinning for innovation in localities. Co-training is very important in the context of change (for example involving both NHS and social care staff). Premises (not just GP practices) are a key driver of new approaches, in Norfolk a really good example is the operation of the community hub in Aylsham.

In an international best practice contribution which resonates with this aspect of the evidence, Professor James Rourke (Memorial University of Newfoundland) identified that in Canada systems are seeking now to focus more directly on the patient. Rural health care is not accessed as frequently as urban health care. Equitable targets for care need to be established to drive planning. There is a view that there has been perhaps too much focus on rural doctors and not enough on developing integrated rural health care teams supported by regional networks of care. Recent rural doctor graduates are trained for and eager to work as members of integrated multi-professional teams and not as solo rural practitioners.  rather than other team aspects and focus around health and care which are important. As team members, nurse Nurse practitioners are becoming an a very important means of providing access to care and this can be further improved by telemedicine when it works well. He went on to indicate that where health care is delivered in rural settings it is very important to encourage Government to apply a rural lens to conceptualising the issues and developing policy.

### Social care provision– there is often less choice and higher costs for people in the care system in rural areas

In terms of structural arrangements for the delivery of health and care services in rural settings, Sue Bradley (Age UK North Craven) identified the lack of a joint agenda around health and care as an impediment. She went on to explain that the absence of a fresh policy for social care and the fact that we are still waiting for the Adult Social Care Green Paper is a challenge in terms of rural settings as key issues remain unaddressed. These relate to the disproportionately high number of care home residents per head of population in rural settings and the distance from service challenges facing rural communities in terms of acute care. Both these issues lead to less choice and higher costs for people in the care system in rural England.

Maggie Oldham (Isle of Wight NHS Trust) in relation to the point about the challenges of the split between health and care drew attention to the benefits of having structural linkages within one framework as a distinctive benefit of the arrangements driven by its island status on the Isle of Wight. On the island there is an integrated trust covering mental health, community and ambulance services.

More widely in relation to the provision of care services, a general picture of underfunding emerges. This is referenced in more detail in the next section of this report on the differential costs of providing services in rural areas. It is also a picture which is disconnected from wider health service planning in localities. George Coxon (Care Home Owner, Devon) identified that from his perspective decisions affecting service provision are often taken by policy makers who are too remote from local contexts. Mr Coxon identified that service provision had been enhanced by the development of the Devon Care kitemark a key aspect of which is about sharing learning. Devon has a large number of care homes (513 across the county) and a mixed economy in terms of care providers driven by its rural/coastal context.

### Primary Care – rural GP practices should have scope for innovation and to play an active role in communities

Dr Ian Hulme (BMA GP Committee) drew attention to the challenges in the current arrangements for the delivery of health care in relation to the GP perspective. From his viewpoint in terms of examples of best practice in system working, rural practice used to be the "jewel in the crown" of the NHS. We have some things to learn from this. 25 years ago practices were responsible for and had scope for innovation and were an active part of the community. Personal direction of flexible care based on a multi-health hub was possible in relation to primary care. Over the years this model has been eroded. Some of the challenges have been linked to historic under investment in primary care in relative terms. This is starting to be redressed but things are having to be rebuilt from a low base. Rural practice is not now attractive to new people coming through. Norfolk has 10% fewer GPs than required for example.

### Pharmacies – the driver for the Dispensing Doctor approach

Dr Richard West (Dispensing Doctors Association) drew attention to the challenges of pharmacy in rural settings. He drew attention to the fact that the Pharmacy contract has changed recently. From his perspective this brings with it some positives around wider pharmacy. Dr West posed the question: is there scope to reverse some of the proposed changes to the role of pharmacists into GP practices? He identified the prescriptive approach to the training of pharmacists as being unhelpful. The opportunity to train staff in GP practices could be a real positive.

> The regulatory regime for medical devices currently provides a series of challenges for businesses seeking to bring forward new meditech applications


**Rural practice is not now attractive to new people coming through. Norfolk has 10% fewer GPs than required.**

### Emergency Services – there is no real recognition in contractual arrangements of additional costs of providing services in rural areas

Rural issues also provide a distinctive service delivery challenge in relation to emergency services. Helen Ray (North East Ambulance Service [NEAS]) identified in relation to her contractual arrangements how there is no real recognition of the additional cost of providing services in rural settings. NEAS has a block contract, with a conveyance penalty/incentive targeted at reducing conveyance to emergency destinations. A divert provision is also in place to support the ambulance handover issues. Both of these have been suspended during the Coronavirus pandemic and will probably be areas of negotiation in the upcoming contract round of financial settlement. The funding basis for the NEAS contract is the ORH review process (ORH is the name of a private business contracted to support and evaluate the operation of emergency services) which sets challenging efficiencies for the organization, some of which are unrealistic for the lowest funded, lowest cost ambulance service in England.

Also, this is not consistent with acute providers who operate on an average cost basis via the national tariff. The current contract also applies national tariff efficiency as well as applying efficiency to fund the investment in the service (i.e. the additional funding provided comes from efficiencies which the service is expected to make). Simply put, the tariff efficiency pays for the CCG QIPP, the service efficiencies pay for the service investment required. There is no significant rural consideration in any of these arrangements.

### National regulatory structures can stifle rural adaptation of delivery

Across different types of health and care provision, a number of examples of the constraining impact of the regulatory structures associated with national delivery models were raised by witnesses. Sian Lockwood (Executive, Community Catalysts) drew attention to the challenging impact of Care Quality Commission regulation on the creation of small micro-care businesses. Mr Robin Batchelor (Care Software Providers Association [CASPA]) identified that the regulatory regime for medical devices currently provides a series of challenges for businesses seeking to bring forward new medi-tech applications. Helen Ray (North East Ambulance Service) identified that the response time regime and funding arrangements for ambulance services did not take account of the challenges of working in a rural milieu. Sir Tom Hughes-Hallett (Founder, Helpforce; former Chair of Marie Curie; former Chair of Chelsea & Westminster Hospital Foundation Trust) identified that regulation and a potentially rigid application of standards was the biggest challenge to the effective deployment of volunteers in health settings. Dr Krishna Kasaraneni (GP Executive Team, Workforce Lead, British Medical Association) explained that pension regulations have impacted on GP retention – they provide a disincentive for people to stay in practice generally. Denise Thiruchelvam (Director of Nursing and Quality in Surrey, representing the Royal College of Nursing) identified how flexible approaches to paying nurses in rural settings don't extend to the way mileage payments operate which are governed by national policy. The rates drop significantly after 10,000 miles. Dr John Wynn-Jones (World Organisation of Family Doctors) along with a number of other witnesses identified how the current arrangements for GP training and accreditation militate against local discretion and innovation.

# 2.2 The different / extra costs of providing health and care in rural areas

## Section Summary

The inquiry heard from a range of witnesses about the issues relating to the funding of health and care in rural areas. These covered the issues facing emergency services, hospital trusts and, in particular, social care provision:

- **Emergency services** – funding formulas do not properly reflect the impact of rurality on service delivery costs
- **Hospital trusts** – just six rural hospital trusts carry a quarter of England's health service funding deficit, with rural area funding adjustments being outweighed by other factors
- **Social care** – the costs of funding adult social care are an issue nationally, but rural local authorities often spend a disproportionately high part of their budget on these services
- **Innovation** in integrated service delivery and use of technology offer ways to mitigate the burden of adult social care costs, but overall demand and costs are still rising
- **Island and coastal communities** funding formulas do not reflect the particular circumstances and costs of service provision in these settings

## Emergency services – funding formulas do not properly reflect the impact of rurality on service delivery costs

For Ambulance Trusts, Helen Ray (North East Ambulance Service) explained how many Trusts serve a significant rural population, where less frequent calls and more widely spaced incidents have an impact on their ability to meet response time standards, the length of their job cycle time and the cost of operating the service. Ambulance Trusts are funded by CCGs. While the funding formula includes an Emergency Ambulance Cost Adjustment (EACA) which is intended to reflect increased service costs in rural areas, if/how this additional funding is passed on varies across CCGs – with some using the EACA tariff and others working on a block budget basis.

Ms Ray explained how "it is unrealistic that patients in rural areas should expect the same level of urgent care in rural areas…we should aspire to the same level of service, but service pressures across the whole community and the realities of the economics of service provision mean that delivery and funding of equitable performance is unrealistic".

In respect of other blue light services, Lee Howell (Chief Fire Officer, Devon and Somerset Fire and Rescue Service) described how up until 2004 there were national standards for fire and rescue response times: 5 minutes for urban places and 20 minutes for rural places. This has shaped the location of fire stations and the funding formula. Response times are now set locally by the respective Fire Authority rather than at a national level. At the same time, demand for traditional fire services has reduced by 19% over the past 10 years with 28% of incidents now fire related, 43% false alarms, and 32% non-fire related incidents. Devon & Somerset Fire & Rescue provide a co-responding service whereby its 83 stations can be mobilised by the ambulance service.

> In terms of funding for his organisation the key issue is that the capitation formula, which is urban biased and mitigates against Cornwall

## Hospital trusts – just six rural hospital trusts carry a quarter of England's health service funding deficit, with rural area funding adjustments being outweighed by other factors

Dr Billy Palmer (The Nuffield Trust) provided evidence on the performance of hospital trusts in rural areas. He explained how, in 2015, ACRA analysed the potentially higher costs faced by hospitals which are 'unavoidably too small to achieve full economies of scale.' The analysis identified 12 hospitals which fitted the unavoidable smallness criteria: St Mary's Hospital (Isle of Wight), North Devon District Hospital (Barnstaple), Furness General Hospital (Barrow), West Cumberland Hospital (Whitehaven), Pilgrim Hospital (Boston), Hereford County Hospital (Hereford), Cumberland Infirmary (Carlisle), Scarborough General Hospital (Scarborough), Hexham General Hospital (Hexham), Dorset County Hospital (Dorchester), Royal Shrewsbury Hospital (Shrewsbury) and Friarage Hospital (Northallerton).

In 2018 the Nuffield Trust was commissioned by the National Centre for Rural Health and Care (NCRHC) to explore the impact of rurality and sparsity on the costs of delivering rural health care. This review looked at the key factors for calculating health allocations to local areas: with adjustments in funding made for population need, unmet need/inequalities, costs and financial stability. The key determinant here is population and demographic needs within a given area. A further adjustment is made for the higher costs of running hospitals with 24-hour A&E departments in remote areas. Funding from Clinical Commissioning Groups (CCGs) to rural areas adjusts for (i) the extra cost of ambulance provision and (ii) an allowance for remoteness. However, these two factors are outweighed by a further two factors (iii) market forces and (iv) health inequalities. The impact of iii and iv sees the total budget for core services move around £600 million of funding from predominantly rural areas to urban and less rural areas. Dr Palmer shared Nuffield's further analysis which revealed just six rural hospital trusts carry a quarter of England's health service's funding deficit.

Data provided to the Nuffield Trust by NHS Improvement suggests that, to November 2018, 17 trusts had applied for local modifications. Of these applications, the majority (11 applications) are for rurality (or sparsity/economies of scale); with the remainder consisting of rationale relating to case-mix complications (2), Private Finance Initiatives or estates (2), A&E services (2), and clinical negligence scheme costs (1). To date, only one trust, Morecambe Bay, has been successful in its request for formal compensation for higher costs due to rurality. Bob Seeley MP identified that the 20 MPs with populations served by unavoidably small hospitals could harness their common interest and help those Trusts to make a collective case around exceptional funding support.

Phil Confue (Lead for Strategy and Planning: Countywide Services and Chief Executive Officer, Cornwall Partnership NHS Foundation Trust; Programme Director, Cornwall and Isles of Scilly STP) explained that in terms of funding for his organisation the key issue is that the capitation formula, which is urban biased and mitigates against Cornwall. Weightings in the formula for Houses In Multiple Occupation, which have no prevalence in Cornwall, as an example, discriminate against the county. Assessments of health service productivity are also compromised by travel times but this is not recognized in the assessment of the effectiveness of service provision.

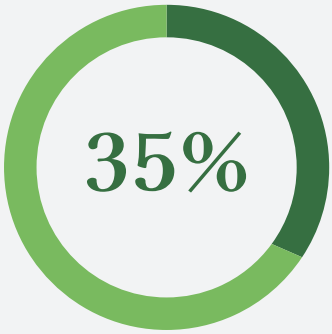
## Social care – the costs of funding adult social care are an issue nationally, but rural local authorities often spend a disproportionately high part of their budget on these services

Councillor Andrew Leadbetter (Cabinet Member for Adult Social Care and Health Services, Devon County Council) and Stephen Chandler (Director for Adult Social Services, Lead Commissioner for Adults and Health, Somerset County Council) both drew attention to the challenges around the funding of adult social care and the issues arising from the lack of a clear policy approach to the agenda. Mr Chandler identified that at the heart of the problems facing local government was a shortage of cash. He indicated that at a national level adult social care spends £700 million a year less than in 2010 according to the King's Fund. Pay rates of staff (nursing and adult domiciliary care) are lower in real terms that in 2010. He indicated that there is also a perception that working in a nursing home is not as important as working in an acute setting. However, the acuity of people in nursing homes and their own homes has significantly increased and so therefore have the demands on care staff.

Analysis undertaken for the Rural Services Network based on a survey of local authorities in 2018/19 identified that in a number of rural authorities, adult social care (ASC) spending is a disproportionate part of their overall budget: in North Yorkshire and Shropshire, ASC spending is over 40% of the overall budget; in Hampshire it is over 60%.

Councillor Lee Chapman (Shropshire Council) explained that in terms of the current funding formula the headline for the Council is that it is a rural area with an aged demographic and a low council tax base (challenged further by farming which is a huge local economic sector but doesn't contribute to business rates).

To date a 91 % reduction in Revenue Support Grant has been only in part ameliorated by the "hotch potch" approach of one-off funding streams. There is no longer a rolling funding plan from Government that enables the local authority to plan forward effectively. Shropshire is involved in the national policy work on the foundation formula which offers some hope of change. Councillor Chapman suggested that a change from the Index of Multiple Deprivation to a measure based on the number of over 65s within the funding formula would be really important.




**Councillor Chapman identified how good service management has enabled the Council to achieve a 35% reduction in adult social care costs.**

## Innovation in integrated service delivery and use of technology offer ways to mitigate the burden of adult social care costs, but overall demand and costs are still rising

Councillor Chapman identified how good service management has enabled the Council to achieve a 35% reduction in adult social care costs. The Council is head of class in terms of hospital discharge where an integrated team of nurse practitioners, occupational therapist and social workers operate together. Another example of innovation is the "two carers in a car" model. The Council know that their approach to managing care is effective.

The Council has harnessed an electronic process system for care referrals – this is sophisticated, and GIS mapped in terms of domiciliary care needs assessment and demand profiling. Notwithstanding this, costs in terms of adult social care in Shropshire are rising at £8million p.a – a 1% in council tax brings in £2million. The Council currently has a £35 million deficit in relation to adult social care. Radical solutions are the only way forward. These approaches need to consider the economics of the care market. Care is the largest economic sector in Shropshire.

In terms of international comparisons Dr Manabu Saito (Director, Rural Generalist Program [Japan] and Medical Director, Teuchi Clinic, Shimo-koshiki Island, Kagoshima, Japan) explained the Japanese model for paying for social care which involves contributions by people from the age 40 onwards as part of a national recognition of the challenges of paying for social care – in return a full social care service is available to individuals with Government meeting 90% of the cost from 65 onwards.

## Island and coastal communities funding formulas do not reflect the particular circumstances and costs of service provision in these settings

The Inquiry found that national delivery models and funding formulas are further complicated when applied to island and coastal settings. Darren Catell (Isle of Wight NHS Trust) indicated how the national funding formula, especially in terms of emergency services, means the Trust cannot cover its operational costs. "The long term strategy is to work with mainland partners to ensure clinical and financial viability. At a national level, financial allocation strategies require further refinement to recognise these cost drivers for atypical trusts like the Isle of Wight". Vaughan Thomas (Isle of Wight NHS Trust) identified island specific issues. These are based on the relatively small size of the Isle of Wight (in population terms compared to the mainland), which nonetheless still has the largest number of people of any island in the UK. This makes it difficult to provide services as it effectively falls between two stools, being neither so small as to just incorporate into a wider system with a locus outside the island but being too small to drive out economies of scale.

Maggie Oldham (Isle of Wight NHS Trust) gave two very powerful examples of the impact of isolation and small population thresholds on provision in remote coastal settings. One recent example of this has been the need to establish the special care baby unit, which has been downgraded from a neo-natal intensive care unit. Due to the small scale of demand on the island there are some days and even weeks with no babies in this facility. In some cases, this leads to the strange and distinctive challenge (in a traditionally hard-pressed national picture of the NHS) of how to motivate a workforce which might not even have a patient at certain times. Another example is the older people secure mental health ward, which currently has just four patients. Many services on the island are dependent on agency staff who face regular challenges in accessing it.

# 2.3 People: the key role of the health and care workforce

## Section Summary

The most substantial body of evidence from witnesses in relation to rural health and care relates to workforce issues. We have organised the evidence based around a sector-wide overview at the beginning of this section, followed by thematic areas of delivery. At the end of the section, we include a range of evidence from an international perspective:

**Rural health and care sector overview**
There are workforce challenges due to high demand but low supply in rural areas, with overall fewer NHS staff per head in rural areas. But there are opportunities too, based around promoting the variety of roles available, the attraction of rural areas to many health staff, and finding new ways to recruit both young people and people who want a 'second chance'

**General practice**
New thinking is required in recruitment and retention of rural GPs to meet staffing shortages, through, for example, choosing students from rural areas and ensuring students have early experience of rural settings. Greater emphasis on 'rural generalism', with rural GPs developing skills in a wider range of specialisms, alongside rural-proofing new approaches, could tackle current shortages and bring care closer to where people live. Multi-disciplinary working and the use of technology (so GPs do not have to be physically present to deliver all services) are key for delivery of rural general practice

**Nursing**
Although retention rates are better in rural areas, recruitment is harder than in urban areas; one distinctive rural issue is supporting the greater proportion of mature students. Ensuring parity of esteem between nursing in clinical and social care settings is key in rural areas, which have high demand on community and social care

**Social care**
Recruiting and retaining the required number of social care staff in rural areas is a key issue, with high demand, low wages, access to transport and high turnover all being major factors. Social care roles are perceived as the poor relation to other health and care sector roles and this clearly also has a major impact on recruitment. Providing clear career pathways and opportunities for continuing professional development is key in recruiting and retaining social care staff

**Volunteers**
There is potentially a large bank of volunteers willing to serve in rural settings. Voluntary organisations can often provide key support to the health and care sector, as well as driving innovation and new approaches. More widely, involving communities and patients in service delivery can also have a major impact on health outcomes

**International perspectives**
In countries around the world, there are challenges related to recruiting GPs to rural practices. Especially in developing world countries, roles such as physician associates and community health animateurs can help overcome shortages of fully-qualified clinical staff, as well as more fully involving local communities in health and care provision

## Rural health and care sector overview

**There are workforce challenges due to high demand but low supply in rural areas, with overall fewer NHS staff per head in rural areas**

George Bramley (University of Birmingham) gave a summary of the workforce challenges and opportunities facing rural England based on the analysis in the report "Rural Issues in Health and Care" for the National Centre for Rural Health and Care and University of Birmingham (October 2018). The challenges include the older population in rural areas, which has implications for demand and for labour supply. There are also relatively high employment rates and low rates of unemployment and economic inactivity, which mean that the labour market in rural areas is relatively tight. Despite there being fewer NHS staff per head in rural areas, a rural component in workforce planning is lacking. And the conventional NHS service-delivery model is based around specialist services in central (generally urban) locations, which are particularly attractive to workers who wish to specialise and advance their careers.

But there are opportunities too, based around promoting the variety of roles available, the attraction of rural areas to many health staff, and finding new ways to recruit both young people and people who want a 'second chance'

**The opportunities identified by Mr Bramley are as follows:**

1. Realising the status/attraction 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/ 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/early intervention and enhance service delivery.
9. Using technology so face-to-face staff resources are concentrated where they are most effective.

> "Despite there being fewer NHS staff per head in rural areas, a rural component in workforce planning is lacking."

## General practice

**New thinking is required in recruitment and retention of rural GPs to meet staffing shortages through, for example, choosing students from rural areas and ensuring students have early experience of rural settings**

Dr Rob Lambourn (Royal College of GPs) identified that staffing issues especially in terms of recruitment and retention are challenges. Attracting people at an early age is key from his perspective. He takes the view that extended training programmes are important – the University of Keele Medical School is an example of good practice in terms of medical students becoming GPs. In England overall he estimates we are 5-6,000 GPs short across the board.

Dr Sue Fish (Clinical Senior Lecturer Community and Rural Education Route (CARER) Programme [Aberystwyth], Cardiff University) identified that the remuneration of GPs in rural areas is challenging. Many practices do not have full list sizes, funding via the GP contract is often therefore less than urban areas.

Professor Stuart Maitland-Knibb (Director, National Centre for Remote and Rural Medicine, UCLAN) drew attention to his organisation which offers a graduate programme focusing on remote and rural practice. He identified that generating a sense of excitement and engagement with third parties is important in getting people to want to work in rural settings. Engaging those without the expected qualifications and growing your own are both important facets of responding to the rural health challenges around recruitment and retention.

**Dr John Wynn-Jones (World Organisation of Family Doctors) identified in terms of recruitment and retention there are 3 globally relevant factors:**

1. Choose students from rural areas. This may not be easy as aspirations are low and many of these students will need support in their final years at school

2. Ensure that students have significant and substantial rural experience as early as possible in their undergraduate training. Developing an understanding of rural issues through an immersion in rural practice

3. Provide specific rural GP training schemes designed to equip future GPs with the skills needed for rural practice

The military approach is an interesting example of a route into medicine – it follows a non-traditional approach to recruitment and its operating environment has much to link it with rural settings. His view is that the STP focus is on secondary care and there is scope for diversification and innovation, given primary care a higher primacy, if we are prepared to take a different attitude towards the management and scale of risk.

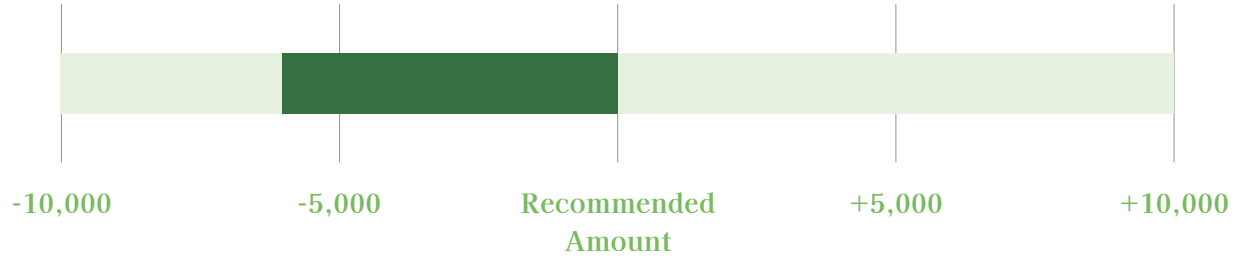
Dr Wynn-Jones went on to explain that there are good examples in Scotland and Wales where priority is given to rural origin students. The medical schools reach out to recruit from rural schools. Local recruitment in Wales is important from a cultural and language perspective. Much more could be done however, and these interventions are at an early stage.

In terms of key infrastructure, both Richard Murray (The King's Fund) and Dr Gill Garden (University of Lincoln) identified the challenges in relation to workforce availability linked to the general dearth of medical schools in rural counties. They pointed to a strongly held view within the health and care community that individuals are very often likely to develop their career where they train. The urban focus of most medical schools exacerbates this trend.

**Greater emphasis on 'rural generalism', with rural GPs developing skills in a wider range of specialisms, alongside rural-proofing new approaches, could tackle current shortages and bring care closer to where people live**

Dr Wynn-Jones identified that "Rural Generalism" provides a key opportunity to develop rural GP practice in the future. The Australian College of Rural and Remote Medicine (ACRRM) defines Rural Genearlist Practice as "A rural generalist is a medical practitioner who is trained to meet the specific current and future healthcare needs of rural and remote communities, in a sustainable and cost-effective way, by providing both comprehensive general practice and emergency care and required components of other medical specialties"

He explained that Rural Generalism describes a broader scope of practice needed to meet the needs of the communities where the GPs work. The Rural Generalist concept developed in Australia to meet the challenges of access to health care associated with distance and difficult terrain. Rural Generalism is however country, health system and context specific. Despite the smaller distances in Europe compared with Australia, Canada and the USA he believes there must be a European perspective on rural generalism. Skills such as advanced obstetrics, surgery and anesthesia may not be relevant but other skills such as mental health, emergency medicine, general medicine, public health, dermatology etc could make a huge contribution to current shortages and bring care closer to where people live.




## In England overall, Dr Rob Lambourn (Royal College of GPs), estimates that we are 5,000-6,000 GPs short across the board.

Dr Wynn Jones noted that too often policy can have an adverse impact on rural communities and rural practice unless it is rural proofed at an early stage before implementation. Both the new GP contracts in England and Scotland were not rural proofed and concerns persist that they will have an adverse impact on rural practice.

Dr Krishan Kasaraneni (BMA) identified that GP training is quite generalist in the way it currently functions. There is no funding currently available to address this. On the basis of local initiative integrated training is happening in patches but without more direction it will not become a national approach. He identified the tensions between the system-based desirability of having more generalists but the career recognition and pay issues which still focus very strongly on encouraging people to specialise. He went on to explain that from the BMA perspective the Enhanced Recruitment Scheme had made some major in-roads in addressing the challenges of recruitment in relation to rural GPs. https://www.england.nhs.uk/gp/the-best-place-to-work/starting-your-career/recruitment/

**Multi-disciplinary working and the use of technology (so GPs do not have to be physically present to deliver all services) are key for delivery of rural general practice.**

Professor Stephen Singleton (Director, Cumbria Learning and Improvement Collaborative [CLIC]) took the view that the generalist specialist is not the antidote to many of the challenges faced; from his perspective multi-disciplinary working is the most important issue. Training to be a multi-disciplinary player is key. Training approaches are often anti-pathetic to the use of technology which can help enable this. CLIC use a Scottish system called “attend anywhere” to make this happen in practice https://www.attendanywhere.com/.

From Professor Singleton’s perspective co-production has been a useful driver for thinking about recruitment in terms of generating an understanding of the wider workforce issues in localities. People being prepared to commit to a job in terms of “place” is an important component in this context.

The CLIC academy for GPs puts all the Continuing Professional Development in one place – responding to the fact that some people can’t find what they’re looking for. A focus of the approach is on portfolio working which is managed for individuals. CLIC is currently involved in job matching 70 GPs without contracts that prefer sessional work.

A further theme is continuous quality improvement. A huge issue concerns the notion of the manageable day (in terms of workforce challenges). This is often driven by “other messy stuff” not directly related to the work of the clinician. Seeking to develop a manageable day for people in all health and care professions should be a key priority. Bureaucracy drives mileage in some workload cases in rural settings.

Shared training and joint learning represent potent ways of overcoming a number of workforce challenges driven by professional specialisation which CLIC is following. In a nutshell the approach championed by CLIC for rural settings is

- The importance of being a multidisciplinary team player
- The idea that you don’t have to be physically present to deliver all services
- The importance of the community voice in terms of organisation

## Nursing

**Although retention rates are good in rural areas, recruitment is harder; one distinctive rural issue is supporting the greater proportion of mature students**

Dr Ruth May (Chief Nursing Officer for England) identified three priorities applicable to agenda around nurse recruitment and retention in rural areas:

- Workforce challenges
- Pride and celebration of the work of nurses
- Collective leadership

Dr May identified that urban areas are often the main attractors for nurses. It is from her perspective however easier to retain people in rural settings, but more difficult to recruit to them. Organisations on the coast have some of the most acute experiences. Continuing professional development is a very important issue in the context of retaining staff in rural areas. She identified that this will be a key area of emphasis in her links with the CEO of the NHS as part of the build up to the Comprehensive Spending Review. Increasing clinical placement capacity will also be an area of emphasis.

Dr May went on to identify that there is an issue about the distinctive profile of rural students many of whom are mature students. The lack of the cost-of-living allowance makes it difficult for mature students who often have more extensive cost commitments to participate in training. The loss of the £3000 per student bursary per year has had a real impact especially for those students with children.

Dr May also drew attention to the Interim People Plan published by Baroness Harding on 3 June 2019 https://www.longtermplan.nhs.uk/wp-content/uploads/2019/05/Interim-NHS-People-Plan_June2019.pdf. She identified it as another activity which led her to reflect that we need to have more of a focused differential response to how we develop the nursing profession in rural settings.

**Ensuring parity of esteem between nursing in clinical and social care settings is key in rural areas, which have high demand on community and social care**

The connection between acute and primary care settings is an important factor to consider in relation to the rural nursing agenda. Parity of esteem between social care and clinical settings is important. Susan Aitkenhead (Deputy Chief Nursing Officer for Policy and System Transformation) identified that traditionally nurse training has been delivered around a range of different "silos". Breaking down the different training silos for nursing is very important moving forward. Training placements should also reflect the virtue of providing nurses with a diverse range of learning experiences. Hospital discharges are a key interface area linking nurses across the acute and social care divide. The increased acuity of care in community settings is changing the demands on nurses in social care.

Sue West (Nursing and Midwifery Council) identified that the new set of standards for future nurse proficiencies have as their central aim to provide nurses and nursing associates with greater depth of knowledge to meet needs of individuals across different care settings. More needs to be done to encourage people to join and remain in the social care sector. The key question is how do we sell social care to our future workforce? This must involve activities such as enhanced placement learning opportunities and enhanced investment in training and development more actively.

Denise Thiruchelvam (Royal College of Nursing) identified a number of challenges facing nurses in rural settings. The Agenda for Change national pay system has helped address some of the additional cost challenges associated with working in rural areas– however this doesn't extend to the way mileage payments operate which are governed by national policy. The rates drop significantly after 10,000 miles. She went on to say that as a Director of Nursing her perspective is that the biggest challenge to running community hospitals in rural settings is a real lack of workforce capacity. She identified that innovation around the deployment of practice nurses important. She indicated that the reduction of training budgets is a real challenge around the rural service delivery agenda. In terms of overall staffing levels, she went on to draw attention to the legislation around ensuring a safe supply of professionals around health delivery in Scotland and Wales and indicated that this would be a very good development to transfer to England, from the Royal College of Nursing perspective in the context of registered nurses.

In terms of key infrastructure both Richard Murray (The King's Fund) and Dr Gill Garden (University of Lincoln) identified the challenges in relation to workforce availability linked to the general dearth of medical schools in rural counties. They pointed to a strongly held view within the health and care community that individuals are very often likely to develop their career where they train. The urban focus of most medical schools exacerbates this trend.


## Social Care

**Recruiting and retaining the required number of social care staff in rural areas is a key issue, with high demand, low wages, access to transport and high turnover all being major factors**

Georgina Turner (Director of Engagement, Skills for Care) identified that, overall, the biggest challenge is in recruiting and retaining a skilled and values-driven workforce – before the pandemic there were 122,000 vacancies in social care on any one day. The workforce will need to grow significantly, by 2035 we will need an extra 520,000 roles – this was updated in November 2021 to represent respectively: 105,000 vacancies and 490,000 roles. Rural barriers to recruitment are a challenge, proximity to work is an issue, affordable housing is not available to the social care workforce so workers can't afford to live near to where they work, accessing CPD and having choice/options around CPD are a challenge and seasonal employment in holiday geographies make it easier to recruit in winter not summer.

Councillor Sue Woolley (Executive Councillor: NHS Liaison, Community Engagement, Lincolnshire County Council) identified retaining the social care workforce as the biggest challenge facing the sector. At the operational level, the social care sector competes with food factory jobs and other sectors which also pay the minimum wage, leading to a significant instability of workforce. In her experience key issues include a high turnover of staff in social care particularly during holiday periods and travel/distance issues in terms of the costs of getting from A to B for domiciliary care workers in the light of low wages.

**Andy Tilden (Interim CEO, Skills for Care, now Emeritus) provided evidence from the Skills for Care national data set, which identified the following distinctive characteristics of rural areas: 4.1% higher turnover, vacancy rates 0.7% higher, average age of workers 0.2 years higher, average rural hourly rate for a carer is 9p higher, workers travel 2.4km further to get to their place of work. He went on to identify 7 key areas of distinctiveness in the context of rural areas and the care agenda:**

1) transport (lack of public transport and car insurance costs are prohibitive to young workers);

2) accommodation costs (lack of affordable housing);

3) seasonal attraction in coastal areas (services find it easier to recruit in winter, less so in summer);

4) broadband coverage;

5) access to learning and development physically;

6) the age profile of clients;

7) the disconnect between people who need care to available workforce, characterized in part by the isolation that staff and managers describe.

> High turnover of staff in social care particularly during holiday periods and travel/distance issues in terms of the costs of getting from A to B.

**Social care roles are perceived as the poor relation to other health and care sector roles**

Councillor Andrew Leadbetter (Devon County Council) indicated from a non-professional point of view social care is a poor relation to other aspects of the health and care agenda. This needs to change because of the connectivities between social care and other aspects of the NHS agenda. Many community hospitals have closed. Councillor Leadbetter indicated that huge amounts of council budgets are being absorbed by social care. In terms of Devon's rural credentials, half of the population live in areas of rural deprivation where transport costs drive up the cost base. Infrastructure challenges are an issue particularly in poor weather. Lone working is also an issue compounded by poor connectivity. Poor housing quality is a further challenge. GP appointment times are often insufficient. The Council has launched a project aimed at addressing a number of these challenges which is called "Doing What Matters."

Steven Chandler (Somerset County Council) indicated the need to work hard to address the challenges of recruiting and retaining social care workers in relation to the issue of parity of esteem. Somerset still have 14 community hospitals a number of which are very small. The council is looking at redesigning the health and care system to address some of the issues linked to the high-cost base arising from its current pattern of provision. The challenge is that the nursing home beds will need to replace the loss of beds in community hospitals. Working in an integrated way has also led to better Delayed Transfer of Care (DTOC) rates in Somerset. Reablement has been an important part of this agenda. Not relying on historical roles is important. The Council remain concerned that there will not be enough professionals to meet the long-term challenges of supporting the diversity of individual needs in the future. We need to look very closely at the extension of support roles for traditional professions more heavily.

**Providing clear career pathways and opportunities for continuing professional development is key in recruiting and retaining social care staff**

Professor Martin Green (Care England) identified that the social care workforce needs a clear skills and competency framework and career pathways aligned to NHS roles. The challenges of supporting people in social care are as complex as in other health settings but the remuneration and esteem is far less. The skills mix of those providing care in rural areas is vital as there is not the same access to specialist skills and you need to be solutions focused. Another key challenge is how to encourage care homes to provide future student learning placements. Therefore, selling the real difference you can make to elderly people is a key component in this agenda.

Sue West (Nursing and Midwifery Council) drew attention to a lack of funding for continuing professional development (CPD), which is a real area that needs to be addressed. We need to consider how to revalidate nurses every 3 years to demonstrate 35 hours of CPD and reflection, aligned to the code they have to adhere to with a view to broadening and updating of their skills. It is also important to consider how can we support people to take on more advanced roles in homes or hubs. Education has to be central to any integrated system or vision for the future of social care as a profession.

Ms West outlined from her perspective why people don't want to work in care settings. The issues are around: equity of pay with NHS workers, transport (needing a car) and third parties not valuing the workforce that are making a difference. Ms West explained that because of the wide ranging and small-scale nature of providers a complete picture of the social care sector in England is not available. This makes planning and strategy implementation complicated and challenging at a macro level.

## Volunteers

**There is potentially a large bank of volunteers willing to serve in rural settings**

Volunteers have a key role to play alongside staff employed in the health and social care sector. Sir Tom Hughes-Hallett (Helpforce) identified that in in rural settings health and care volunteers have to be reliable and well supported. He identified that there is a minimum level of competence that volunteers need to meet. In his view we should be setting the same standards for volunteers as for employed staff. In rural areas the single biggest issue is transport, and the single biggest challenge is regulation and legislation. He reflected that from his analysis there is an "army of volunteers" waiting to serve rural settings and that the fastest growth in volunteers is amongst the under the 30s. This view is in line with the witness testimony of Katherine Nissen (Cornwall Rural Community Charity) about how the Covid-19 pandemic has encouraged a climate of enhanced volunteering.

**Voluntary organisations can often provide key support to the health and care sector, as well as driving innovation and new approaches**

Nikki Cooke (Chief Executive LIVES) identified the extremely powerful impact volunteers can have in supporting the emergency services agenda through the organisation's first responder service. LIVES has 600 volunteers it is the largest voluntary sector first responder scheme in country. The organization has a tradition of working in partnership with the fire service to deliver a co-responding service lining up with the ambulance service. LIVES operates under its own clinical governance. The organization also provides community education to teach a full spectrum of disciplines from first aid to life-saving procedures at the roadside. The organization motto is: "It takes a team to save a life." Volunteers come from a range of backgrounds nurses, paramedics and hospital doctors all volunteer. Volunteers undertake additional training in their own time and at their own expense and they do it because they care.

Ms Cooke outlined a number of examples of innovation in relation for example to the Community Emergency Medicine project which provides "Doctor Cars". Doctor Cars comprise a multidisciplinary team involving 2 people in 3 crews responding to category 2 and 3 calls – this approach was piloted in 2019 and has been fully operational since April 2020. 56% of patients avoid hospital and other health interventions, 15% avoid emergency admission but access other health services elsewhere. This approach works as it delivers services differently based on the fact that the team has been set up to bridge the gap between primary care and hospital care and frequently make decisions in the communities they work in.

A strong theme in both the examples of Sir Tom Hughes-Hallett and Ms Cooke is the level of professional support and recognition, extending even to a full clinical governance approach which characterises effective approaches to volunteering through initiatives such as LIVES and Helpforce. This is particularly relevant in the way both initiatives have been able to develop their volunteering initiatives to take account of rural challenges.

**Involving communities and patients in service delivery can also have a major impact on health outcomes**

More widely Dr Mark Spencer (Healthier Fleetwood) identified how the creation of a patient led community hub had made significant inroads in terms of both personal but also wider family outcomes. This approach which builds more effective responses to self care can be particularly powerful in complementing traditional approaches to primary care in rural and remote settings. It also has resonances with the extended use of community health animateurs referenced on an international level by both Dr Pavitra Mohan (Co-Founder & Secretary, Basic Health Care Services, Udaipur, Rajasthan, India) and Dr Mayara Floss (Family Medicine Resident, Grupo Hospitalar Conceição, Porto Alegre, Brazil) in the following section on international perspectives.

## International Perspectives

We were very struck during the inquiry by the strong parallels between the issues arising from witnesses talking about the English experience and the evidence of witnesses from international setting. Workforce is a consistent challenge across many rural settings across the world. The international perspectives below provide some very useful insights about how these issues both manifest themselves and how approaches to address them have been developed.

**In countries around the world, there are challenges related to recruiting GPs to rural practices**

Professor Roger Strasser (University of Waikato) identified that the 3 factors most strongly associated with rural practice entry are: rural upbringing, then rural experience, third targeted rural practice. He referenced a Northern Ontario School of Medicine case study. Northern Ontario is a geography where distributed, community engaged learning is the key model. The learning operates across 90 sites. GP training is varied and based in a range of widely dispersed clinical settings. This has led to the development of a Longitudinal Integrated Clerkship programme which has been very successful.

Dr Manabu Saito (Rural Generalist Programme [Japan]) drew attention in the international session to the campaign focused on the recruitment of GPs to isolated island settings he has led in Japan. His recently published article "Development of the Rural Generalist Program Japan: meeting the needs of Japanese rural

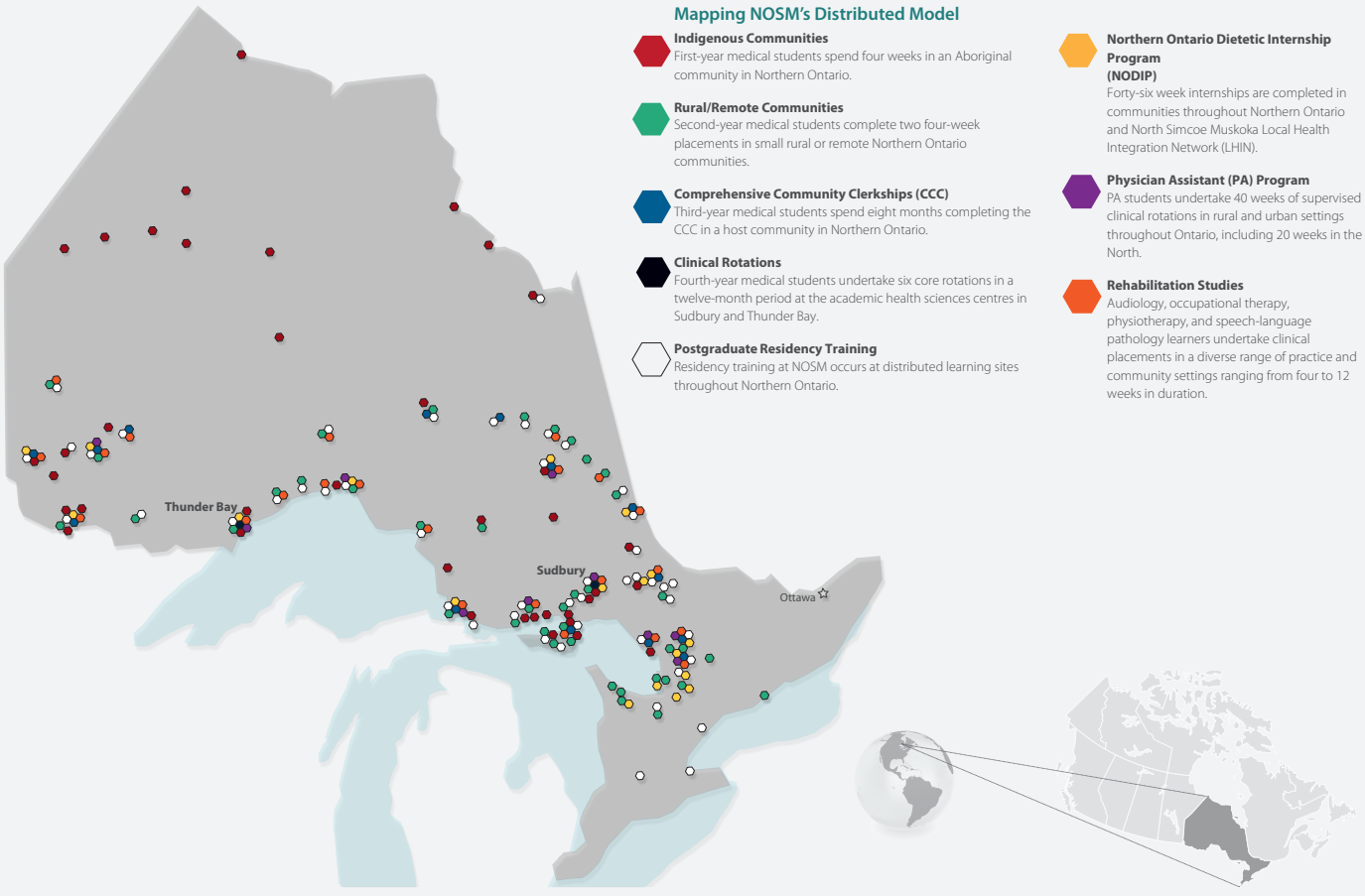
communities" provides more information on the approach of this programme.

Alan Morgan (CEO National Rural Health Association USA) identified that in their free market model workforce shortages are the key issue. Tele-health has helped to ameliorate these challenges. 43% of rural hospitals are operating at a loss – in a rural context payment based on episodic care has led to a number of facilities closing. Federal Government intervention has helped but hospitals are still closing. In terms of recruitment and training in general in the USA, the method has been to take the best students and they mostly come with an urban bias. Rural residency training programmes focused on rural youngsters working on their own ground have made a huge difference in addressing this challenge.

**Especially in developing world countries, roles such as physician associates and community health animateurs can help overcome shortages of fully-qualified clinical staff, as well as more fully involving local communities in health and care provision**

Professor Ian Couper (Stellenbosch University) drew attention to the significance of physician (clinical) associates which are an important part of the response to the health care challenge of a lack of fully qualified doctors. These individuals undergo a 3 year training programme – the term "associates" makes it clear that these individuals have some self determination. Their training focuses on relationships with patients from day one. From 2011 these individuals have become well established in the South African health system.

Dr Pavitra Mohan (Basic Health Care Services, India) and Dr Mayara Floss (Grupo Hospitalar Conceição, Brazil) drew attention to models of community health animateurs focused as non-clinical roles on engaging individuals with effective prevention related behaviours linked to primary care strategies. In these low and middle income settings community engagement and prevention are at a higher premium due to a lack of resources for acute/secondary care. Dr Floss explained that community health workers are local people embedded as the eyes and ears of doctors. Local health councils have also been developed as part of a community response to the management and communication of local health needs. Dr Mohan explained the key role of local animateurs within the first of the three tiers of the Indian health care system based on the connections between: health care centres, sub district hospitals and district hospitals.



# 2.4 The wider / interdependent factors influencing health issues in rural communities

## Section Summary

There are a wide range of external factors that influence the rural health and care landscape. This section concentrates on two of these factors which witnesses identified as having a particularly important inter-relationship with rural health and care – digital technology and housing – and also discusses key broader factors (transport, the economy, the environment and education).

**Digital technology in the rural health sector**
Digital approaches can potentially improve the experience of patients in a wide range of contexts, from remote appointments, care co-ordination, multi-disciplinary working and virtual discharges. Social media, videoconferencing and mental health apps can help address isolation and loneliness and improve well-being. A particular benefit of technology in rural areas is improving access to services, where local availability or travel distances would otherwise cause difficulties. The lack of a critical mass of users / organisations in rural areas, however, may militate against the development of rural focused digital products.

**Digital technology in the rural care sector**
There is also a role for technology in care settings, with the biggest impact often being on the experience of the cared for and their carers, rather than direct cost savings. In rural care settings, three factors could help further adoption of technology: a high-level technology roadmap that helps care providers understand how technology can help; financial support to care providers to take up digital approaches; increased digital maturity and skills among care providers.

**Housing and planning**
There is a lack of affordable housing in rural areas, with affordability ratios often much higher in villages than in cities and towns; there is a particular shortage of bungalow/level access or adapted housing. The loss of social rent homes through the Right to Buy scheme is a particular issue in rural areas, where new housing development costs makes replacement of social rent homes more challenging. There need to be changes in the housing planning system to support access to affordable rural housing. The Community Housing Fund was a significant policy to support community-led development of affordable housing, but it closed to new rural bids in December 2019 and has remained closed despite calls from community groups and MPs.

**Other key factors: transport, economy, environment and education**
Transport issues caused by greater travel distances and by poor infrastructure are a key factor in rural health and social care. Transport issues are often distinctive to individual rural places, and seasonality is an additional issue for some coastal and island communities in particular. Not meeting the health care needs of our rural population brings a significant economic cost – to employers, the government and the economy as a whole. There are clear links between the environment and health. Investing in education and skills can bring health benefits to rural populations.

## Digital technology

**Digital approaches can potentially improve the experience of patients in a wide range of contexts, from remote appointments, care co-ordination, multi-disciplinary working and virtual discharges**

Brendan Brown (Chief Executive and System Lead, Airedale NHS Foundation Trust) and Victoria Pickles (Director of Corporate Affairs, Airedale NHS Foundation Trust) identified a core list of areas where the application of digital technology can impact on the patient experience. GP triaging and wide geographical coverage are both very big themes. Medication reviews, falls risk assessments, keeping people at home, single point of access for care coordination are all possible through the use of IT. Multi-disciplinary working can be more effectively facilitated through digital approaches. Training has been enhanced by IT reducing the need for travel. Virtual discharge has been enabled through the use of e-enabled approaches with tele-nursing, pharmacists, mental health and other clinicians now being played into enabling this.

**Social media, video-conferencing and mental health apps can help address isolation and loneliness and improve well-being**

In a pre-pandemic session Professor Clive Ballard (Pro-Vice Chancellor & Executive Dean, University of Exeter Medical School) identified the contribution digital technology can make to addressing isolation/loneliness in the context of mental health and well-being. He explained that digital technology can help ameliorate but not solve this challenge. Social media can be a positive element within this process, creating a new medium for engagement with people. There has been much stereotyping that older people don't use digital – this is often not true – there is a rise in the incidence of older people engaging with social media often characterized as "silver surfers". In terms of other issues around well-being, he explained that digital technology can be used to highlight people who might have health risk factors – through well-being apps for example. There is increasing evidence that supported digital mental health applications are effective. Professor Ballard identified that systemised approaches are the key – a scoping exercise linked to the potential of digital technologies accompanied by pathfinder projects could make a real difference to realizing the potential of digital health applications, but it needs national policy attention. He emphasized the role of digital tools in both monitoring and for triggering personal interventions.

Professor Alison Marshall (University of Cumbria) in a pre-pandemic session identified explained that some of the apps and tele-monitoring systems, which have been developed require a change to the "care paradigm" and are more difficult to implement than something which is powerful but simple such as video-conferencing. She also indicated that the challenge of training staff to feel comfortable using technology is under-rated.

**A particular benefit of technology in rural areas is improving access to services, where local availability or travel distances would otherwise cause difficulties**

Richard Alcock (Director of Primary Care Technology, NHS Digital) indicated that access to services is a key challenge in rural settings. A number of e-enabled activities are helpful in overcoming the challenge of distance including providing access to client records to enable remote working and undertaking remote consultations by video and telephone. Other examples of opportunity include increased use of high-resolution images which allow GPs to review for example skin conditions and undertake other forms of diagnosis without the need for the patient to present. This approach can result in reducing appointment requirements. One further area, which has been given greater prominence through Covid-19 is remote monitoring through tele-health products, this is an area with growing potential. This can include blood pressure checks and other condition monitoring facilities. A further consequence of the Covid-19 pandemic is the far wider application of the "total triage" approach, seeking to engage every GP client remotely where possible in the first instance.

> "Rural areas lack the critical mass to put them at the forefront of product testing and roll-out."

**The lack of a critical mass of users / organisations in rural areas may militate against the development of rural focused digital products**

Graeme Tunbridge (Director of Devices, Medicines and Healthcare Products Regulatory Agency [MHRA]) identified that in rural areas a lack of tertiary centre focus, in terms of testing, might militate against the development of rural sensitive products. In essence rural areas lack the critical mass to put them at the forefront of product testing and roll-out. He identified that the development of Artificial Intelligence (AI) applications was the next key stage of development which offers significant potential for the provision of services which support the health care needs of people in rural settings. Specific focused effort will be needed to ensure rural places are included in the application of these approaches because to date the push has been to specialization, which mitigates against roll out to smaller rural centres in this context where there are fewer people to master the full functionality of devices.

James Palmer (Programme Head – Social Care, NHS Digital) noted that scale up of good practice is one of the biggest challenges we face as a country. Mr Palmer went on to explain that resources in terms of staff time to embrace innovation and the commissioning process in terms of creating a safe and secure digital environment are the biggest challenges faced in the context of scale up. Feedback from projects suggests that digital connectivity is a key factor. Access via the rural gigabit scheme is an important opportunity to enhance capacity to make the best of new technology innovations in rural settings. He went on to explain that the current Shared Care Record (SCR) and Interoperability Platform has been critical in responding to the pandemic and has operated as a powerful communications channel during the crisis. Digital urban settings have been at the heart of this model and it is important to ensure its functionality is adopted in rural settings as widely as possible. There is currently a rural deficit in the use of this platform.

**There is also a role for technology in care settings, with the biggest impact often being on the experience of the cared for and their carers, rather than direct cost savings**

Piers Ricketts (Chair, The Academic Health Science Network (AHSN) Network; Chief Executive, Eastern AHSN) explained the difference between rural and urban settings in terms of care homes and indicated that this is a challenge that needs more consideration. Care homes are often more basic in rural areas, access to wifi even is sometimes a challenge in this context.

James Palmer (NHS Digital) referenced his work in looking at the role of technology in care settings. This work has considered over 60 projects looking at different forms of technology – from the use of secure emails to the use of acoustic monitoring. He explained that results so far had revealed that cash releasing benefits are seldom big, instead the greatest benefits are societal. The biggest impacts are a better experience for the cared for and the release of time for the carer.

**In rural care settings, three factors could help further adoption of technology: a high-level technology roadmap that helps care providers understand how technology can help; financial support to care provider to take up digital approaches; increased digital maturity and skills among care providers**

Robin Batchelor (Chairman & CEO everyLIFE Technologies Limited; Care Software Providers Association [CASPA]) identified 3 challenges to promoting further successful adoption of technology in rural areas: (i) the need for specific guidance from Government & Regulators – he explained that a high level technology roadmap that recognises the interdependency between health & social care, that understands the important differences between the two systems and that leverages the existing successful adoption of technology would be most welcome. In effect, the DHSC & CQC clearly showing both care organisations and technology providers their required direction of travel. (ii) Financial support – he explained that structurally adopting technologies comes at a price, both in upfront hardware and ongoing service costs. While some of this can be offset from ongoing operating efficiencies, care providers need a means of funding this positive structural change. As the benefits of this change will accrue to both care providers, the NHS and Government agencies, this cost could be shared. (iii) Increased digital maturity, a third of existing technology customers are based in rural locations. Challenges to further use are twofold; firstly in attitude and expectation (why change & we can't change), and secondly in ongoing improvements in telecom infrastructure e.g. improved broadband and 4/5G. While many technologies work both online and offline, the greatest impact is experienced when online.

> The loss of affordable housing in rural areas can have a social impact on individuals.

## Housing and planning

**There is a lack of affordable housing in rural areas, with affordability ratios often much higher in villages than in cities and towns; there is a particular shortage of bungalow/level access or adapted housing**

The nature of the housing stock and its costs are both major challenges in rural settings which have knock on effects in terms of rural health and care. Jo Lavis (Rural Housing Solutions) reconfirmed the link between housing and health. From her perspective health, social care and housing go hand in glove. Housing is a key part of the prevention agenda that lies at the heart of the Care Act. In rural areas affordable housing is core to a cohesive community where family and friends can support more vulnerable members and assist them to live independent lives. We also know that affordability ratios are much higher in villages than towns. Data produced by Hampshire County Council recently found that in villages the affordability ratio was 10:1 in villages and 6.9 in urban cities and towns. If you cannot afford to buy a home your chances of finding a home in a village are limited. 8% of housing stock in villages of less than 3000 people is social housing – compared with 19% in urban areas.

**Thanks to the housing needs surveys undertaken by Rural Housing Enablers (RHEs), we can gain a better understanding of the size and nature of unmet housing need at community level. The most recent evidence was collected between January and March 2020 RHEs. They covered 10 counties and undertook local housing needs surveys in 26 villages. They identified:**

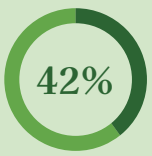

383 households looking for affordable housing


71% of these were looking for a home to rent


60% earned less than 30k per annum and half of these less than 20k


35% were aged 16 – 30


21% were older than 60




42% were looking for a house


56% were looking for a bungalow/level access or adapted housing

**The loss of social rent homes through the Right to Buy scheme is a particular issue in rural areas, where new housing development costs makes replacement of social rent homes more challenging**

Tarun Bhakta (Assistant Policy Officer, Shelter) identified overall there is a significant demand for social rent. Last year 17,000 social rent homes were lost through the Right to Buy scheme. Since discounts were increased 85,000 Right to Buy sales have been processed leading to only 28,000 replacement homes. This is a particular issue in rural areas due to higher development costs, which make replacement more challenging. Delivering replacement housing given the use of sales receipts rules may only be achievable in a local town where development is cheaper, this has the effect of people being decanted out of their communities. A recent Shelter research report showed 50% of respondents affirmed this impact. A lack of bungalows as a consequence of Right to Buy sales has made the situation more challenging still as these are particularly hard to replace because of their bigger land footprint. The loss of affordable housing in rural areas can have a social impact on individuals where relationships are lost when people find they are unable to stay in their local communities. Shelter has information based on 2017 research, which shows a significant link between housing and mental health.

**There need to be changes in the housing planning system to support access to affordable rural housing**

Ms Lavis explained that some 70% of rural communities it is not possible to gain affordable housing on-site from developments of less than 10 dwellings. She suggested reinstating Local Planning Authorities rights to set their own size thresholds to trigger on site affordable housing contributions in all rural communities. Tom Chance (Chief Executive, Community Land Trust Network) discussed the 'hierarchy of settlements': "too often this sill rules out or frustrates development in small rural communities. No rural community should be ruled out, and often new housing can be critical to sustain villages, and the school, shop, post office etc". Mr Collett also highlighted the importance of "rightsizing", in matching the distribution of housing stock to what rural residents need: "policy should also consider the best means of incentivising people to move to properties which best suit their needs as they grow older".

**The Community Housing Fund was a significant policy to support community-led development of affordable housing, but it closed to new rural bids in December 2019, and re-opened for a short window for more advanced projects from August-December 2021, but its future remains uncertain despite calls from community groups and MPs.**

Tom Chance identified that the most significant policy to support community led evolution of affordable housing in rural areas was the Community Housing Fund. It provides revenue and capital funding for community led housing projects, and is more flexible on tenure, allocations and housing delivery than the conventional affordable housing programme. This is absolutely ideal for rural communities and their specific local needs. Since it was launched in 2018 it has increased the potential pipeline across England from 5,000 to 23,000 homes.

Homes England had to close the fund to bids in December 2019, with over 10,000 homes now "stuck" in its system. The Government put a further £4m into the fund in 2021-22, re-opening it for applications from only more advanced projects with a short window of opportunity from August-December 2021. The fund remains open to projects of all stages in London until 2023, but lots of rural communities have now been left high and dry.

The Community Housing Fund has also invested in the sector's infrastructure, providing training and resourcing for regional organisations which support local communities. Many of these are connected to rural housing enablers and are able to support communities to bring forward projects that address the full range of local needs – housing, health, economic, environmental, and so on. Community Led Homes and the Community Land Trust Network have been deliberately developing this infrastructure to be self-sustaining on the social enterprise model, but the funding for this ended in March 2020 after just 18 months, which is not long enough. Despite calls for the Fund to be re-opened by hundreds of community groups and over 70 MPs and Peers it remains closed across rural England. One other issue raised by some rural specialists is the hierarchy of settlements. Too often this still rules out or frustrates development in small rural communities. Mr Chance believes that no rural community should be ruled out, and often new housing can be critical to sustain villages and the school, shop, post office etc. Indeed, most Community Land Trusts (CLTs) are started with this wider vision – to build homes and steward land so that they can ensure the sustainability of their village, and so their community can thrive.

## Other key factors: transport, the economy, the environment and education

**Transport issues caused by greater travel distances and by poor infrastructure are a key factor in rural health and social care**

A key defining factor of rural communities is that people in these communities need to travel further to access services (or, in the case of the health and care workforce, to provide services). This places an increased emphasis on good transport infrastructure.

In section 1.4, we set out evidence from Sue Bradley (Age UK North Craven) on Age UK's painful journeys report on the issues faced by older people in getting to hospital appointments. Cuts to bus services, long and uncomfortable transport journeys, and underfunding of community transport services were all cited as particular issues for rural places. Also in this section, Helen Ray (North East Ambulance Service) explained the impact that sparse settings have in relation to emergency services. When an emergency occurs in a rural area, this can result in delays in the nearest resource arriving on the scene and the response times in rural areas are considerably longer than in urban areas. This is compounded in winter months when road conditions deteriorate significantly. In Section 2.3, we explained how numerous witnesses stated that transport and "getting from A to B" was a major workforce issue in recruitment and retention – particularly of social care staff. Andy Tilden (Skills for Care) provided evidence from the Skills for Care national data set, which identified that rural social care workers travel 2.4km further to get to their place of work than their urban counterparts. He identified transport, including lack of public transport and car insurance costs that are prohibitive to young workers, as one of the key distinctive issues of rural social care provision.

**Transport issues are often distinctive to individual rural places, and seasonality is an additional issue for some coastal and island communities in particular**

Dr Debbie Freake (Northumberland NHS Trust) noted that rurality is not uniform and it is important to think about it in all its diversity. In relation to access to transport, part of the diversity is not about proximity to health facilities, but more broadly to settlements in terms of their full functionality; she drew comparisons between Hexham (well served) and Whitehaven (less well served). Another issue affecting many coastal communities in particular is seasonality: Katherine Nissen (Cornwall Rural Community Charity) explained that Cornwall only has one hospital and significant travel times challenges for those accessing acute services. In the summer months, the capacity of roads to take emergency or NHS service related transport is very challenged. Finally, Dr Mark Spencer (Healthier Fleetwood) explained how poor transport links can result in a community sense of isolation even if there is relative proximity to larger urban areas (Fleetwood is on a peninsula which is approximately 10 miles from Blackpool).

> This inquiry has been seeking international examples of transferrable practice, whilst contexts are different some of the solutions could work equally well in different rural settings.

**Not meeting the health care needs of our rural population brings a significant economic cost – to employers, the government and the economy as a whole**

Dr Peter Aitken (Director of Research & Development, Devon Partnership NHS Trust) discussed the correlation between poor mental health and economic failure. This was reaffirmed by evidence from Jim Hume (National Rural Mental Health Forum) who highlighted the link between poor mental health and economic success. Both referenced The Stevenson/Farmer Review of mental health and employment. The Review sought to quantify the cost of poor mental health to employers. There is a large annual cost to employers of between £33 billion and £42 billion (with over half of the cost coming from presenteeism – when individuals are less productive due to poor mental health in work) with additional costs from sickness absence and staff turnover. The cost of poor mental health to Government is between £24 billion and £27 billion. This includes costs in providing benefits, falls in tax revenue and costs to the NHS. The cost of poor mental health to the economy as a whole is more than both of those together from lost output, estimated at between £74 billion and £99 billion per year. Ursula Bennion (Rural Housing Alliance) described how poor housing contributes to health problems to the tune of £1.4 billion a year to the public purse – this is the sum attributed to the physical impact of poor housing on health. Tarun Bhakta (Shelter) highlighted research showing the impact of housing problems on mental health. 1 in 5 English adults (21%) said a housing issue had negatively impacted upon their mental health in the last five-years.

**There are clear links between the environment and health**

The links between health and the environment were set out in the Environment Agency report, State of the environment: health, people and the environment. In particular, the report noted that 'Air pollution is the single biggest environmental threat to health in the UK, shortening tens of thousands of lives each year. And climate change has major implications for rural health and social care. The 2019 report of The Lancet Countdown on health and climate change stated: "Climate change threatens to disrupt health systems' ability to deliver high-quality care and undermine the past 50 years of gains in public health, with more intense heatwaves, higher risks of flooding and damaging storms, and a changing pattern of emerging infectious diseases."

**Investing in education and skills can bring health benefits to rural populations**

In the previous section 2.3, we looked at a broad range of evidence from witness about having the right training and professional development to provide a workforce with the right skills for rural health and care. But investing in the education and skills of the whole rural population is also interwoven with the health of rural communities. The Health Foundation has stated that "By the age of 30, those with the highest levels of education are expected to live four years longer than those with the lowest levels of education." The Health Foundation explains that a good education helps build strong foundations for supportive social connections, accessing good work, life-long learning and problem solving, feeling empowered and valued.

# 2.5 The impact COVID-19 is having on rural communities in terms of health and care

## Section Summary

A number of witnesses identified how the Covid-19 pandemic has changed the landscape of rural health and care services:

- The Covid-19 pandemic has had some major negative impacts on rural health and care, particularly on the care sector
- The pandemic has highlighted the key importance of cross-boundary working and the integration of systems - in particular, greater integration between health and social care
- Remote service delivery has been accelerated by the pandemic, but it is important to note that remote delivery does not suit every rural case
- The Covid-19 pandemic has accelerated the adoption of digital technologies and products in rural places
- Another positive impact arising from the pandemic is the growth of volunteers at the micro-level supporting their local community

**The Covid-19 pandemic has had some major negative impacts on rural health and care, particularly on the care sector**

There have been significant negative impacts on rural areas arising from the pandemic. George Coxon (Care Home Owner, Devon) identified that many smaller care homes have been adversely affected by the pandemic and are in a state of significant financial vulnerability. He believes we now need to think about what life will look like post Covid-19.

We want to maintain and sustain some of the good habits, which people have picked up during the lockdown. Any short term loss of care homes will exacerbate a lack of choice and opportunity in the rural/ coastal parts of the county.

Georgina Turner (Skills for Care) identified that the wellbeing of the care workforce has been negatively impacted during COVID and many are considering leaving the sector and we risk losing experienced and knowledgeable staff.


**The pandemic has highlighted the key importance of cross-boundary working and the integration of systems - in particular, greater integration between health and social care**

Sue West (Nursing & Midwifery Council) drew attention to the extraordinary levels of skills, perseverance and bravery during the pandemic of care workers which has created a lot of learning around joined up working, integration of systems and communication. She went on to explain that the system has proved eventually flexible enough to enable deployment of nurses from temporary registers to address the extra pressures in the system and she wanted to draw attention to the real benefits of this achievement. She reflected that the pressure exerted on the current workforce has renewed the challenge of being clear that we have strategies in the longer term to enable us to "grow our own" more effectively and manage their deployment well.

Professor Helen Stokes-Lampard (Chair of the Academy of Medical Royal Colleges) identified that Covid-19 has provided an opportunity through multi-tasking and radical deployment strategies to fashion a positive discussion (in the context of professional accreditation and approaches) to the opportunities for more generalism and cross boundary working. Dr Adrian Tams (Workforce Transformation Manager, Midlands Transformation Team, Health Education England) further identified that from his perspective NHS England is on the cusp of a tide of change, driven by the pandemic. He identified that a rural and coastal programme is being developed with the NHS working as an anchor in rural settings. The multi-disciplinary agenda is also important in this context.

Piers Ricketts – Chair, The Academic Health Science Network (AHSN) Network & Chief Executive, Eastern (AHSN) took the view that, in agreement with a number of other witnesses the joining up of health and social care has been pointed out to be more acutely a challenge through Covid-19.

**Remote service delivery has been accelerated by the pandemic, but it is important to note that remote delivery does not suit every rural case**

Richard Alcock (NHS Digital) identified that the adoption of remote working and information sharing had been accelerated by the pandemic. Notwithstanding progress with the adoption of these approaches Mr Alcock emphasized that we still need to be careful to ensure that remote service delivery (which does not suit every rural case) is not seen as the only option for people in remote settings. Piers Ricketts (Academic Health Science Network) explained that during the pandemic the approach to rural areas needs a different approach. He referenced how in London and other city settings increased use of technology such as "GP at Hand", had reduced the pressure on services

Josep Vidal-Alaball (Head of the Central Catalonia Innovation and Research Primary Care Unit, Institut Català de la Salut, Catalonia, Spain) identified how the pandemic has been a major disrupter – it has been particularly acute in rural settings where low critical mass has led to the closure of small facilities. During the height of the pandemic face to face visits were a very small aspect of the overall agenda in his part of Catalonia. E-consultations have been really useful as part of the care agenda going forward. The use of these consultations has increased significantly. Video consultations have been less popular and effective than more basic levels of engagement. This approach is challenged in some rural settings where there are no links to medical records and it does not work well in areas with slow broadband. In his view in future post pandemic more remote monitoring would be useful.

Dr Vidal-Alaball explained how "telemedicine provides opportunities and choices but should be driven by patient capacity and need. It needs to be based on a patient centred approach. Over time…the successful application of telemedicine will build acceptance and effective patient use and response to the choices it provides for them".

Graeme Turnbridge (MHRA) identified that tele-health and tele-care has been radically enhanced through the Covid-19 experience. Patient records and access has been freed up as regulation has become more flexible in this period. Organisations are traditionally worried about needing to comply with the regulatory framework at MHRA but the agile approach arising from the pandemic has led to a dialogue about how to refine the medical device compliance requirements.

**The Covid-19 pandemic has accelerated the adoption of digital technologies and products in rural places**

Richard Alcock (NHS Digital) illustrated how COVID-19 has accelerated what had previously been a patchy adoption of digital technologies and products in rural places. Mr Alcock cited telehealth products that treat hypertension using a home blood pressure monitor; and total triage, a model introduced by NHS England and NHS Improvement during the pandemic to support general practices in England implement telephone and online consultations. These tools were seen as providing patients with improved access to advice, support and treatment and reducing visits to secondary care. GP Connect and Summary Care Records have been adopted by GP practices and enable a patient's medical information to be made available to all appropriate clinicians (such as current medication, allergies, contact information of the patient).

Mr James Palmer (NHS Digital) highlighted the use of NHSmail which over a seven week period during COVID-19 led to an increase from 300 carers to 12,000 carer users – providing a secure communication route between different providers in health and care during the pandemic. Mr Graeme Tunbridge (MHRA) described the agility of the regulatory framework during COVID-19 in working with partners and stakeholders to rapidly identify where flexibilities in the regulation of medicines and medical devices were possible. Mr Alcock explained that the key focus as we come through the pandemic is on rolling out such approaches further. This includes Digital Social Care, a partnership programme between NHS Digital and social care providers which supports the adoption of digital innovation in the care sector. The witnesses from the MHRA and NHS Digital referenced the work of NHSX's NHS AI Lab which is supporting the testing, evaluation and scale of promising AI-driven technologies through the £140 million AI in Health and Care Award. This includes automating early lung cancer detection and developing deep learning software that could improve the NHS Breast Cancer Screening Programme.

**Another positive impact arising from the pandemic is the growth of volunteers at the micro-level supporting their local community**

Katherine Nissen (Cornwall Rural Community Charity) identified that the pandemic has led to a new found neighbourliness, one aspect has been the process of looking at how longer term visitors can be regarded as part of local communities rather than just seen as second home owners. In the short term some local food chain innovation has cropped up through the use of farm outlets and very local supply arrangements and it would be a shame to lose this as we exit the pandemic.

# Part Three: Addressing the issues

In this part of the report we consider how three of the major issues for providing rural health and care can be addressed. First, we look at how to attract recruit and retain the right workforce for rural areas.

Then we consider how to improve access to services, particularly ways to overcome barriers of distance, in rural areas. Finally we look at how to overcome health inequalities.

# 3.1 How can we attract, recruit and retain the right workforce for rural areas?

## Section Summary

Witnesses gave a broad set of perspectives on this theme, discussing topics around recruitment and training, remuneration and conditions, and ways of working and delivering services:

**Recruitment and training**

- A key theme in recruitment and training is developing 'rural friendly' approaches that ensure people are recruited from rural areas and that training includes rural experience
- There are examples internationally and from the UK of rural sensitive approaches, especially the 'rural generalist' approach to medical training, initially developed in Australia
- Another key theme is integration of training and breaking down silos so that the workforce can be provided with a diverse range of learning experiences and develop diverse skills to meet rural needs.

**Remuneration and conditions**

- The pay and conditions of health and care workers are major challenges which need to be overcome if recruitment and retention challenges are to be addressed
- In the care sector, low wages lead to significant instability of the workforce; taking a more person-centred approach to care, rather than commissioning driven models, can be one way to make roles more attractive and better meet needs.

**Ways of working and delivering services**

- Multi-disciplinary working and the deployment of new professions can achieve equality of outcomes through non-traditional approaches in rural settings
- Place-based solutions to workforce challenges which understand local community needs were identified as particularly important and valuable
- In addition to the work of paid and professional staff, an increasing importance is attached to the role of volunteers.

## Recruitment and training

**A key theme in recruitment and training is developing 'rural friendly' approaches that ensure people are recruited from rural areas and that training includes rural experience**

In this section of the report it is useful to return to the three core components which underpin good practice in terms of the development of a "rural friendly" workforce from his experience of globally relevant approaches to rural recruitment and retention of GPs presented by Dr John Wynn-Jones (World Organisation of Family Doctors).

1. **Choose students from rural areas.** This may not be easy as aspirations are low and many of these students will need support in their final years at school.

2. **Ensure that students have significant and substantial rural experience** as early as possible in their undergraduate training. Developing an understanding of rural issues through an immersion in rural practice.

3. **Provide specific rural GP training schemes designed to equip future GPs with the skills needed for rural practice.**

He drew attention to two innovative medical courses which are being established in Scotland and plan to start in 2019 & 2020 respectively.

ScotGEM is jointly led by the University of Dundee and St Andrews. Students work closely with their GP mentor throughout their course. They will spend more than half their time learning and working in the Highlands in remote and rural locations.

HCP-MBChB Edinburgh is even more innovative and is aimed at established rural health professionals wanting to convert to medicine (Nurses, pharmacists etc.) They undertake three years part time distance learning in their work setting before going to Edinburgh for a final two years. Both schemes are subject to final GMC approval but we need have more innovative rural schemes such as this. There are other similar innovations globally that we can learn from.

Rural GP training still remains fairly elusive. Scotland has a National Rural Track Training Programme. It also offers a limited number of registrars the opportunity of undertaking a further 12-month rural fellowship programme where they can develop further skills. Dr Wynn-Jones is aware of a similar programme which is underway in Northumberland. The opportunity to undertake specific rural GP training needs to be increased dramatically so as to ensure that our future rural GPs are "rural" trained

Dr Robert Lambourn (Royal College of GPs) set out how attracting people at an early age is key in rural areas. Extended training programmes are important – the University of Keele Medical School is an example of good practice in terms of medical students becoming GPs through this approach.

Dr Ruth May (Chief Nursing Officer for England) identified that Continuing Professional Development is a very important issue in the context of retaining staff in rural areas. Increasing clinical placement capacity should be an area of emphasis.

Dr Richard West (Dispensing Doctors Association) reflected that a local recruitment strategy could make a real difference to a joined up solution to care for non-clinical jobs using pharmacy as a local example.

Professor Stuart Maitland-Knibb (National Centre for Remote and Rural Medicine) in discussing the need to develop a broad church in rural settings identified that people providing health and care services don't have to be doctors. Nurse led approaches can be very powerful. We do need to be able to link programmes of support to a rural medical training model. People need to be trained to interact remotely through wider approaches to health and social care training. This should also link into mental and adult social care models. The focus should be on being in communities.

> "Attracting people at an early age is key in rural areas. Extended training programmes are important."

## Longitudinal Clerkships in General Practice in Wales

Dr Sue Fish (Clinical Senior Lecturer CARER Programme (Aberystwyth), Cardiff University) set out an example of a highly successful initiative based on an approach which started in Cambridge, Australia and Western Ontario – Longitudinal Clerkships in General Practice.

This involves sending a medical student to live and practice in rural areas for an entire academic year. The first cohort of seven students began in Cardiff last year supplemented by five in Bangor.

**A number of benefits of the scheme include:**

- Medical students are influenced by role models and this approach is powerful in that context.
- Evidence suggests a programme like this impacts on the career choices of students going forward, this is the case in Australia with students considering rural careers even if they are not from a rural area.
- The scheme provides an opportunity to promote the benefits of quality of life in rural areas and for students to value what rural areas offer including the variety of skills they need to work in rural settings.
- The scheme involves students who spend half the week in a rural GP surgery, 1 day training and 1 day allocated to a specific project throughout the year with a GP and rural focus. Feedback is that students enjoy the one to one relationship with a dedicated tutor and the intimacy of a small team working environment.

**There are examples internationally and from the UK of rural sensitive approaches to recruitment and training, especially the 'rural generalist' approach to medical training, initially developed in Australia**

Dr Wynn-Jones identified the international example of the "Rural Generalist Movement" which started in Queensland and has had an extraordinary impact in a few years. Prospective rural generalists/GPs receive 3 years of GP/Family Medicine Training. They then receive a further year's training in a speciality of their choice. These include Obstetrics & Gynaecology, Anaesthetics, Mental Health, Aboriginal Health, Public Health, Surgery, Academic Practice, General Medicine, Emergency Medicine and Paediatrics. This has transformed health care in Queensland, eliminated vacancies and rural generalism has become a first career choice amongst medical students. It has become so successful that Australia has appointed a Rural Health Commissioner and one of the remits has been the roll out of rural generalism across the whole country. A similar process is happening in Canada. New Zealand has established a rural hospital generalist programme where doctors are trained to provide health care in its smaller district rural hospitals.

A number of witnesses from more affluent countries identified the virtue, often in complex and well-resourced health settings, of the rural generalist. Manabu Saito (Rural Generalist Programme Japan) identified that this approach was particularly potent in island settings in Japan. He explained how transnational cooperation with Australia had led to the development of the programme in Japan. He also identified the importance of approaches in rural settings, often characterised in Japan by isolated, ageing populations which effectively reflect the complicated and isolated health needs of those communities. Professor Roger Strasser (University of Waikato) identified examples of rural generalist approaches in practice with reference to the Northern Ontario School of Medicine and The Recruit and Retain-Northern Peripheries Programme covering Sweden, Norway, Scotland, Iceland and Canada which has at its heart a generalist approach to medicine, taking the long view, putting a premium on long term planning, aligning approaches with local needs, profiling recruits, supporting spouses, focusing on team work in localities and developing enabling approaches (taking account of distance) to CPD. The EU funded five country, seven-year arctic programme focused on recruitment and retention of health and other public sector workers in remote rural communities and resulted in the development of the Remote Rural Workforce Stability Framework.

Dr Ed Smith (Royal College of Emergency Medicine) indicated the value of the rural generalist as a concept acknowledging the challenges of training and supporting such individuals in remote settings. From his point of view the challenge is about understanding how we select, support and incentivise rural independent

> Seeking examples of good practice to consider transferability as some international systems and contexts are radically different to the UK.

thinking skills to manage rural patients. This process should involve links with hospitals to support decision making around when people enter acute care. It involves working across the patient care pathway and bringing people together in a decision making dialogue.

Dr Alex Degan (NHS Devon CCG) referenced that workforce is the biggest challenge facing rural areas. It means for example it is difficult to support people at home and for them to return home from acute settings. The definition of workforce in this context should be wide to encompass key professions such as pharmacy. Recruitment in too small an initial pool of skills has the effect of relocating rather than adding to the sum of those available.

Richard Murray (The King's Fund) In relation to the The King's Fund experience of best practice in terms of urgent and acute care recruitment suggested that Scotland would be a good starting point, The King's Fund have also worked with Canterbury in New Zealand and an Alaska example of interesting practice. It is important in seeking examples of good practice to consider transferability as some international systems and contexts are radically different to the UK.

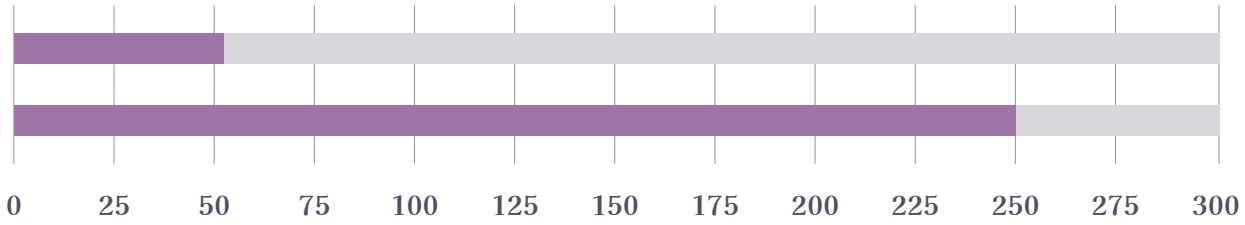
**Another key theme is integration of training and breaking down silos so that the workforce can be provided with a diverse range of learning experiences and develop diverse skills to meet rural needs**

Professor Stephen Singleton (Cumbria Learning and Improvement Collaborative) explained that broader workforce issues in rural settings are really key challenges – what you train is not the only issue; who you train is also important. The creation of an integrated workforce of the future is the answer. At a national level the problem is that flexibility can rob "Peter to pay Paul" as a consequence of the general shortage of people which means that imaginative deployment is sometimes constrained by too few people being available in the first place.

Susan Aitkenhead (Deputy Chief Nursing Officer) established that breaking down the different training silos for nursing is very important moving forward in rural areas. Training placements should also reflect the virtue of providing nurses with a diverse range of learning experiences particularly in rural settings.

Dr Jayne Clarke (Associate Medical Director – Education, Wye Valley NHS Trust) referred to a programme of innovation in postgraduate training. She identified an approach developed by Health Education England to recognize existing competencies and keep people in the NHS enabling them to transfer into other roles. It is hoped that this could lead to a rural alternative at the consultant level. This involves sharing between royal colleges and their different training requirements through the development of blended role qualifications. It could reduce costs and make employment more interesting for clinicians. She further explained that meeting national standards in career development is not possible for many small rural hospitals under the current royal college accreditation and competency requirements. There are a number of areas where more could be done to support rural settings, for example colleges could commit to fill rural training places first and then urban which would reduce rota gaps and address the perception that roles in rural settings are second rate.

Professor Martin Green (Care England) Identified in terms of the workforce challenges in the system, particularly in relation to care, the approach likely to work best is to think strategically about how we can train and support people. Training resources in the NHS through Health Education England also need to be offered to third parties so that they are not just "siloed" within the NHS as a system.




**54 places were initially filled in year one of the operation. The number of participants is now running at 250 places linked to areas with recruitment issues.**

## Remuneration and Conditions

**The pay and conditions of health and care workers are major challenges which need to be overcome if recruitment and retention challenges are to be addressed**

Denise Thiruchelvam (Royal College of Nursing)) identified that the core of the problem in relation to nursing was that successive Governments have underfunded provision. This needs to be addressed by significant future investment. In terms of rural settings isolation is a key issue. Onerous travel times and lone working have created conditions that have led to a shortage of nurses in rural areas.

The Agenda for Change national pay system has helped address some of the additional cost challenges associated with working in rural areas– she went on to explain however this does not extend to the way mileage payments operate which are governed by national policy which drop significantly after 10,000 miles.

Dr Krishna Kasaraneni (BMA) recognised that many GPs choose to work in the place where they trained and this makes it a challenge for some rural areas to recruit GPs. The Targeted, Enhanced Recruitment Scheme, which provides a £20,000 supplement over a 3 year period in areas where vacancies are hard to fill has had a major impact in addressing recruitment challenges. This has changed things dramatically. 54 places were initially filled in year one of the operation. The number of participants is now running at 250 places linked to areas with recruitment issues. Recruitment is less of a challenge than retention from his perspective.

Dr Kasaraneni explained that the main problem is that we are losing specialist and long served GPs. Pension regulations have impacted on GP retention – they provide a disincentive for people to stay in practice generally. The issue relates not just to GPs at the end of their career. The annual allowance issues affect some GPs from their 40s. Perversely working longer hours due to a shortage of GPs increases the pension problem for GPs.

He also identified that workload is a real challenge facing many GPs, Primary Care Networks are being seen as a potential response – GPs are looking out to work with others around them to fashion more holistic approaches. Primary Care Networks (PCNs) will help drive this. PCNs will have a potentially powerful impact in rural areas where a lack of service options is a spur to networking.

Dr Kasaraneni indicated that from his perspective the biggest problem with rural General Practice is the urban mindset of policy makers – big is beautiful. Investment in buildings is an example of the challenges faced where small development of GP practice is not attractive in terms of funders who prefer investment in larger scale urban estates. This was further borne out by Dr Paul Johnson (Clinical Chair, Devon CCG) who explained that many young GPs are wary or having limited means to acquire a partnership with property owning GPs. Dr Johnson feels that the restricted scope for movement arising from the ownership of property is a risk and not a “nest egg” in the current economic climate.

**In the care sector, low wages lead to significant instability of the workforce; taking a more person-centred approach to care, rather than commissioning driven models, can be one way to make roles more attractive and better meet needs**

In terms of care, Councillor Sue Woolley (Lincolnshire County Council) explained that the biggest challenge facing the sector involves staffing for social care which currently at the operational level competes with food factory jobs and other sectors which also pay the minimum wage leading to a significant instability of workforce.

Sian Lockwood (Community Catalysts) identified that in terms of barriers to recruitment there is a limited perception of the way people can be paid for care. The Community Catalyst model is not about people being recruited to an organisation but providing a variety of ways that people can earn an income, opportunities for shared lives (sharing homes and care). The perception is care is poorly paid and low status. People want to work locally and earn an income and make a difference to a person's life so the Community Catalyst worker ethos is slightly different it is person focused.

In terms of barriers in the social care provider market – there is limited understanding of market with commissioning tied to traditional markets, risk aversion and debates on professionalization are not driven by users but by commissioners. The Community Catalyst model involves the flow of money to less traditional forms of support, it involves the relocation of retirees (most Community Catalyst supported micro enterprises are made up of people over 50 years often pursuing a second career). The approach involves locally designed and delivered services and presents opportunities for local people and communities: the carer services are run by local people, for local people and are responsible to their local community.

With regards to reform, care needs to be relevant and important to everyone in a locality, it can't be" a thing over there" for older people that we hope we don't need. It should be central to the local community and its prosperity and wellbeing. Where the approach works well it involved self-help opportunities to avoid the need for formal services, promote independence, encouraging people to stay connected including economically, it involves self-directed support to draw on the user to design their own support. It involves a shift from longer term support to community embedded approaches drawing on local resources and technology. The significant benefits arising from this approach have been evidenced by a recent report commissioned from the New Economics Foundation (nef).

## Ways of working and delivering services

**Multi-disciplinary working and the deployment of new professions can achieve equality of outcomes through non-traditional approaches in rural settings**

Professor Tahir Masud (British Geriatrics Society) identified that their initiative with Royal College of GPs on Integrated Care for People with Frailty initiative is a powerful example of the benefits of mutli-disciplinary working in rural areas. He identified that advanced clinical and nurse practitioners have a particularly valuable role to play especially when they are embedded more deeply in the community. He went on to identify that medication reviews in care homes for example are helpful when well planned. He identified that pharmacists could have a key role in this agenda if it was systematically extended.

Professor Ian Couper (Stellenbosch University) identified the importance of physician (clinical) associates as part of a strategy for addressing a shortage of fully qualified doctors in rural settings. In South Africa, physician (Clinical) associates are an important part of the agenda. These are people who can provide care in appropriate circumstances without needing the full doctor training to make things work. They undertake a 3 year training programme – the term "associate" makes it clear that these individuals have some self determination. Their training focuses on relationships with patients from day one. From 2011 these individuals have become well established as part of the South African system. Professor James Rourke (Memorial University of Newfoundland) identified the importance of vocational training as a focus for rural development in Canada where the emphasis is seeking now to focus more on making it work for the patient as opposed to making the patient fit the system. This approach recognizes which seeks in part of focus on the often traditionally late presentation in rural areas and identifies that in addition to traditionally there has been too much the traditional focus on rural doctors there needs to be more development of  at the cost of other team aspects of professional care delivery. Nurse practitioners are now recognised as very important as part of this integrated rural health care team agenda.

Dr Debbie Freake (Northumbria Healthcare NHS Foundation Trust) indicated that there is evidence of rural innovation in rural areas around actions in relation to joint tasking for example in terms of combined rotas, dual trained medics, more use of advanced practitioners, composite workforce approaches which involve bringing a team response to replacing traditional functions.

Expert generalist roles are also acknowledged as being very important. She identified that the Northumberland A&E approach based on networks has made a real difference to workforce availability – with links to different centres. This has removed the specialists problem, whereas in neighbouring Cumbria this is still an issue.

Dr Freake also identified that co-location of community facilities and GP surgeries is a powerful driver of integrated care – which can also look outwards towards housing. IT is not as fully and as effectively utilized as it might be. Telehealth and remote consultations are very important facilities which if used well can improve health outcomes in rural settings.

Sheila Childerhouse (West Suffolk NHS Foundation Trust) explained that integration between acute services and mental health and social care is a driver of new ways of working. She identified that local recruitment is very important. She indicated it is easier to recruit to a community hub for people in adult domiciliary care than individual service settings.

Lee Howell (Devon and Somerset Fire and Rescue Service) widened the perspective outside of health and care in terms of good practice and multi-disciplinary working. He identified that a number of fire and rescue services provide a co-responding service. Devon and Somerset fire service has 83 fire stations and can be mobilised by the ambulance service directly not through the fire call centre – they can pick up defibrillation and trauma equipment and work to the ambulance trust and then return to the station once a call is completed.

The service meets the cost of co-responding via a grant from the ambulance trust. The cost of fire fighters undertaking this approach versus non-paid for community responder services can be a tension in some areas and this needs to be managed carefully. Rural fire stations have fire-fighters living in communities and this provides a good opportunity to think more insightfully about the opportunities to develop fast emergency responses in rural settings.

Local fire-fighters live in communities and know them, they have a good level of training to deal with medical problems, technical expertise with physical support to move patients safely and understand how to optimise the provision of immediate emergency care in rural locations.

> In a rural community it is important to have GPs with flexible skills. Community engagement is important and this should lead us to be sensitive.

**Placed-based solutions to workforce challenges, which understand local community needs, were identified a particularly important and valuable**

Councillor Andrew Leadbetter (Devon County Council) exemplified how Devon is building place-based approaches into its delivery of adult social care. In Devon (as across most of England) age rates are a key issue people can earn more in basic retail jobs than supporting individuals through the care profession. Devon experiences a 41% turnover in year 1 of employment in care. The authority had launched a "Devon Proud to Care" campaign. In terms of adult social care the Council fully fund travel time, they will not pay for less than 30 minute per appointment. They provide guaranteed hours for workers. They only fund visits which have a clear rationale. The Council is growing its own social workers. It is celebrating its work force.

Dr Gill Garden (University of Lincoln) set out the nature of the challenge in Mablethorpe a deprived coastal settlement by way of an example of the impact of place on workforce. She explained, it requires for example a 2 hour bus journey from Mablethorpe to access treatment services in Lincoln or Boston. At the GP practice in Mablethorpe 76% of patients are frail and there are just 2 full time GPs. The area has the fewest clinicians per patient in the country. Professionals are professionally and socially isolated in places like this on the Lincolnshire coast. In such places there is always a danger that practices can develop which may not be up to date or desirable. Building on evidence referenced from international settings. Dr Sue Fish described how Cardiff Medical School introduced the application of the immersed, dispersed Longitudinal Clerkship approach in Wales as an example of the development of a learning approach focused specifically on the concept of locality.

Dr Ian Hulme (BMA GP Committee) identified some of the key dynamics in a rural setting which need to be taken account of. He explained that in a rural community it is important to have GPs with flexible skills. Community engagement is important and this should lead us to be sensitive about the implementation of change. Urban models aren't always transferable to rural settings. Isolated GPs face increased workload and higher levels of vulnerable older patients than their urban counterparts.

In terms of appropriate planning geographies Dr Hulme's experience is that his area - Norfolk and Waveney is a natural community which runs also into Suffolk and works as a logical area. The pattern of acute care is also determined by the geography of the area with the fixed need for 3 acute centres based on the distribution of the population.

Tarun Bhakta (Assistant Policy Officer Shelter) and Jo Lavis (Rural Housing Solutions) identified how the failure of the rural housing market impacts on the living options for essential workers and more widely makes it difficult for people of modest means to live in rural settings. Mr Bhakta referenced the notion of affordability – home ownership is out of reach for a large proportion of the population - 63% of renters have no savings, the wider cost of home repair and up-keep including the challenge of funding adaptations to enable people to live in housing which meets their needs should be recognised. The impact of the "Right to Buy" in rural areas has left people with some properties with challenging maintenance problems. A failure to replace bought up homes in rural areas makes the situation worse and this is further exacerbated by a lack of downsizing opportunities. One of the barriers is the lack of attractive alternative housing in many rural localities.

This was further reinforced by Sian Lockwood (Community Catalysts) who identified proximity to work is an issue, affordable housing is not available to the social care workforce so workers can't afford to live near to where they work, accessing CPD and having choice/options around CPD are a challenge and seasonal employment in holiday geographies make it's easier to recruit in winter not summer.

**In addition to the work of paid and professional staff, an increasing importance is attached to the role of volunteers**

Andy Tilden (Skills for Care) identified that volunteers have a crucial role to play in preventive activities in the context of health and care and support roles working alongside the paid workforce. Mr Tilden sees little distinction in terms of the role and nature of volunteers in the context of rural as opposed to urban settings apart from perhaps a higher premium being put on the ability to drive.

Sir Tom Hughes-Hallett (Helpforce) explained that the problems challenging health and care are systems based and can be addressed in part by a new more professionalized approach to volunteering. Through a Christmas appeal in 2018 with a national newspaper asking for time not money, Helpforce developed a very significant increase in NHS volunteers. There is a huge demand to volunteer a fair proportion of which is in rural areas. Helpforce doubles the income for its activities which is provided by the NHS contributing £1 for every £1 raised for a volunteering project.

Sir Tom Hughes-Hallett drew attention to a number of further examples of activity: In Warwickshire the fire service are involved in supporting hospital discharge, in Norwich and Norfolk retired professionals wait at home for the patient to arrive providing a settling in home service this means hospitals can discharge patients sooner with reduced risk of rapid readmission.

Sir Tom Hughes-Hallett reflected that there is an “army of volunteers” waiting to serve rural settings and that the fastest growth in volunteers is amongst the under the 30s. Health and Care is a natural magnet for volunteers in rural and town settings; for example Northumbria NHS Health Trust is now the main employer in its area and same is true in terms for example of Huddersfield.

Nikki Cooke (LIVES) identified that whilst her organisation is staffed principally by volunteers it provides a nationally significant response service significantly enhancing the statutory provision available in Lincolnshire in relation to the emergency response agenda.

Helpforce doubles the income for its activities which is provided by the NHS contributing £1 for every £1 raised for a volunteering project

# 3.2 How can we improve access to services?

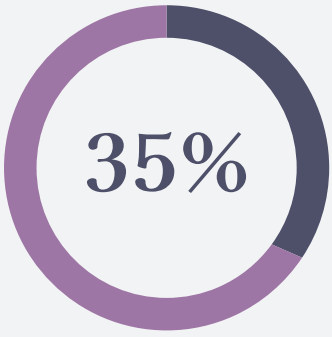
## Section Summary

Evidence submitted to the Inquiry looked at how access to services could be improved through using community-led approaches, reconfiguring physical assets, and greater use of digital and other innovative services to overcome distance barriers:

- Applying community-led solutions, such as community micro-enterprises, can result in more person-centred approaches as well as building social connectedness
- It is possible to redefine assets such as care homes so that they are seen as a more central part of the community
- New housing that is designed to allow for care at home can help rural residents to stay in their own homes for longer, improving quality of life as well as reducing costs
- Digital solutions can help overcome barriers of physical distance, although they should be seen as a complement to, rather than a replacement for, personal interaction
- In social care, digital technologies can help service delivery and the experiences of people receiving care – particularly the transition between health and care setting
- Tele-health and other innovative support services can also play a key role in overcoming barriers of distance in rural areas
- Innovations in delivery of emergency services through joint working can improve access in rural areas

**Applying community-led solutions, such as community micro-enterprises, can result in more person-centred approaches as well as building social connectedness**

Rhys Davis (Community Catalysts) described their small community enterprise model to deliver care which has provided support to more than 300 people to become self-employed carers. Ms Sian Lockwood (Community Catalysts) described the approach as "carer services run by local people, for local people who are responsible to their local community".




**Supporting recruitment and retention in social care – 35% of those surveyed said they would be unlikely to work in social care had they not set up a micro-enterprise.**

In May 2020, the New Economics Foundation published a report on community micro-enterprise in social care. This highlighted the work of Community Catalysts in supporting the establishment of micro-enterprises that are:

- Spreading a new form of entrepreneurship that is accessible to, and benefits a wide range of, people – including older women looking for rewarding and flexible work.
- Creating roles that offer more autonomy and control than a typical care job – with 61% of those surveyed feeling less stressed and anxious since setting up their micro-enterprise.
- Supporting recruitment and retention in social care – 35% of those surveyed said they would be unlikely to work in social care had they not set up a micro-enterprise.
- Enabling more personalised care by devolving decision making to people in need and those providing support.
- Building social connectedness by helping people to participate in their communities.
- Growing resilience, creativity and diversity in the social care sector.

Mr Piers Ricketts (Academic Health Science Network) referred to Just One Norfolk, services for Norfolk families, commissioned by Norfolk County Council and provided by Cambridgeshire Community Services NHS Trust. It uses the Solihull approach, a whole system approach to improving emotional health and wellbeing for children and young people. It empowers Norfolk parents to support the optimum health and wellbeing of their children (0-19 years). It is available in multiple languages and contains interactive resources, peer support, quizzes and games to encourage learning. Parents and children can also access confidential support telephone lines or text chats. During COVID-19 the platform has been supporting families with learning, technology, food, finances and online safety. Similarly, NEDCARE in Dartmoor was cited as an example of good practice by Dr Alex Degan (NHS Devon CCG) because of the level of community engagement in providing home care services.

## Community catalysts (Somerset)

1. Community micro enterprise model – this involves really tiny enterprises that charge for what they do and are led by local people who provide support for local people. Over the 5-year period that the model has been operating, some 500 enterprises have supported 2,000 people to deliver 20,000 hours of care a week across Somerset. 46% of these hours are spent on providing direct care to an individual in their own home, with the remaining time allocated to low level support activities (e.g. dog walking, cleaning, shopping). Providers have a range of different structures from CIC to sole traders. In this network Community Catalysts enables local people to do things well, legally and sustainably. Community Catalysts also works with public bodies to look at their systems and cultures and to support them implement community led models.

2. Local area coordination – this has adapted a model from Australia and involves putting coordinators in rural places. Coordinators are usually employed by local authorities with mixed funding, they are based in the local community and work with anyone who is able to help deliver their mission. The coordinators work is preventive and involves supporting people with complex 64 needs to draw on their own, and community resources, so they become net contributors to the local community.

**www.communitycatalysts.co.uk**

**It is possible to redefine assets such as care homes so that they are seen as a more central part of the community**

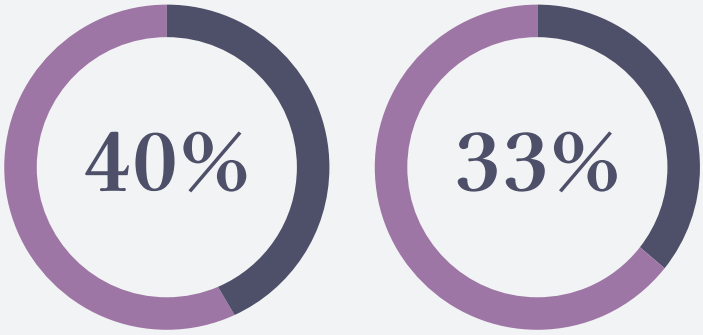
Professor Martin Green (Care England) called for the redefinition of the care home model to enable them to become hubs to support people in local communities: "when a carer can't cope they ring 999 and end up in acute services. Could they phone their local care home? Care homes also have the potential to offer services such as food delivery, laundry etc. The discussion is always about the NHS, care providers and Local Authorities but it should be about how we experience the service, about outcomes, not the structures that underpin it". Professor Green noted how care homes are located and focused on communities and might also house the local shop, library or post office and provide new opportunities to discuss care needs which could feed into locality planning processes. He said: "when people think about care they think about decline and we need to make going into a care home more normal to demystify this".

The Inquiry heard inspirational examples, including the ground breaking Bell View in Northumberland which offer a range of health, wellbeing and social activities from its Resource Centre and also day care and support to people in their own home – thus demonstrating how health and care can be provided in remote rural places. And Norton-sub-Hamdon Community Land Trust which also owns the local village shop and has harnessed volunteers during COVID-19 to deliver care packages to self-isolating and vulnerable residents.

Alan Morgan (National Rural Health Association, United States) described how the concept of the rural hospital has been redesigned in the United States. This includes hospitals in rural places that have established 24/7 emergency and outpatient services that operate as needed, supported by telehealth, and that focus on public health, primary care and keeping local communities healthy.

**New housing that is designed to allow for care at home can help rural residents to stay in their own homes for longer, improving quality of life as well as reducing costs**

Peter Moore (Chief Executive, Cornwall Rural Housing Association [CRHA]) conveyed in his evidence that general needs homes built in rural areas need to be capable of being flexible enough in terms of size and design to meet the changing needs of current and future residents. CRHA provided examples of the provision of two-bedroom bungalows in Poundstock and Blisland which have been let on a flexible approach (i.e., allocated according to need rather than full occupation) where designs such as a shower room, work or study space and room for overnight carers to stay had led residents to be discharged from hospital sooner and delayed some residents accessing social care. Mr Moore described how "CRHA experience shows that the investment made in affordable housing, particularly in rural areas, can help reduce reliance on other public services". According to Councillor Sue Woolley (Lincolnshire County Council) "prevention strategies aiming to keep people in their own homes for longer are a key target which can significantly increase positive outcomes and drive down costs". Graham Biggs (Rural Services Network) highlighted the impact of the pandemic in showing the need to re-label key workers and the need for a housing policy that delivers housing for health and care workers in or near rural places.




The right tools enhance workforce skills and development, leading to a 40% higher retention rate in care staff and a 33% higher retention rate in nurses in care homes.

> We need to think carefully about the application of technology as it is not a panacea but can make a significant difference.

**Digital solutions can help overcome barriers of physical distance, although they should be seen as a complement to, rather than a replacement for, personal interaction**

Richard Alcock (NHS Digital) indicated how technology and e-enabled solutions can overcome physical distance for patients and clinicians. For example, new medical imaging technology which makes diagnostics quicker, safer and without the need for the patient to necessarily travel to see the specialist. Professor Clive Ballard (University of Exeter) highlighted several initiatives, including 'protect' – an online platform that has enabled 50,000 people to participate in clinical trials and provided cognitive training to 20,000 people; and social media and a chat room provided by Alzheimer's Society. Professor Ballard described how "there is increasing evidence that supported digital health applications are effective" such as tele-health, wellbeing apps and digital support for people with mild cognitive impairments; and how "there has been a stereotyping that older people do not use digital – this is often not true. There is a rise in the incidence of older people engaging with social media". Professor Ballard suggested a scoping exercise be undertaken to identify the potential of digital applications and tools, accompanied by pathfinder projects.

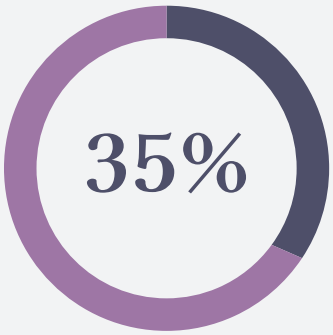
Professor Ballard described how "digital interventions should be a complement to, not a replacement for, personal interaction. We need to think carefully about the application of technology as it is not a panacea but can make a significant difference. Systemised approaches are key". Indeed, Phil Confue (Cornwall Partnership NHS Foundation Trust) described the experience of Cornwall, which had participated in a pilot of digital technologies back in 2010, "but with no subsequent investment the systems established became outdated. In remote rural locations capital allocations are small so there has been no opportunity to renew the technology and bring it up-to-date". This view was also echoed by Dr Richard West (Dispensing Doctors Association) who highlighted how the specific resource costs of developing innovative services are often missed in the drive to join services up.

**In social care, digital technologies can help service delivery and the experiences of people receiving care – particularly the transition between health and care setting**

Robin Batchelor (Care Software Providers Association) indicated the benefits of the deployment of digital technologies in rural places for the delivery of social care. These included:

- Improving transparency and accountability – by sharing up-to-date care records and providing a clear audit trail.
- Better management of risk – timely information ensures medicine errors are less likely to be made.
- Social care provider and individual staff member efficiencies – because of the reduction in staff needing to travel to deliver care.
- Staff recruitment and retention – the right tools enhance workforce skills and development, leading to a 40% higher retention rate in care staff and a 33% higher retention rate in nurses in care homes.

However, Mr Batchelor noted how 70% of social care providers remain paper based and the importance of moving to digital systems "facilitates the sharing of information, enabling the right information to be in the right hands at the right time". In relation to social care, Mr Batchelor explained how digital systems could enable care notes and activities to be shared in real time (online) or near time (offline) with family members; and enable social care staff to interface with multidisciplinary teams reducing the need for residents and staff to travel for consultations and monitoring. These points were echoed by George Coxon (Care Home Owner, Devon), particularly around the importance of managing the transition between health and care settings. According to Mr Batchelor, "It is only by adopting technology that social care can play its part in interacting with healthcare, enabling true two-way data interoperability to ultimate benefit individuals as their care needs change".




**Councillor Lee Chapman (Shropshire Council) highlighted several examples which had led the Local Authority to achieve a 35% reduction in adult social care costs.**

**Tele-health and other innovative support services can also play a key role in overcoming barriers of distance in rural areas**

Witnesses suggested rural places could be testbeds for the more innovative delivery of health and care. Dr Ed Smith (Royal College of Emergency Medicine) explained how "this should not be seen as dumbing down a service…but due to the distances involved you may need to do things slightly differently".

Victoria Pickles (Airedale NHS Foundation Trust) outlined how the Trust has developed the Gold Line, a 24/7 telephone service for people who may be in their last year of life and their families across Airedale, Wharfedale, Craven and Bradford. The care provided by nurses running the helpline and the services they coordinate has meant a higher proportion of people have been able to die in the place of their choosing (at home).

Councillor Lee Chapman (Shropshire Council) highlighted several examples which had led the Local Authority to achieve a 35% reduction in adult social care costs. These included: '2 Carers in a Car', a project launched in July 2017 which involves two professional carers, based in their car, who provide bespoke night time support in the community; a first point of contact telephone service – which has led 85% of adult social care queries to be resolved over the phone and 15% requiring follow-up; and an integrated NHS and Council team called Integrated Community Services to help patients leaving hospital and patients needing support to avoid unnecessary hospital stays.

## Gold Line Telephone Service (Airedale)

Airedale and partners have established a dedicated 'gold line' telephone service across Airedale, Wharfedale and Craven, providing one point of contact for residents and their carers for help and advice, 24 hours a day, seven days a week, supporting them in their preferred place of care wherever possible. One of the aims of the service is to prevent the gold line residents having to go into hospital by providing support at home. However, hospital admissions will be arranged when required. Calls are answered by a team of experienced nurses in the telehealth hub at Airedale Hospital. The nurses are linked up to community-based teams, who can visit residents if necessary.

Airedale and partners also provide a secure video link to care homes across the county, which connects with a digital care hub. The hub is staffed 24 hours a day, 365 days a year by a multidisciplinary team of doctors, nurses and therapists. Care home residents are assessed by the clinical team, who are able to advise and suggest treatment for a variety of complex health needs. The telemedicine service is particularly useful in residential homes, where staff are not usually medically trained, and the clinical team are able to provide extra support which benefits the residents. Care home residents are assessed and, if necessary, treatment is arranged without the need for a hospital admission or emergency department attendance. In a single month, the centre received over 1,500 calls, more than half of which occurred out of hours. Of the calls received, more than 1,300 resulted in the patients being able to remain in their place of residence.

These systems offer the potential to enhance the quality of care, and to reduce inappropriate GP call outs, ambulance calls and admissions from care homes to hospital. They can also help palliative care residents die in the place of their choosing.

**www.airedale-trust.nhs.uk/services/the-gold-line/**

## Community paramedic scheme

A team of paramedics from the North East Ambulance Service (NEAS) work alongside GPs in Berwick and surrounding areas. The scheme is a joint initiative between the NHS Northumberland Clinical Commissioning Group (CCG) and NEAS. It operates across the Well Close Medical Group, the Union Brae and Norham Practice and Berwick Infirmary minor injuries unit (MIU). A paramedic is available from 9am-9pm for seven days a week. The paramedics use a rapid response vehicle with the primary care teams at the two GP practices from 9am-6pm and work alongside the MIU from 6-9pm on Mondays to Fridays. They also work with the MIU from 9am-9pm on Saturdays and Sundays. The scheme provides:

- Improved access to community-based health care
- Minimises the time taken to respond to life-threatening emergencies
- Uses NHS resources more efficiently by reducing the number of patients taken to hospital unnecessarily.

The team support the GPs by making urgent visits to patients, help with the care plans for patients with long-term medical conditions and work with other healthcare staff, such as the district nursing team. The primary role of the paramedics will continue to be to respond to lifethreatening emergencies in the Berwick area if they are the nearest ambulance resource.

Ms Helen Ray (NEAS) describes how the scheme has "considerably shortened the arrival time of the first resource to cardiac arrests and other emergencies".

**www.neas.nhs.uk/news/2021/january/25/berwick-community-paramedicscheme-thanked-for-its-support-during-coronavirus-pandemic.aspx**


**While the scheme has been successful it has only been possible because of funding from Northumberland Clinical Commissioning Group (CCG) – this initially provided 50% of the funding**

**Innovations in delivery of emergency services through joint working can improve access in rural areas**

Helen Ray (North East Ambulance Service) explained how because of the dispersed population and road networks "the model of [emergency] delivery in rural areas has to be different and coordinated with other healthcare professionals in the area". Ms Ray highlighted the work of community paramedics and the support they provide to patients to enable them to remain in their community, avoiding long distance travel to a hospital. Ms Ray underlined that while the scheme has been successful it has only been possible because of funding from Northumberland Clinical Commissioning Group (CCG) – this initially provided 50% of the funding with the remained provided by NEAS in year 1 but since year 2 the CCG has provided 100% of the investment.

Lee Howell (Devon and Somerset Fire and Rescue Service) identified co-responding as a powerful means of supporting ambulance capacity in rural settings. Devon and Somerset Fire and Rescue Service has 83 fire stations and can be mobilised by the ambulance service directly not through the fire call centre. They can pick up defibrillation and trauma equipment and work to the ambulance trust direction and then return to the station once a call is completed. He believes this works well because local fire-fighters live in communities and know them, they have a good level of training to deal with medical problems, technical expertise with physical support to move patients safely and understand how to optimise the provision of immediate emergency care in rural locations.

# 3.3 How can we reduce health inequalities?

## Section Summary

- Existing data on deprivation and need should be applied through a rural lens to ensure rural need is not masked by aggregation of data and that factors such as distance from essential services and the proportion of older people are considered
- Giving a central role to local communities which puts residents in the lead can help promote health and well-being
- Integration and collaboration are key themes in ensuring improved health outcomes for rural populations
- Person-centred approaches that provide holistic care can help deliver improved health outcomes.
- One example is a 2017 West Suffolk test and learn initiative using the the Buurtzorg model of care. This model was originally developed by a social enterprise in the Netherlands in 2006, and involves small teams of nursing staff providing a range of personal, social and clinical care to people in their own homes in a particular neighbourhood.

**Existing data on deprivation and need should be applied through a rural lens to ensure rural need is not masked by aggregation of data and that factors such as distance from essential services and the proportion of older people are considered**

Dr Rashmi Shukla (Public Health England) highlighted two issues which limit the utility of the Index of Deprivation (IMD) to rural places. Firstly, the aggregation of data sources to create composite IMD measures mask the negative characteristics faced by rural places. Secondly, some of the indicators used are more applicable to urban places compared to rural places.

**Dr Shukla highlighted two examples where new and more rural sensitive indices for deprivation are being developed:**

### New ways of measuring rural deprivation

1. PHE is working with the Small Area Health Statistics Unit at Imperial College London using IMD and the Scottish Carstairs index to see if it can be better describe, in spatial terms, the heterogeneous nature of areas. This approach, which omitted data relating to urban small areas from both indexes, showed eastern and western coastal areas and the areas near the Scottish borders had the highest levels of deprivation in rural areas in England. This pattern was confirmed locally by Directors of Public Health operating in these localities.

2. PHE is advising the Work led by Professor Andy Jones at the University of East Anglia (UEA) to explore the development of a more precise means of measurement for rural deprivation to complement the IMD. This approach uses Norfolk as a test bed, and has also been applied to Lincolnshire. It uses some of the IMD data sets relevant to rural areas and adds in average travel time to essential services and a population factor – looking at the ONS mid-year estimates of those aged 75years and over. This has led to the production of a new Rural Deprivation Index, and further analysis to test its utility is underway.

Dr Shukla described how "drilling down into the housing and transport indicators within the IMD paints a more nuanced picture of the real lived lives of rural dwellers". Dr Shukla suggested it would be insightful to look at the distinctive needs of rural residents – starting with the outcomes required – and then to see what data and statistics have to offer to interpret and provide insight. These statistical tools should be complemented by "local insights in terms of their application and taking account of local contextual issues".

Professor John Shepherd (Birkbeck College) outlined new research with Professor Jones at UEA to apply the Rural Deprivation Index (RDI) to the county of Lincolnshire. Professor Shepherd explained how the English Indices of Deprivation 2019 focus on concentrations of deprivation in small areas whereas rural deprivation is more scattered in dispersed settlements; and many of the measures are based on easily counted data where are some rural issues (e.g. aspects of health and welfare) are under-reported. Professor Shepherd has used the RDI (see the text box above), compared this with IMD data from 2019, and applied this evidence to Lincolnshire. In the IMD, only 10 LSOAs in Lincolnshire appear in deciles 1 and 2 (i.e. 6% of all rural LSOA types) compared with 55 (32%) of urban LSOA types. When the RDI is applied, there is an increase of 41 LSOAs in decile 1 and of 16 LSOAs in decile 2. These are predominantly 'rural' LSOAs - 25 in the case of Rural Town and Fringe types and 24 in the case of Rural Village and Dispersed types. The RDI provides a starting point from which a more appropriate indicator of deprivation in rural places might be constructed – by applying a rural lens through existing datasets.

In terms of rural housing evidence and analysis, Jo Lavis (Rural Housing Solutions) called for a "rural cut" of housing needs evidence and how Local Plans should treat meeting rural housing needs as a strategic policy area in the same way as they do for urban centres.

**Giving a central role to local communities which puts residents in the lead can help promote health and well-being**

Professor Sir Michael Marmot's research on health inequalities led GP practices in Fleetwood, Lancashire to work with residents and other health and community services to transform the health and wellbeing of local people. Dr Mark Spencer (Healthier Fleetwood) described how "on the ground residents were fed up with short term consultation. A longitudinal approach to active listening has been the way forward". The scheme, known as Healthier Fleetwood, has been running for more than four-years and not only listens to residents but also builds their confidence by enabling them to do activities and better support themselves. Dr Spencer described the experiences of one of his patients who had told him "it's not the fear of dying that stresses me out, it's the fear of living". Healthier Fleetwood is building a new sense of community and focusing on wellness.

## Healthier Fleetwood

Fleetwood, Lancashire is an urban community suffering from high deprivation, where the life expectancy of its 26,000 residents is significantly lower than the national average. 53% of residents live in the worst quintile of poverty in all neighbourhoods in England. The peninsula has poor transport links and even though it is 10 miles from Blackpool (and 17 miles from an A&E department), it feels isolated.

The Healthier Fleetwood scheme is a partnership of residents, healthcare providers, charities and other groups, which is supporting local people to make life changes to support their long-term health and wellbeing. Based in the local Health and Wellbeing Centre, the scheme organises events such as free sports lessons, a Harmony and Health Singing Group, mental health support classes and drop-in sessions to engage residents with new programmes. GP practices are also working with other services, including community pharmacists to expand their team of health professionals across the area that can respond to the different needs of their patients.

There are now over 100 clinicians, including GPs, nurses and mental health teams, working to support Fleetwood residents in a range of areas from mental health to drug abuse. Local schools are also involved in mental health access schemes; helping to provide support and build resilience amongst school children. Fleetwood is helping to support its local community to live well and focusing on school children can help to prevent the development of long-term conditions and ensure they live healthy lives.

**www.healthierfleetwood.co.uk**

> The patient is not worried about who owns the service, as long as they receive it.

## Wessex pathway for Isle of Wight residents

The Wessex Kidney Centre (WKC) provides a comprehensive renal service to an adult population of approximately 2.2 million, covering the majority of Hampshire, the Isle of Wight and the adjacent parts of Wiltshire, West Sussex, Berkshire and Surrey.

The Renal and Dialysis Unit, based at St Mary's Hospital, Newport, is a satellite centre for Portsmouth Hospitals NHS Trust and enables Island-based patients to receive treatment on the Isle of Wight rather than travelling to the mainland. The unit has also trained patients on the Island to use portable dialysis machines at home, rather than patients having to travel to the mainland for such training.

In an international context, Dr Mayara Floss (Grupo Hospitalar Conceiçã, Brazil) described the work of community health workers (CHW) – literate adults who are often selected by local health committees and who work in the community where they reside. The CHWs receive formal training at regional health schools, supervised field training and ongoing training. The CHWs provide comprehensive care in rural places through promotive, preventive, recuperative and rehabilitative services. CHWs register the households in their area, empower communities and link them into the formal health system. CHWs are able to resolve many low-level problems, such as checking to make sure patients are taking their hypertension or diabetes medication correctly or may refer more complex issues to the appropriate professional. Multidisciplinary teams—which include physicians, nurses, and community health workers—are responsible for registering every family in their area, monitoring living conditions and health status, and providing primary care.

**Integration and collaboration are key themes in ensuring improved health outcomes for rural populations**

Vaughan Thomas (Isle of Wight NHS Trust) highlighted the importance of integration. The Trust is the only integrated acute, community, mental health and ambulance health care provider in England. Established in April 2012, the Trust provides a full range of health services to an isolated offshore population of 140,000. This includes acute care services, community health services, mental health services and ambulance service. Mr Thomas also emphasised the importance of partnership working. He described how "the patient is not worried about who owns the service, as long as they receive it".

Nikki Cooke (LIVES) described the role of community responder services in ensuring patients get on the right care pathway, tapping into the resourcefulness and community spirit in local communities. She said: "just because you live rurally does not mean you should have less good health outcomes than if you lived next door to a hospital".

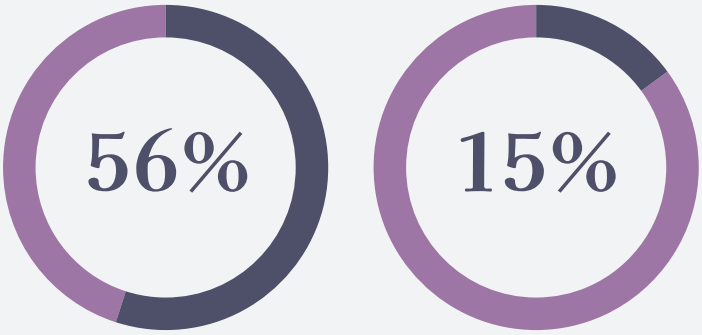
## LIVES – it takes a team to save a life

In a medical emergency, every minute counts in getting that vital first medical support to the patient as quickly as possible. Those first golden minutes can make all the difference to a patient's life. LIVES has an army of skilled volunteers who give up their spare time to respond to 999 medical emergencies, in their communities, right across greater Lincolnshire. The support LIVES provides fits into two main strands of work:

1. Community responders – this began in 1989 and since then the number of responders and their role has evolved. In 2019, LIVES responded to 15,000 calls, or 40 responses a day. 83% of first responders arrive before the ambulance service. In 2020, the critical care team of 17 clinicians responded to 980 calls and used their surgical and anaesthesia skills 130 times. LIVES has its own clinical governance and has been CQC registered since 2013 – the charity employs its own medical director and clinical governance manager. There are now 26 first responder schemes across the country, but LIVES is the largest with 57 clinicians regularly volunteering their time. The LIVES response costs just £200 per incident.

2. Emerging models of care - doctor cars "community emergency medicine": this provides a multidisciplinary team comprised of 2 people and 3 crews that respond to CAT 2 calls (e.g. stroke, serious injury) and CAT 3 calls (e.g. fractures, abdominal pain). The doctor car was piloted in 2019 and has been fully operational since April 2020. From the patients treated so far, 56% of patients avoided hospital and other health interventions and 15% avoided the emergency department but accessed other health services. The doctor car scheme is delivering emergency health care differently because the team are bridging the gap between primary care and secondary care and are making decisions with the patient in their local community.

**www.lives.org.uk**




**From the patients treated so far, 56% of patients avoided hospital and other health interventions and 15% avoided the emergency department but accessed other health services.**

> Just because you live rurally does not mean you should have less good health outcomes than if you lived next door to a hospital.


Ms Cooke noted that "first responder schemes do not benefit from statutory funding and do not meet Lottery grant criteria…the biggest issues facing LIVES, and the sector more generally, are sustainability, funding, scalability and profile…first responder schemes fly under the radar and have immense potential, a small investment in them could yield huge benefits". Ms Cooke noted that LIVES responders fundraise for equipment and training and carry out their voluntary role alongside their day job. Responders carry £30,000 worth of equipment with them to call outs, and doctor cars have £100,000 worth of equipment on board.

**Person-centred approaches that provide holistic care can help deliver improved health outcomes**

Sheila Childerhouse (Chair West Suffolk NHS Foundation Trust) referenced the Buurtzorg approach to nurse recruitment as an important innovation (Dutch in origin) which provides person-centred holistic care– covering all of the social as well as medical aspects of their care. She indicated that this had been a very positive but challenging approach to recruit to. It has been hard to recruit nurses into the approach which involves a breaking down of traditional boundaries in the work of a nurse. Engagement of the third sector is important in the context of Buurtzorg but more widely as a principle in terms of the delivery of health and care interventions. West Suffolk are working with the The King's Fund to evaluate the impact of this approach. The Trust are now pioneering community hubs bringing all community skills including social care into one envelope. This is a patient centred approach. More work is needed to fully engage GPs in this context but it is making progress. George Bramley (University of Birmingham) also highlighted the Buurtzorg model as a way of bringing different communities to work together to deliver health and care.

# Going Dutch in West Suffolk – the Buurtzorg model

The Buurtzorg model of care, developed by a social enterprise in the Netherlands in 2006, involves small teams of nursing staff providing a range of personal, social and clinical care to people in their own homes in a particular neighbourhood. There is an emphasis on one or two staff working with each individual and their informal carers to access all the resources available in their social networks and neighbourhood to support them to be more independent. The nursing teams have a flat management structure, working in 'non-hierarchical self-managed' teams. This means they make all the clinical and operational decisions themselves. They can access support from a coach, whose focus is on enabling the team to learn to work constructively together, and a central back office.

In 2017 a group of NHS and local government organisations in West Suffolk, who had joined forces in a project to support older people to live independently at home, initiated a test-and-learn of the Buurtzorg model. They recruited a team of nurses and assistant practitioners to provide health and social care to people in line with the principles of the Buurtzorg model. They worked with The Kings Fund to share learning.

The King's Fund published its report in 2019. This identified five areas of key learning in trying to implement the Buurtzorg model in England:

1. The challenge of implementing an entire care model in a new setting is that the impact of implementation is not predictable. A significant part of how things turn out is down to the people involved (and their attitudes, behaviours, values) and what else is going on in the local context (from the state of organisational relationships to national workforce crises).

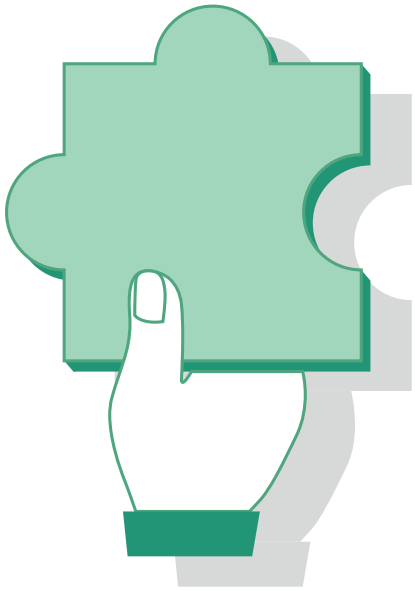
2. In West Suffolk, managers were admirably ambitious and counter-cultural in devolving as many decisions as possible to the new frontline nursing team. From the test location, through IT systems, to referral criteria, the team (with support) were in the driving seat. However, by doing the infrastructure development work themselves, nurses had to wait before they could get on with what they were really motivated by: directly providing excellent holistic care.

3. 'Hierarchy' is written into the DNA of nursing, the NHS and social care sectors (and British society more broadly). Learning to work in a non-hierarchical way requires just that, learning. Teams need extensive support and time to develop and practise new ways of working together, fathoming out issues such as: how will we make decisions? How will we manage disagreements? How will we draw on and nurture expertise and specialisation without introducing a management hierarchy by stealth?

4. Shifting to self-managed teams is a long and complex journey. Some colleagues need to let go of power and responsibility, while others need to step up. And they need to do this together, in a co-ordinated and evolving dance.

5. Protect new ways of working from system pressures as much as you can. And system leaders need to take seriously the extent of the space and time (at least 5-10 years) required to cultivate genuinely new ways of working and to appreciate that the benefits of such innovations may show up in a range of ways not captured by emergency admission rates.

**www.kingsfund.org.uk/publications/review-west-suffolk-buurtzorg-test-and-learn-2017-18**



# Part Four: Conclusions

**The previous parts of this report have considered the distinctiveness of rural health and care needs, the landscape in which the sector operates and the issues that rural health and care faces. These considerations have led us to a set of four conclusions about what is needed to achieve better rural health and care:**

1. Build understanding of the distinctive health and care needs of rural areas
2. Deliver services that are suited to the specific needs of individual rural places
3. Develop a structural and regulatory framework that fosters rural adaptation and innovation
4. Develop integrated services that provide holistic, person-centred care

In this part of the report, we look at each of these overarching conclusions in turn, setting out the key issues related to each.

> You cannot attract, recruit and retain a skilled and values driven workforce in health and social care if people view working rural communities as providing them with a less good career structure.

# 4.1 Build understanding of the distinctive health and care needs of rural areas

## Policy makers lack a 'rural lens' through which to view the health and care issues facing rural communities

Almost 10 million people live in rural communities in England. But this rural population is, of course, much smaller than the urban population of almost 47 million. The result of this disparity is that strategies and policies are developed with a focus on the urban majority. Amongst policy makers, there is often a simple lack of knowledge and understanding of the issues that affect rural communities. Our witnesses have explained that what policy makers lack is a 'rural lens' through which to view and comprehend the health and care issues facing rural communities. Repeatedly, we have heard that 'one size fits all' models of healthcare provision do not provide the appropriate scale, standards, regulations and efficiency for rural communities.

**The way that deprivation data is aggregated masks rural health and care inequalities**

One of the results of this lack of knowledge is that the health inequalities in rural communities are not commonly understood. The view that people living in rural places are healthier and wealthier than their urban counterparts must be dispelled. A key issue is that broad-brush indicators – such as the English Indices of Deprivation – mask rural pockets of deprivation and poor health for two main reasons. First, deprivation in rural areas is typically more dispersed than in urban areas, and so at the population-level at which data is aggregated, rural deprivation can be overlooked. Secondly, the wide range of indicators used in the Indices of Deprivation are not all relevant and appropriate for understanding rural health and care needs.

This means that less weight is given to the indicators that are relevant: housing, access to transport, distance to services and particularly the higher proportion of older people in rural communities. The upshot is that while evidence-based policies are (rightly) promoted, the base of quantitative evidence for rural communities is not readily available to access, understand and use.

**Developing a workforce that understands rural health and care needs is vital**

Lack of understanding of rural communities is also a workforce issue. You cannot attract, recruit and retain a skilled and values driven workforce in health and social care if people view working rural communities as less desirable for their careers and their livelihood. Thus, there needs to be greater promotion of the variety of roles available and the attraction of rural living, combined with new ways to recruit and train staff.

# 4.2 Deliver services that are suited to the specific needs of rural places

## Although rural places are often very different, there are common characteristics that shape rural health and care needs

In section 1.4, we set out five common characteristics that shape rural health and care needs:

**Ageing Population**
Rural areas have a disproportionate number of older people leading to higher levels of demand

**Mental Health**
Isolation and loneliness can heighten mental health issues in rural areas and there is also limited data available on rural mental health

**Distance From Services**
People in rural areas need to travel further to access treatment and often have less access to specialist provision and to emergency services

**Housing**
Issues in rural communities such as the cost of housing, prevalence of older properties, fuel poverty and living alone can increase vulnerability to poor health and chronic illness

**Cultural and Attitudinal Differences**
Combined with remoteness from specialist provision, often lead to rural patients seeking medical help late; rural poverty and deprivation is linked to lack of confidence and aspiration.

> It is clear that rural areas cannot be defined as homogenous – and different places need different approaches.

**These rural characteristics link to broader structural and policy areas beyond health and care – particularly with how digital approaches can enhance rural services**

All of these factors affect how health and care services can be delivered most effectively. They also show how intertwined health and care policies are with other broader policies and structures around, for example, transport, housing, and the environment. In particular, witnesses explained how technology can act as a key enabler of effective rural health and care. A key benefit of digital approaches is improving access to services, where local availability or travel distances would otherwise cause difficulties. But the benefits go beyond overcoming challenges of distance, with digital approaches supporting multi-disciplinary working, GP triaging, care co-ordination and virtual discharging. Technology in rural areas, however, comes with challenges too. Numerous witnesses described the need for improved connectivity and infrastructure in rural areas. And witnesses also explained how digital should be seen as a complement to, not a replacement for, established approaches – for example, remote service delivery will not suit every rural case and should not be seen as the only option.

**Place-based approaches which understand local community needs and recognise 'place difference' are key**

Developing approaches to rural health and care that recognise and adapt to the type of common rural characteristics discussed above is essential, but still insufficient. It is clear that rural areas cannot be defined as homogenous – and different places need different approaches. For example, national delivery models and funding formulas fail fully to consider the costs of service delivery in 'unavoidably small due to remoteness' rural areas, as well as island and coastal settings, leading to operational cost shortfalls and gaps in provision. Nuffield Trust analysis reveals that six rural hospital trusts carry a quarter of England's health service funding deficit.

Developing health and care systems that are based around their relationship to place is key to working better with local partners and achieving better outcomes for the local rural population. Place-based approaches also promote greater links between health and care services and local communities.

# 4.3 Develop a structural and regulatory framework that fosters rural adaptation and innovation

**A 'big is beautiful' standardised approach to health services is a barrier to meeting rural needs**

Numerous witnesses referenced a one-size-fits-all model as being a key characteristic of the NHS, and noted the challenges of making NHS approaches and structures fit localities. For example, it was noted how GP discretion and innovation has been eroded by standardised approaches which emphasise referral and processing of patients rather than the 'see, treat' agenda of the rural GP. Another example relates to community hospitals some of which are very small and difficult to resource under the current NHS funding system. As Richard Murray (Kings Fund) queried:

"If other national models can run smaller units of care rather than massive hospitals then it is perfectly reasonable to ask: why not here?"

It should be noted that the social care sector has some different service delivery challenges, principally around management of scarce resources compared to health settings issues around NHS standardisation.

A number of examples of the stifling impact of national regulation and funding regimes were raised by witnesses from fields including the social care sector, software providers, emergency services, the voluntary sector, nursing and GP provision. For example the challenging impact of Care Quality Commission regulation on the creation of small care micro-businesses, which could provide better and more adaptable care provision in rural areas. One present opportunity is the disruption and change that has resulted from the Covid-19 pandemic: tele-health and tele-care has been radically enhanced through the Covid-19 experience. Patient records and access has been freed up as regulation has become more flexible in this period. Organisations are traditionally worried about needing to comply with the regulatory framework at MHRA but the agile approach arising from the pandemic has led to a dialogue about how to refine the medical device compliance requirements.

## Current structural approaches need further refinement

The current NHS structures relating to the shaping of local services received a mixed review from witnesses. Some felt that transition to Integrated Care Systems (ICS) and a move towards more integrated planning of health and care would allow more holistic approaches, not limited to the NHS . Some saw Primary Care Networks as potentially providing a bridge between ICS and localities – with the possibility for some adaptation for rural populations in recognition of the small scale of some localities. The importance of the scale and boundaries of ICS' and of locality planning was emphasised.

> If other national models can run smaller units of care rather than massive hospitals then it is perfectly reasonable to ask: why not here?

## Professional silos are a barrier to developing new types of professional roles

We heard from a range of witnesses how new types of integrated and multi-disciplinary roles can help meet future health and care needs. We also heard that to overcome the workforce recruitment and retention challenges in the social care sector, there needs to be greater parity of esteem between the health and care sectors, which can be unwittingly reinforced through different professional standards. A key challenge here is to move away from 'silo thinking' that sees different professional roles as separate and incompatible: the Buurtzorg model (see section 3.3) where small 'non-hierarchical self-managed' teams of nurses support all aspects of personal, social and clinical care to people in their own homes is a good example. The continuing strong cultural and attitudinal pull towards the traditional hierarchy and separation of roles within health and social care provision is however acknowledged.

There are a number of examples of how the regulatory role of Royal Colleges impinges on the operational flexibility required to really fit workforce development to rural issues. There are, however, some positive signs of change – for example, the new set of standards for future nurse proficiencies which have as their central aim to provide nurses and nursing associates with greater depth of knowledge to meet needs of individuals across different rural care settings. More however still needs to be done to encourage people to join and remain in the social care sector.

# 4.4 Develop integrated services that provide holistic, person-centred care

**Integrated, person-centred approaches that encourage multi-disciplinary working and joint working between different services are vital**

We heard a wide range of inspiring examples from diverse settings about how integrated approaches have led to better health outcomes for people living in rural communities. For example, a community paramedic scheme designed around the challenges of emergency and primary healthcare insparsely populated north Northumberland (see section 3,2) and the integrated approach of the Isle of Wight NHS Trust, covering mental health, community and ambulance services. Multi-disciplinary working is a key theme here; we heard evidence about the work of the Cumbria Learning and Improvement Collaborative which aims to support the entire health and social care workforce in North Cumbria through improving cross-cutting skills, promoting collaboration and supporting ongoing quality improvement.

**Integration across health and social care is central to a truly integrated rural health and care system**

There will not be an integrated rural health and social care system if health care and social care are seen as distinct and separate. And the current lack of integration is central to many of the health and care issues faced by our rural communities. First, we have heard evidence that, nationally, the social care sector is under-resourced, under-staffed and with a workforce that is under-paid in comparison to the health sector. Repeatedly we heard that the social care workforce does not have 'parity of esteem' with the health care workforce. And these difficulties are heightened by the unique challenges of rural social care. The rural population is older on average than its urban counterpart, with a proportionally higher level of care home residents; rural local authorities often spend a disproportionately high part of their overall budget on adult social care; and the greater travel distances are a barrier to both staff recruitment and to ensuring that people access the care they need.

We have seen examples of where integration can effect positive change. For example, the Airdale Gold Line Telephone Service, staffed by experienced nurses linked to community-based teams. The service provides one point of contact for residents and their carers for help and advice, supporting them in their preferred place of care wherever possibleand providing a secure video link to care homes across the county staffed 24/7 by a multidisciplinary team of doctors, nurses and therapists.

We have also seen examples of integrating social care into the local community, notably the Community Catalysts (Somerset) approach of providing support to self-employed carers and care micro-enterprises – see Section 3.2

**The voluntary and community sector has a key role to ensure that local people feel involvement and ownership of local health and social care provision**

Rural health and social care should be seen as something that local people and communities – not just the health and care workforce – are involved in and can improve. In particular, through focusing on health and wellbeing in their broadest sense, community-led projects can act as early, preventative interventions that stop more acute health needs developing. We heard the example of the Healthier Fleetwood project: a partnership of residents, healthcare providers, charities and other groups, which is supporting local people to make life changes to support their long-term health and wellbeing – see Section 3.3

> There will not be an integrated rural health and social care system if health care and social care are seen as distinct and separate.

And voluntary and community organisations – many largely comprising volunteers rather than paid staff – can help to bring health and care provision closer to the needs of people in local communities. Sir Tom Hughes-Hallett (Helpforce) reflected that from his analysis there is an "army of volunteers" waiting to serve rural settings and that the fastest growth in volunteers is amongst the under the 30s. This view amplifies the testimony of witnesses about how the pandemic has impacted in terms of creating a climate of enhanced volunteering, and the extremely powerful impact first responder volunteers can have in supporting the emergency services. A strong theme is the level of professional support and recognition, extending even to a full clinical governance approach which characterises some of the most effective approaches to volunteering. This is particularly relevant in the way initiatives have been able to develop their volunteering initiatives to take account of rural challenges.

# Part Five: Recommendations

In this section, we set out 12 specific recommendations aligned with the conclusions set out in the previous part of the report. If the changes in these recommendations are to happen, we all have a part to play, not just government.

Government can set policy and adjust delivery plans and budgets – but the change that is needed will require more than that. It will require a change in attitude and in culture in both the public and private sector – within regulators and in communities.

> Without including rural experience in curricula, rural areas will always find it harder to attract doctors, nurses and other health and care professionals.

# 5.1 Build understanding of the distinctive health and care needs of rural areas

## Recommendation 1

**Rurality and its infrastructure must be redefined to allow a better understanding of how it impinges on health outcomes.**

DEFRA has been tasked with overhauling the rural definition. The new definition must reflect the complex interconnected aspects of rurality. It must also have the capacity to flex depending on the policy or budget use to which it is to be put. The concept of rural proofing while well intended currently does not work well enough. The solution does not lie in taking an urban model and adjusting it. It requires a fresh "piece of paper".

DEFRA must consult with DHSC, DLUHC, DCMS, DfT in its work on redefinition of rurality taking into account the current position rural communities find themselves in and understand the health and care impact of that position. Rural health and care policy must be grounded in the reality of its geography and consequent housing, transport and technology infrastructure.

Lead responsibility DEFRA/ONS - by December 2022

## Recommendation 2

**Identify and measure drivers of health inequalities at a greater level of granularity (1000 head of population should be a denominator)**

Health inequalities are driven by poor housing, poor transport links, poor technology infrastructure, distance to and lack of services and products. None of this is measured at small community level and the challenge resulting is hidden. Health and care choices, health and care service provision, health and care service take up are not measured at this level either. In England many rural areas flank urban towns and their hinterland and the deprivation and lack of services are masked in these bigger numbers.

Health and care outcomes are also inappropriately measured. Here the problem is not only lack of granularity but lack of understanding of the age demographic and the typical arrival and departure ages from the community. If we don't measure the right things we will continue to get the wrong answers.

The Cabinet Office must instruct the ONS working with the NAO and health economists to rethink how they measure inputs, outputs and outcomes of government policy and spending at a very granular level.

Lead responsibility Cabinet Office, Defra & ONS – by December 2023


## Recommendation 3

**Include specific rural content in every first degree in medicine, nursing and social care. Mandate rural work experience in every general practice course, every geriatrician course, every nursing course and all core health care training**

Individuals tend on balance to practice where they train and in specialisms they have experienced. Most medical schools and colleges of further education offering care courses are in urban areas. Those that are located in rural parts of the country such as the South West are none-the-less based in cities and provide no rural experience. Those that do, such as the new medical school in Lincoln are a rarity. Without including rural experience in curricula, rural areas will always find it harder to attract doctors, nurses and other health and care professionals.

The schools of medicine in universities, the care faculties in further education provision and the Royal Colleges of Medicine should be asked by government to work together to address including rural content and rural work experience in curricula for all medical and care professionals whatever the specialism.

Lead responsibility Secretary of State for Health and Care and NHS England – by December 2024

# 5.2 Deliver services that are suited to the specific needs of rural places

## Recommendation 4

**Core health and care pathways for cancer, heart disease, stroke, mental health and all emergency care must be urgently reviewed to better meet the rural need**

Rural settings do not have the geography or physical infrastructure to enable a one size fits all pathway to be followed. Target waiting times cannot be and are not being met. Target "misses" are considerably greater in rural communities.

Ambulance waiting times for example simply cannot be met in many rural areas. The ambulance service cannot consistently - without deploying fire and police - meet the emergency care need. The emergency services need to be reviewed together to create a better model of urgent health related response.

The pathways for geriatric health and care in particular need to be rewritten to reflect the challenge of treating complex co-morbidities. It is not always desirable or even possible for one patient to be treated by several specialists at the same time. Treatment solutions clash and overlap and contradict each other. It is not cost or time effective nor does it deliver optimal health outcomes. In practice now, the most urgent or acute issue is usually addressed first in isolation of many of the others.

Many pathways depend on attendance at a central specialist treatment centre. In rural areas these often do not exists within any reasonable journey time. New option will mean a review of acceptable managed risk and greater use of technology.

NHS&I must undertake a root and branch review of key health and care pathways and assess their validity, efficacy and sustainability in rural practice.

Lead Responsibility – NHS&I by December 2024

## Recommendation 5

**"Rural health proof" housing and planning, transport and environment policy**

It's not just rurality, but the health impact of that rurality across so many government departments, including housing, transport and the built environment which needs to be recognised by the department of health and other government departments. This rural impact needs to be hard wired into decision making. The cabinet office has a core role here pulling the rural thread through all government departments. For example, old poor quality housing has a disproportionate impact on health outcomes. The quality of rural housing is generally pretty poor and of old construction which does not lend itself to retro fitting insulation. In relation to transport, if there is no bus service at all, which is common in rural areas, then elderly people get about less, access services less and become lonely and isolated.

Communication and joined up policy making across government is key. Once a definition of rurality has been developed the cabinet office needs to establish a rural health task and finish group to rural health and care proof existing policies across government and to review new policies assessing their positive and negative impact on rural health and care outcomes.

Lead responsibility – Cabinet Office – by December 2023

## Recommendation 6

**Develop a rural technology health and care strategy and platform**

A technology impact assessment needs to be hard wired into decision making within DHSC. NHSX has a core role here. Technology is a key enabler in rural health and care settings. NHSX needs to be asked to develop a rural technology health strategy and platform, and identify and encourage investment by the private sector in new delivery methods, concepts and Apps. The strategic intent must be to look at how poor health and care outcomes can be prevented with diagnosis, condition monitoring, treatment and therapies delivered virtually through new technology interfaces.

Lead responsibility – NHSX/NHS England – by December 2022

# 5.3 Develop a structural and regulatory framework that fosters rural adaptation and innovation

## Recommendation 7

**Enable and empower local placed-based flexibility in the ICS structure**

For both infrastructure and service delivery, the straitjacket of current rigid funding mechanisms does not enable place-based solutions. The language of the Health and Care Bill and its preceding white paper talk about the need for local decision making – but not flexibility. Binary yes or no options will not work. Local health and care communities are very good at working out what is most effective as many primary care networks have demonstrated. There are many good examples in this report of how this can be – and is being done.

Clearly leadership is the key.  Good leaders make good decisions. But this is not going to make the difference it can without the power and authority to do things differently. One rural place is just that:one rural place. Perhaps one good recent example. Post Covid mental health support was constrained as to how it could be spent. As a result very effective solutions had to be paused and abandoned because they didn't fit the scheme and provider criteria. That was a lose-lose.

NHS England needs to step up to the plate and codify the best practices which have emerged in this and other reports and from its own pilot schemes most of which never see the sunlight, never mind the energy and oxygen to be rolled out. Good ideas are not being shared or leveraged. That needs to inform all new funding schemes and be retrospectively applied to any longer term initiatives beyond December 2022.

Lead responsibility NHS England – by December 2022.

## Recommendation 8

**With the Royal Colleges and NHS England, review the match between the existing health and care professional structures and the skill needs of today to meet health and care demands with a view to creating a wider variety/diversity of health and care professionals with shorter training courses**

The training of a fully qualified doctor takes a minimum of eight years. While skills shortages can be partially addressed through immigration, retraining and stemming early retirement, that will provide neither the diversity nor the quantity of medically qualified individuals needed to meet current workforce models in the necessary timescale.

The introduction of Physician Associates was a great step forward but we need more new careers in health. We need to include conversion courses for those coming from both health and non-health backgrounds crossing the traditional divide between physical and mental health and social care to ensure new professionals can be deployed across a variety of health and care settings.

Training across health and care should be integrated, for example nursing training. Nurses should receive training (including work experience) in both health and care and be able to be redeployed at short notice from one setting to the other. This is crucial in rural areas where a flexible workforce is crucial to maintain service delivery and standards.

Health Education England in future within NHS England must assess the range and quantities of competencies and skills needed, and look at creating new professions and new pathways into health and care.

Lead Responsibility NHS England – by December 2022

## Recommendation 9

**Hard-wire generalist skills training across the medical professions, in both core and update CPD training**

While every clinician receives basic generalist life-saving alongside other skills training, it is largely superficial and often not reinforced through CPD. It is not enough to be able to confidently deal with the range of one-off health incidents that may be encountered in isolated rural practice.

General medical and surgical skills should be taught and reinforced so that if needed and at short notice any medical practitioner could play a contributory role in accident and emergency or general practice. In both these settings the unexpected is a regular occurrence across a very wide range of medical disciplines.

What these medics have in common is an ability to diagnose and prioritise. Every clinician in any specialism must be trained in acute and urgent care and in chronic complex co-morbidity health management with regular update hands-on training. Online training is not enough. This should enable better use of a clinical resource and enable deployment of all clinicians in an emergency, for example the recent pandemic.

The schools of medicine in universities and the Royal Colleges of Medicine should be asked by government to work together to address including better generalist training in curricula for all medical professionals whatever the specialism, and improving the urgent/generalist content not just in primary training but in regular update CPD training.

Lead responsibility NHS England and Royal Medical Colleges – by December 2024

# 5.4 Develop integrated services that provide holistic, person-centred care

## Recommendation 10

**Fund research into the nature, connectedness and integrated treatment of complex co-morbidities across primary, secondary health and social care**

We are aware that the government is already committed to research in this area – but there is little evidence of what is being done, by whom, and what success is thought to look like. This work has to be collaborative between pharma, private equity and governments around the world. It won't be quick and it will cost – but the resulting savings in cost of treatment and improved health outcomes make this a well worth while venture.

We are also aware of the research being spearheaded internationally into dementia. Historically and somewhat bizarrely these initiatives have been led by BEIS not DH. DH needs to take some responsibility and ownership of this problem. To leave it to the charitable and private sectors isn't good enough. Its about leadership not money.

The chief medical officer needs to write a clear brief and instruction setting out what needs to be explored including: the range and depth of conditions in the comorbidity package; the range of specialists and treatments involved; any commonalities of pathway or treatment and any conflicts; what an integrated efficient treatment pathway looks like and what this means for GP, A&E and Geriatrician training; how the solution can best be delivered across primary, secondary and social care: and finally the economic and health payback metrics.

Lead Responsibility NHS England and Chief Medical Officer -by December 2023

## Recommendation 11

**Integrate health and social care budget setting in rural areas as a test pilot of the Health and Care Bill's ambition, and measure combined health and care outcomes against that budget**

With an aging demographic, rural areas have a substantial disproportionately large cohort of residents needing both health and care support. The cross working is clunky bedevilled by budget disputes. The Health and Care Bill does not provide for budget integration – wrongly in our view. While the budgets technically cross two government departments, that is not a reason not to integrate them and related decision making at local level. Given the paucity of resources and creaking infrastructure, the gap between the two systems is more than just a bed blocking problem. For example, there are real concerns given the number of nursing care home closures regarding the knock-on impact on quality and safety of care in residential care homes and more crucially in private homes where the CQC has no remit if there is no care plan in place.

The Health and Care Bill provides for the private sector cost of care to equal the public sector contribution. Historically the extra private sector costs were (illegally) used to subsidise state care. If funding for the publicly funded patients doesn't increase it is unclear how this square is to be circled ensuring good quality care for those paying privately and those being funded by the state

The Secretaries of State for DCLG and DoH should identify six pilot study areas and ask officials to prepare a fully integrated health and care budget for each with local stakeholders and put in place a set of input, output and outcome metrics to measure success

Lead responsibility Secretary of State for health – by July 2022

## Recommendation 12

**Empower the community and voluntary sector to own prevention and wellbeing**

Given the natural geographic and demographic challenges of rural health and care delivery, prevention is even more important. Key to this is increasing health self-awareness and responsibility and realising the potential of the community and its wealth of volunteers as the third health and care service.

Flexibility and empowerment are key – not professionalisation which is totally counter cultural to the spirit of volunteering. Recognition, thanks, training and seed core funding are what is needed – not a formal commissioning arrangement (recognising that there are some exceptions for example in patient transport).

The role of the community and voluntary sector is a critical part of care reform and needs to go further than the provisions set out in the recent Care White Paper. Care begins in the home and in the community. Empower communities in their local plans, in their patient forums and in their parish and town councils to have this as a core responsibility. Collect and share the many examples of good practice in this report and elsewhere. Seed core funding should be provided against a strategy and plan that a community comes together to produce.

Lead responsibility Secretary of State for Health– by December 2021.

Many of these recommendations are challenging and ambitious as they should be. Many if followed will have benefit well beyond rural communities. The reality is rural communities have been so left behind that future health and care challenges will hit here first, where we are least able to address them. Addressing these issues matters.

# Appendix: List of witnesses

| # | Name of Witness | Session theme | Date |
|---|---|---|---|
| 1 | Dr Peter Aitken – Director of Research & Development, Devon Partnership NHS Trust | 9b. Mental Health | 25-Aug-20 |
| 2 | Susan Aitkenhead – Deputy Chief Nursing Officer for Policy and System Transformation | 4. Workforce challenges and opportunities | 06-Jun-19 |
| 3 | Richard Alcock – Director of Primary Care Technology, NHS Digital | 7. Technology opportunities and challenges | 28-May-20 |
| 4 | Professor Sheena Asthana – Director, Plymouth Institute of Health & Care Research (PIHR) | 9b. Mental Health | 25-Aug-20 |
| 5 | Professor Clive Ballard – Pro-Vice Chancellor & Executive Dean, University of Exeter Medical School | 1. What are the needs of rural communities and how are they different from their urban counterparts? | 30-Oct-18 |
| 6 | Robin Batchelor – Chairman & CEO everyLIFE Technologies Limited; Care Software Providers Association (CASPA) | 7. Technology opportunities and challenges | 28-May-20 |
| 7 | Andy Bell – Deputy Chief Executive, Centre for Mental Health | 9b. Mental Health | 25-Aug-20 |
| 8 | Ursula Benion – Chief Executive of Trent and Dove Housing Association; Chair of the Rural Housing Alliance | 8b. Housing in the context of Health and Care | 23-Jun-20 |
| 9 | Stephanie Berkeley – Manager, Farm Safety Foundation | 9b. Mental Health | 25-Aug-20 |
| 10 | Tarun Bhakta – Assistant Policy Officer, Shelter | 8b. Housing in the context of Health and Care | 23-Jun-20 |
| 11 | Sue Bradley – Chief Officer, Age UK, North Craven | 2. How are rural health and social care needs currently met? | 05-Feb-19 |
| 12 | George Bramley – University of Birmingham, City-REDI (Regional Economic Development Institute) | 1. What are the needs of rural communities and how are they different from their urban counterparts? | 30-Oct-18 |
| 13 | Brendan Brown – Chief Executive, Airedale NHS Foundation Trust | 7. Technology opportunities and challenges | 28-May-20 |
| 14 | Darren Catell – Director of Finance, Isle of Wight NHS Trust | 8a. Coastal issues | 23-Jun-20 |
| 15 | Tom Chance – Joint Chief Executive, National Community Land Trust Network | 8b. Housing in the context of Health and Care | 23-Jun-20 |
| 16 | Stephen Chandler – Director for Adult Social Services, Lead Commissioner for Adults and Health, Somerset County Council | 4. Workforce challenges and opportunities | 06-Jun-19 |

| # | Name of Witness | Session theme | Date |
|---|---|---|---|
| 17 | Councillor Lee Chapman – Portfolio Holder for Adult Services, Health and Housing, Shropshire Council | 3. What is not working rural communities and why? | 01-Apr-19 |
| 18 | Sheila Childerhouse – Chair, West Suffolk NHS Foundation Trust | 4. Workforce challenges and opportunities | 06-Jun-19 |
| 19 | Dr Jayne Clarke – Associate Medical Director – Education, Wye Valley NHS Trust | 5. Education and training: challenges and opportunities | 09-Sep-19 |
| 20 | Martin Collett – Operations Director, English Rural Housing Association | 1. What are the needs of rural communities and how are they different from their urban counterparts? | 30-Oct-18 |
| 21 | Phil Confue – Lead for Strategy and Planning: Countywide Services and Chief Executive Officer, Cornwall Partnership NHS Foundation Trust; Programme Director, Cornwall and Isles of Scilly STP | 1. What are the needs of rural communities and how are they different from their urban counterparts? | 30-Oct-18 |
| 22 | Nikki Cooke – Chief Executive, LIVES | 11. Emergency Services | 15-Dec-20 |
| 23 | Professor Ian Couper – Director of the Ukwanda Centre for Rural Health, Department of Global Health, Stellenbosch University (Cape Town, South Africa) | 10. International perspectives | 27-Oct-20 |
| 24 | George Coxon – Care Home Owner, Devon | 8a. Coastal issues | 23-Jun-20 |
| 25 | Rhys Davis – Community Catalysts | 6. Structural challenges of fitting current delivery models into a rural setting with different needs and challenges | 28-Feb-20 |
| 26 | Dr Alex Degan – Medical Director for Primary Care, NHS Devon CCG | 6. Structural challenges of fitting current delivery models into a rural setting with different needs and challenges | 28-Feb-20 |
| 27 | Nigel Edwards – Chief Executive, Nuffield Trust | 12. Summary and review session | 4 Feb - 21 |
| 28 | Dr Sue Fish – Clinical Senior Lecturer CARER Programme (Aberystwyth), Cardiff University | 5. Education and training: challenges and opportunities | 09-Sep-19 |
| 29 | Dr Mayara Floss – Family Medicine Resident, Grupo Hospitalar Conceição (Porto Alegre, Brazil) | 10. International perspectives | 27-Oct-20 |
| 30 | Dr Debbie Freake – Director of Integration, Northumbria Healthcare NHS Foundation Trust | 2. How are rural health and social care needs currently met? | 05-Feb-19 |
| 31 | Dr Gill Garden – Director of Clinical Skills, Lincoln Medical School | 5. Education and training: challenges and opportunities | 09-Sep-19 |

| # | Name of Witness | Session theme | Date |
|---|---|---|---|
| 32 | Tim Goodson – Chief Officer, Dorset CCG | 6. Structural challenges of fitting current delivery models into a rural setting with different needs and challenges | 28-Feb-20 |
| 33 | Professor Martin Green – Chief Executive, Care England | 6. Structural challenges of fitting current delivery models into a rural setting with different needs and challenges;<br>9a. Social care | 28-Feb-20 /<br><br>25-Aug-20 |
| 34 | Stephen Hall – Head of Statistics, Rural Policy Team, Department for Environment, Food & Rural Affairs | 1. What are the needs of rural communities and how are they different from their urban counterparts? | 30-Oct-18 |
| 35 | Dr Jane Hart – Rural Services Network | 1. What are the needs of rural communities and how are they different from their urban counterparts? | 30-Oct-18 |
| 36 | Jonathon Holmes – Senior Policy Analyst, Healthwatch England | 3. What is not working rural communities and why? | 01-Apr-19 |
| 37 | Simon How – Health and Wellbeing Programme Leader, PHE East of England | 3. What is not working rural communities and why? | 01-Apr-19 |
| 38 | Lee Howell – Chief Fire Officer, Devon and Somerset Fire and Rescue Service | 11. Emergency Services | 15-Dec-20 |
| 39 | Sir Tom Hughes-Hallett – Founder, Helpforce; former Chair of Marie Curie; former Chair of Chelsea & Westminster Hospital Foundation Trust | 5. Education and training: challenges and opportunities | 09-Sep-19 |
| 40 | Dr Ian Hulme – BMA GP Committee | 6. Structural challenges of fitting current delivery models into a rural setting with different needs and challenges | 28-Feb-20 |
| 41 | Jim Hume – Convenor, National Rural Mental Health Forum | 9b. Mental Health | 25-Aug-20 |
| 42 | Charlotte James – Director of Communications, Eastern AHSN | 7. Technology opportunities and challenges | 28-May-20 |
| 43 | Dr Paul Johnson – Clinical Chair, Devon CCG | 5. Education and training: challenges and opportunities | 09-Sep-19 |
| 44 | Dr Krishna Kasaraneni – GP Executive Team, Workforce Lead, British Medical Association | 4. Workforce challenges and opportunities | 06-Jun-19 |
| 45 | Dr Robert Lambourn – Rural Forum, Royal College of GPs | 1. What are the needs of rural communities and how are they different from their urban counterparts? | 30-Oct-18 |
| 46 | Jo Lavis – Rural Housing Solutions | 8b. Housing in the context of Health and Care | 23-Jun-20 |

| # | Name of Witness | Session theme | Date |
|---|---|---|---|
| 47 | Councillor Andrew Leadbetter – Cabinet Member for Adult Social Care and Health Services, Devon County Council | 4. Workforce challenges and opportunities | 06-Jun-19 |
| 48 | Jeremy Leggett – Policy Adviser, Action with Communities in Rural England | 1. What are the needs of rural communities and how are they different from their urban counterparts? | 30-Oct-18 |
| 49 | Sian Lockwood – Executive, Community Catalysts | 9a. Social care | 25-Aug-20 |
| 50 | Professor Stuart Maitland-Knibb – Director, National Centre for Remote and Rural Medicine, UCLAN | 3. What is not working rural communities and why? | 01-Apr-19 |
| 51 | Professor Alison Marshall – University of Cumbria | 1. What are the needs of rural communities and how are they different from their urban counterparts? | 30-Oct-18 |
| 52 | Professor Tahir Masud – President, British Geriatrics Society | 2. How are rural health and social care needs currently met? | 05-Feb-19 |
| 53 | Dr Ruth May – Chief Nursing Officer for England | 4. Workforce challenges and opportunities | 06-Jun-19 |
| 54 | Dr Pavitra Mohan – Co-Founder & Secretary, Basic Health Care Services (Udaipur, Rajasthan, India) | 10. International perspectives | 27-Oct-20 |
| 55 | Peter Moore – Chief Executive, Cornwall Rural Housing Association | 8b. Housing in the context of Health and Care | 23-Jun-20 |
| 56 | Alan Morgan – Chief Executive Officer, National Rural Health Association (Washington DC, United States) | 10. International perspectives | 27-Oct-20 |
| 57 | Richard Murray – CEO, The Kings Fund | 6. Structural challenges of fitting current delivery models into a rural setting with different needs and challenges | 28-Feb-20 |
| 58 | Katherine Nissen – Chief Executive, Cornwall Rural Community Charity | 8a. Coastal issues | 23-Jun-20 |
| 59 | Maggie Oldham – Chief Executive, Isle of Wight NHS Trust | 8a. Coastal issues | 23-Jun-20 |
| 60 | James Palmer - Programme Head - Social Care, NHS Digital | 7. Technology opportunities and challenges | 28-May-20 |
| 61 | William (Billy) Palmer – Senior Fellow in Health Policy, Nuffield Trust | 1. What are the needs of rural communities and how are they different from their urban counterparts? | 30-Oct-18 |
| 62 | Victoria Pickles – Director of Corporate Governance, Airedale NHS Foundation Trust | 7. Technology opportunities and challenges | 28-May-20 |

| # | Name of Witness | Session theme | Date |
|---|---|---|---|
| 63 | Helen Ray – Chief Executive, North East Ambulance Service | 11. Emergency Services | 15-Dec-20 |
| 64 | Piers Ricketts – Chair, The Academic Health Science Network (AHSN) Network; Chief Executive, Eastern AHSN | 7. Technology opportunities and challenges | 28-May-20 |
| 65 | Dr Manabu Saito – Director, Rural Generalist Program (Japan) and Medical Director, Teuchi Clinic, (Shimo-koshiki Island, Kagoshima, Japan) | 10. International perspectives | 27-Oct-20 |
| 66 | Professor James Rourke – Co-chair Rural Road Map Implementation Committee, Society of Rural Physicians of Canada; Professor Emeritus & Former Dean of Medicine, Memorial University of Newfoundland | 10. International perspectives | 27-Oct-20 |
| 67 | Bob Seeley MP | 8a. Coastal issues | 23-Jun-20 |
| 68 | Professor (Emeritus) John Shepherd – Birkbeck College | 3. What is not working rural communities and why? | 01-Apr-19 |
| 69 | Dr Rashmi Shukla – Regional Director Midlands & East, Public Health England | 1. What are the needs of rural communities and how are they different from their urban counterparts? | 30-Oct-18 |
| 70 | Professor Stephen Singleton – Director, Cumbria Learning and Improvement Collaborative (CLIC) | 4. Workforce challenges and opportunities | 06-Jun-19 |
| 71 | Dr Ed Smith – Chair - Service Design and Configuration Committee, Royal College of Emergency Medicine | 11. Emergency Services | 15-Dec-20 |
| 72 | Dr Mark Spencer – GP and Lead, Healthier Fleetwood | 8a. Coastal issues | 23-Jun-20 |
| 73 | Professor Helen Stokes-Lampard – Chair of the Academy of Royal Colleges | 12. Summary and review session | 4-Feb-21 |
| 74 | Professor Roger Strasser AM – Professor of Rural Health, The University of Waikato (New Zealand) | 10. International perspectives | 27-Oct-20 |
| 75 | Dr Adrian Tams – Workforce Transformation Manager, Health Education England | 12. Summary and review session | 4 Feb - 21 |
| 76 | Denise Thiruchelvam – Director of Nursing and Quality in Surrey (Representing the Royal College of Nursing) | 4. Workforce challenges and opportunities | 06-Jun-19 |
| 77 | Vaughan Thomas – Chair, Isle of Wight NHS Trust | 8a. Coastal issues | 23-Jun-20 |

| # | Name of Witness | Session theme | Date |
|---|---|---|---|
| 78 | Andy Tilden – Interim CEO, Skills for Care | 5. Education and training: challenges and opportunities | 09-Sep-19 |
| 79 | Dr Keith Tolley – Tolley Health Economics Ltd | 1. What are the needs of rural communities and how are they different from their urban counterparts? | 30-Oct-18 |
| 80 | Graeme Tunbridge – Director of Devices, Medicines and Healthcare products Regulatory Agency (MHRA) | 7. Technology opportunities and challenges | 28-May-20 |
| 81 | Georgina Turner - Director of Engagement, Skills for Care | 9a. Social care | 25-Aug-20 |
| 82 | Dr Josep Vidal-Alaball – Head of the Central Catalonia Innovation and Research Primary Care Unit, Catalan Health Institute, Department of Health, Generalitat de Catalunya (Catalonia, Spain) | 10. International perspectives | 27-Oct-20 |
| 83 | Melanie Walker – Chief Executive, Devon Partnership NHS Trust | 9b. Mental Health | 25-Aug-20 |
| 84 | Robin Wells – Membership Secretary, Care Software Providers Association (CASPA) | 7. Technology opportunities and challenges | 28-May-20 |
| 85 | Dr Richard West – Chair, Dispensing Doctors Association; GP | 6. Structural challenges of fitting current delivery models into a rural setting with different needs and challenges | 28-Feb-20 |
| 86 | Sue West – Nursing & Midwifery Council | 9a. Social care | 25-Aug-20 |
| 87 | Councillor Sue Woolley – Executive Councillor: NHS Liaison, Community Engagement, Lincolnshire County Council | 9a. Social care | 25-Aug-20 |
| 88 | Dr John Wynn-Jones – Working Party on Rural Practice, World Organisation for Family Doctors (Wonca); Senior Lecturer in Rural and Global Health, Keele Medical School | 3. What is not working rural communities and why? | 01-Apr-19 |
| 89 | Dr Simone Yule – Chair, North Dorset GP Locality | 2. How are rural health and social care needs currently met? | 05-Feb-19 |

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## Principal authors

Ivan Annibal and Dr Jessica Sellick (Rose Regeneration) supported by James Turner (independent consultant), Jonny Haseldine (Senior Parliamentary Researcher Office of Anne Marie Morris MP), Professor Richard Parish CBE (Executive Chair National Centre for Rural Health and Care) and Anne Marie Morris MP.