Rural Workforce Issues in Health and Care

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Summary

Aim

This report aims to apply a rural lens to the workforce challenges facing the NHS and social care in England in recognition that *securing the supply of staff* that the health and care system needs to deliver high quality care now and in the future is crucial.

Context

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

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

Methodology

The study entailed:

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

Spatial framework

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

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

Findings

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

1. Rural areas are characterised by disproportionate out-migration of young adults and in-migration of families and older adults.
2. This means that the population is older than averag*e* in rural areas - this has implications for demand for health and care services and for labour supply
3. Relatively high employment rates and low rates of unemployment and economic inactivity mean that the labour market in rural areas is relatively tight
4. There are fewer NHS staff per head in rural areas than in urban areas.
5. A rural component in workforce planning is lacking.
6. The universalism at the heart of the NHS can have negative implications for provision of adequate, but different, services in rural areas and also means that rural residents can be reluctant to accept that some services cannot be provided locally.
7. The conventional service delivery model is one of a pyramid of services with fully-staffed specialist services in central (generally major urban) locations – which are particularly attractive to workers who wish to specialise and advance their careers.
8. Rural residents need access to general services locally and to specialist services in central locations to provide best health and care outcomes.
9. Examples of innovation and good practice are not routinely mapped and analysed, so hindering sharing and learning across areas.

The main *opportunities* for securing workforce supply and maximising impact are

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

Inherent in these challenges and opportunities are a number of *trade-offs* concerning:

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

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

Principle 1: Securing the supply of staff

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

Relevant features of rural labour market dynamics:

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

Key points from primary research:

- *Variations between rural areas*: rural areas are heterogeneous – geographically and socio-economically, and their attractiveness for rural living varies. The precise complexion of labour supply circumstances varies between rural areas.

- *Recruitment and retention*: recruitment poses a greater challenge than retention in many (but not all) rural areas. Achieving an optimal balance between mobility and immobility is important – some churn is valuable in stimulating new ideas, but too much churn is problematic. A segmented approach to recruitment is needed to focus on what makes rural areas attractive to different groups. An 'earn, learn and return' approach to attracting workers from outside the UK for a fixed period is one means of addressing the recruitment challenge.

- *Features of rural labour markets*: recruitment and retention policies need to take account of the demographic characteristics of rural labour markets, notably disproportionate out-migration of young adults and in-migration of families and older adults. Relatively high employment rates and low rates of unemployment and economic inactivity (in aggregate) place a premium on widening participation and inclusive modern model employers. It is necessary to work in partnership across policy domains (e.g. transport, the voluntary sector) to help address workforce issues in rural areas. There is scope to address challenges posed by 'thin' (as opposed to 'thick') labour markets in rural areas by highlighting the opportunities for individual empowerment and the varied roles in the NHS. Advantage can also be taken of the opportunity to capitalise on the status and attractiveness of the NHS as a large employer in rural areas.

- *Trade-offs in addressing key dilemmas in service level provision and workforce implications*: rural (and urban) residents tend to want high quality locally accessible services. Resource constraints mean that it is not possible to provide fully-staffed specialist services in all locations. Rather there is a pyramid of services with fully-staffed specialist services in central (generally major urban) locations. This means major urban locations are attractive to staff who wish to advance their careers through access to a range of high level specialist roles. Ensuring rural residents can access a range of general services locally and take advantage of specialist services at central locations as required in order to provide the best health and care outcomes is crucial.

- *Enhancing attractiveness is important in addressing workforce issues*: from a non-work viewpoint there is scope to market the attributes of rural areas as places to live, while from a work perspective creating and sustaining 'centres of excellence' in particular specialisms is a possible way of attracting and retaining staff in rural areas, while at the same time also promoting 'expert generalist' roles.

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

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

Relevant features of rural labour market dynamics:

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

Key points from primary research:

- *Public attitudes*: were reported as constraining the acceptance of flexible and innovative working practices and new models of delivery in rural areas.
- *Sparsity can stimulate innovation:* generating radical approaches to challenges of service delivery in rural areas (e.g. rotating workforces, getting the community and voluntary sector and local people more involved in health and social care delivery).
- *Technology can be an enabler:* in roles being performed more flexibly and insightfully, with examples including E-medical applications which reduce the number of face-to-face interactions between patients and health professionals and use of technologies to enable individuals to live independently at home.
- *Urban bias:* is apparent in the application of the universal service and standards approach of the NHS; a one-size-fits-all tendency tends to disadvantage rural areas, which is manifest in a lack of training and learning environments in rural areas, increasingly challenging vacancy levels for rural GPs and other roles.
- *House prices in some rural areas:* serve to limit the pool of available workers with a knock on effect for workforce flexibility.

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

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

Relevant features of rural labour market dynamics:

- *A smaller quantity and reduced range and scope of job opportunities in rural areas constrains career opportunities in-situ relative to urban areas* and this has implications for providing broad pathways for structured progression and opportunities for specialisation.
- *In the absence of relatively few large employers in rural areas* those that do exist have a potential advantage of providing a greater range of opportunities in their internal labour market, but progression opportunities need to be visible to employees.

- *In rural and urban areas alike there is a need to think of workforce development in terms of an employment pathway* – from employment entry to in-work progression – with training and support along the way.

Key points from primary research:

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

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

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

Relevant features of rural labour market dynamics:

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

Key points from primary research:

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

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

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

Relevant features of rural labour market dynamics:

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

In rural and urban areas alike:

- *Becoming an 'employer of choice'* where people want to work, with good employee engagement and shared values and goals, is important for recruitment and retention in contexts where staff resources are finite, but at the same time it is important that employees have values and behaviours that accord with those of the organisation.
- *Being an employer of choice involves providing opportunities for co-design* in order that staff are supported in their professional lives (job satisfaction) in ways that are beneficial to their wellbeing.
- *Providing quality work and opportunities for flexible working* are especially important in understanding career determinants across different generations and these determinants – and the ability to meet them – may be influenced (at least to some extent) by geographical location. However, it needs to be recognised that to some extent there is a trade-of between being employee-friendly and having sufficient staff available at certain times to fill a rota: the 'limits to flexibility' need to be acknowledged.
- *Comprehensive rewards and benefits* associated with large employers can make such workplaces particularly attractive in rural areas.

Key points from primary research:

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

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

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

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

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

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

- *The lack of a spatial component in workforce planning*: means that the generic characteristics of rural labour markets are not taken into account.
- *Local pragmatism:* means that in the absence of discrete strategic planning taking account of the importance of the spatial characteristics of different rural settings and circumstances there are local examples of 'bottom up' innovation and 'joining up' between health and care services.
- *The biggest single structural challenge* in terms of workforce and services alignment in rural areas is the significantly smaller number of NHS staff per head of population in rural areas.
- There is *scope for technology* (including for example, artificial intelligence, robotics, monitoring devices) to play a role in supporting health and care staff in rural (and urban) areas, especially in terms of monitoring and prevention. The primary research revealed limited emphasis on technology – especially where it would replace face-to-face care – but it is important that how technology can help staff and residents in performing different functions is important from both care and staff development perspectives. Where technology was mentioned in primary research the emphasis on urban areas tending to be prioritised for cutting edge investments.
- *Institutionally* the 'one size fits all' universal entitlement strategy of the NHS can have negative implications for the provision of adequate, but different, provision in rural areas.

Conclusions
- There is *systemic lack of 'thinking rurally' in workforce planning in health and care*. This poses challenges both for staff development and for access to health services in rural areas. It points to rural disadvantage that remains unacknowledged.
- Sparser and smaller populations, higher employment rates, lower unemployment rates, an older population and relatively fewer younger people *pose challenges for recruitment, retention and workforce development in rural areas*.
- Despite having common features *rural areas are diverse*. There is increasing awareness and recognition amongst policy makers and the general public that 'place matters' in terms of

healthy life expectancy. The importance of *sensitivity to local circumstances* also needs to be taken into account in workforce planning in rural areas.

- Establishing and, as far as possible fostering consensus, on what *health and care service delivery should look like in rural (and urban) areas* and what staffing models are most appropriate to achieve this lies at the heart of workforce supply and development issues.
- *Urban bias* is apparent in the application of the universal service and standards approach of the NHS. This tends to further disadvantage rural areas which can face enhanced challenges relative to urban areas in meeting nationally imposed minimum threshold standards associated with health-related and non-health-related aspects of service delivery.
- There are examples of *good practice* and there has been *innovation in rural areas,* yet there has been no detailed mapping of programmes and funding streams, or an analysis of the extent they have supported innovation in rural areas - including workforce development.

Recommendations following from these findings and conclusions:

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

Next Steps

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

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

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

Table of Contents

List of acronyms

CPD – Continued Professional Development

DWP – Department for Work and Pensions

EEA – European Economic Area

EU – European Union

GP – General practitioners

HEE –Higher Education England

ICA – Integrated Clinical Academic Programme

NHS – National Health Service

NIHR – National Institute of Health Research

ONS – Office for National Statistics

RSN – Rural Services Network

SME – small medium sized enterprise

STP(s) –Sustainability and Transformation Partnerships(s)

STPAP(s) - Sustainability and Transformation Partnership Action Plans

Introduction

Background

City-REDI (Regional Economic Development Institute) at the University of Birmingham and Rose Regeneration, a specialist rural economic development consultancy based in Lincoln, were commissioned by the National Centre for Rural Health and care to **apply a rural lens** to the workforce challenges facing the NHS in England.

The research had two aims:

1. to conduct research into issues highlighted the NHS Workforce Strategy Consultation *Facing the Facts, Shaping the Future*.[1]
2. to distil good practice in rural workforce commissioning and provide suggestions as to how this can be applied across the NHS and in relation to adult social care.

About the National Centre for Rural Health and Care

The National Centre for Rural Health and Care (NCRHC) has been established as a Community Interest Company, national in scope and with a Headquarters in Lincolnshire.

It acts as a governance vehicle for formal collaboration amongst partners interested in four key drivers of impact in rural health and care, as well as influencing policy and strategy:

- **Data** – scoping and measuring the challenge and the response to it.
- **Research** – identifying and testing what works.
- **Technology** – shrinking distances between and adding to the human capacity in rural communities.
- **Workforce and Learning** – making the case for rural settings as the location of choice for ambitious health and care professionals.

Key activities of the Centre include:

- Horizon scanning for good practice and to predict future issues and needs.
- Brokering collaboration where innovation or good practice exists or can be stimulated.
- Supporting the development of bids for funding or specific cases for private investment.
- Supporting the piloting/testing of products and services.
- Working to scale up effective products and services.
- Evaluating the impact of products on services in addressing rural health challenges.
- Through focused dissemination and networking generating wide scale adoption of what works.

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[1] Public Health England (2017) *Facing the Facts, Shaping the Future. A draft health and care workforce strategy for England to 2027.* https://www.hee.nhs.uk/sites/default/files/documents/Facing%20the%20Facts%2C%20Shaping%20the%20Future%20%E2%80%93%20a%20draft%20health%20and%20care%20workforce%20strategy%20for%20England%20to%202027.pdf (accessed 9th August 2018)

About the NHS Workforce Strategy

The NHS Workforce Strategy which stimulated this research represents a departure for the NHS in its national scope and the length of its strategy period. It is based on **six principles**:

1. Securing the supply of staff.
2. Enabling a flexible and adaptable workforce through our investment in educating and training new and current staff.
3. Providing broad pathways for careers in the NHS.
4. Widening participation in NHS jobs so that people from all backgrounds have the opportunity to contribute and benefit from public investment in our healthcare.
5. Ensuring the NHS and other employers in the system are inclusive modern model employers.
6. Ensuring that service, financial and workforce planning are intertwined, so that every significant policy change has workforce implications thought through and tested.

The strategy raises the following **fundamental questions**:

1. Are these the right principles?
2. What measures are needed to secure the staff the system needs for the future; and how can actions already under way be made more effective?
3. How can the NHS ensure the system more effectively trains, educates and invests in the new and current workforce?
4. What more can be done to ensure all staff, starting from the lowest paid, see a valid and attractive career in the NHS, with identifiable paths and multiple points of entry and choice?
5. How can the NHS better ensure the health system meets the needs and aspirations of all communities in England?
6. What does being a modern, model employer mean and how can the NHS meet those ambitions?
7. How can the NHS ensure staff make the greatest possible difference to delivering excellent care for people in England?
8. What policy options could most effectively address the current and future challenges for the adult social care workforce?

Summary of key challenges and opportunities identified in the research

The **golden thread** running through the research is that *securing the supply of staff that the health and care system needs to deliver high quality care in rural areas now and in the future is crucial.*

The research findings pointed to nine key **challenges** facing rural areas and nine **opportunities** for securing workforce supply and maximising impact as depicted in the following box.

Challenges *facing rural areas*:

1. Rural areas are characterised by disproportionate out-migration of young adults and in-migration of families and older adults.
2. This means that the population is older than averag*e* in rural areas - this has implications for demand for health and care services and for labour supply
3. Relatively high employment rates and low rates of unemployment and economic inactivity mean that the labour market in rural areas is relatively tight
4. There are fewer NHS staff per head in rural areas than in urban areas.
5. A rural component in workforce planning is lacking.
6. The universalism at the heart of the NHS can have negative implications for provision of adequate, but different, services in rural areas and also means that rural residents can be reluctant to accept that some services cannot be provided locally.
7. The conventional service delivery model is one of a pyramid of services with fully-staffed specialist services in central (generally major urban) locations – which are particularly attractive to workers who wish to specialise and advance their careers.
8. Rural residents need access to general services locally and to specialist services in central locations to provide best health and care outcomes.
9. Examples of innovation and good practice are not routinely mapped and analysed, so hindering sharing and learning across areas.

Opportunities *for securing workforce supply and maximising impact*:

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

Methodology

To respond to the opportunity to introduce the importance of a rural component to planning and development in relation to workforce issues in the health and care sector the research methodology outlined below was established:

Step	Method	Purpose
1.	*Setting the spatial framework* – by applying the Office for National Statistics Rural-Urban classification to the map of NHS delivery in England.	To provide a clear spatial framework to provide the context for more detailed analysis of the rural dimension – including recognition of different types of rural areas.
2.	*Analysis of economic and labour market data* – using spatially disaggregated indicators available in the public domain *Setting the spatial framework.*	To provide information on the economic context and key features (historical, contemporary and projected) of change in the national and selected sub-national labour markets in which the NHS operates – so providing a context for responding to questions set out in the workforce consultation.
3.	*First sweep application of a rural lens* – to the questions set out in the strategy.	To distinguish which questions in the strategy are of generic relevance and which are particularly pertinent in a rural context.
4.	*Evidence review* – of the academic and grey literature pertinent to rural aspects of questions in the review.	Applying a tried and tested approach of searching, screening, data extraction, synthesis and reporting to identify evidence relating to each question. Results are presented in Appendix A.
5.	*Primary research* – one-to-one interviews and focus groups with delivery agencies (including local authorities in the context of social care), professional associations, stakeholders, etc., in purposively selected rural locations.	To provide a 'deep dive' into specific issues raised in the literature in a range of rural areas to draw out specific perspectives on challenges and opportunities relating to the NHS workforce in a wider context. The areas chosen were: Cumbria, Northumberland, Lincolnshire, Hereford and Worcestershire, Kent and Cornwall. It also involved workshops and sandpits at the launch of the National Centre for Rural Health and Care and a series of facilitated evening discussions with key NHS and rural representatives at a follow on meal. It also involved access to the results of a survey of 13 rural first tier authorities about their experience of Adult Social Care provision through the Rural Services Network.
6.	*Testing and triangulation* – with a reference group of individuals representing different perspectives on workforce development in rural areas.	To 'sense check' emerging findings across different aspects of the research and to provide challenge – thus ensuring that the research captures key issues pertinent to the strategy from a rural perspective.

7.	*Synthesis, analysis and reporting*	To link across the different methodologies and evidence generated to produce a report, which can inform the refinement of the NHS workforce strategy, to ensure effective attention is paid to its rural context and best practice in addressing the key issues relating to it.
8.	*Development of a What Works Guide* – establishment of a manual and short case studies arising from the research to inform practical actions to address the rural workforce issues identified in the report.	This guide will pick up best practice in workforce models in rural settings. It will enable better commissioning of new workforce approaches and provide a 'what works well' source which can be built on. The main aim is to inform HEE and the National Centre for Rural Health and Care about practical workforce steps. It is proposed that this is developed in collaboration with HEE about how most effectively to integrate this element of the work with their 'Workforce Star' toolkit.

Spatial Analysis

The starting point for the analysis is that whilst there is a general recognition that spatial and rural issues impact on the delivery of health and care services in the UK[2] this strategy, covering over 140 pages, has only one reference to 'rural' in a section on global fellowships in South Africa.

STP Geographies

This report uses the sub-division of England into Sustainability and Transformation Plans (STPs) as a frame of reference. Appendix B sets out the rural characteristics of these areas excluding London.

22 of the 44 STPs have a population share equal to or greater than the England average (17%).

The 2016 (March) Five Year Forward View on STP footprints identifies five factors taken into account in "forming footprints" for STPs:

- Geography.
- Scale.
- Fit with existing footprints of change programmes.
- Financial sustainability of organisations in the area.
- Leadership capacity and capability to support change.

There is no indication in this 2016 document or the STPs about how this process has been applied in detail. It has led to a number of anomalies, which emasculate rural geographies by combining them together with urban settings:

- Dorset on this basis has only 16% of its population living in rural areas.
- Lancashire and South Cumbria (16%).
- Northumberland, Tyne and Wear (12%).

We have looked in detail at the top 10 rural STP area strategies by population they are:

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[2] Rural Proofing for Health Toolkit, Institute for Rural Health November 2012

1. Cornwall and Isles of Scilly (62%).
2. West, North and East Cumbria (54%).
3. Norfolk and Waveney (50%).
4. Lincolnshire (48%).
5. Somerset (48%).
6. Cambridgeshire and Peterborough (39%).
7. Shropshire, Telford and Wrekin (39%).
8. Suffolk and North East Essex (38%).
9. Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby (35%).
10. Devon (34%).

All of these areas have at least double the share of rural population than England as a whole.

(Twelve further STP areas – including Herefordshire and Worcestershire and Kent and Medway, have a shares of rural residents in excess of the England average.)

Findings

As set out above, the research findings pointed to nine key **challenges** facing rural areas and nine **opportunities** for securing workforce supply and maximising impact:

Challenges *facing rural areas*:

1. Rural areas are characterised by disproportionate out-migration of young adults and in-migration of families and older adults.
2. This means that the population is older than averag*e* in rural areas - this has implications for demand for health and care services and for labour supply
3. Relatively high employment rates and low rates of unemployment and economic inactivity mean that the labour market in rural areas is relatively tight
4. There are fewer NHS staff per head in rural areas than in urban areas.
5. A rural component in workforce planning is lacking.
6. The universalism at the heart of the NHS can have negative implications for provision of adequate, but different, services in rural areas and also means that rural residents can be reluctant to accept that some services cannot be provided locally.
7. The conventional service delivery model is one of a pyramid of services with fully-staffed specialist services in central (generally major urban) locations – which are particularly attractive to workers who wish to specialise and advance their careers.
8. Rural residents need access to general services locally and to specialist services in central locations to provide best health and care outcomes.
9. Examples of innovation and good practice are not routinely mapped and analysed, so hindering sharing and learning across areas.

Opportunities *for securing workforce supply and maximising impact*:

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

Overview of evidence collected

We present below our synthesis of the evidence we have collected against each of the six principles set out in the Workforce strategies. This synthesis draws on:

- Analysis of Sustainability and Transformation Partnership Action Plans.
- Analysis of secondary data sets on population, economic position, employment, earnings and labour market projections.
- 18 in depth interviews with stakeholders.
- Three sandpit sessions attended by over 60 participants attending the launch of the National Centre for Rural Health.
- Three group discussions.
- A literature review.
- Survey undertaken for All Party Parliamentary Group on adult social care.

Rural STP Analysis: Key findings

There are less than 50 uses of the word "rural" across all ten STP documents covering the STP areas with the largest shares of rural residents. None of the STPs make a clear or developed link between their rural settings and the workforce challenges they face – although in a few very limited examples they do discuss how rurality impacts more generically on delivery in terms of time, cost and distance. This tends to be in generic upfront statements about the area and there are very few direct linkages between rural contexts and the delivery and planning challenges facing STPs.

The STPs fall into two categories on the basis of presence/ absence of rural analysis. Those containing some rural analysis are:

- West, North East Cumbria.
- Lincolnshire.
- Somerset.
- Cambridgeshire and Peterborough.
- Shropshire Telford and Wrekin.

The other five most rural STPs in population terms (Cornwall and the Isles of Scilly; Norfolk and Waveney; Suffolk and North East Essex; Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby; and Devon) do not really have any rural frame of reference in their planning or analysis of the challenges they face.

Key themes, which the STPs collectively mention in the context of rural issues, even if they do not link 'rural' and 'workforce' in their analysis and planning are:

- Recruitment challenges.
- Retention challenges.

- Addressing the challenges in the Francis Report – the findings of the public inquiry into Mid Staffordshire Foundation Trust, particularly in terms of the challenges facing small acute trusts in recruiting staff and deploying them effectively.
- Addressing the challenges in Lord Carter's Review into unwarranted variations in mental health and community health services and the way they are exacerbated by sparsity
- Applying the Buurtzorg model for community nursing - The Buurtzorg approach (which originated in the Netherlands) is based on small, self-managing teams of community nurses who have access to coaches for on-going support and spend at least 60% of their time with patients.
- Widening the skills base of individuals working in health.
- Multi-disciplinary and integrated working.
- Specific "pinch points" around the availability of GPs and in Mental Health.
- Regional collaboration in terms of specialist skills.
- The impact of rurality on health: identifying loneliness as a key challenge and the value of environment and landscape as a key benefit.
- The importance of innovation around acute support in rural settings.
- The relationship between workforce and estates in terms of service delivery – particularly the challenge of managing a diffuse range of buildings in different locations which in many cases do not support the modern demands facing trusts in rural settings.
- The importance of the "extended workforce" and embracing the voluntary and community sector and volunteers to stretch capacity and provision.
- Bed blocking as a challenge.
- Trusts growing addressing their skills shortages by strategies to "grow their own" workforces.
- The challenges more widely of an ageing health workforce.
- IT and digital approaches as a means of shrinking distance.
- The importance of workforce transformation – the value of flexible working especially in terms of driving out preventive outcomes – through moving the focus of intervention to primary care.
- Limited but some references to the importance of workforce progression opportunities.
- An identification that the "market for care" is struggling to respond to workforce challenges – specifically that in rural settings there are not enough workers available to fill the adult social care vacancies which exist.

Principles

The findings of the research are organised around the six principles in the NHS Workforce Strategy which stimulated the research. The principles are considered in turn below.

In each case the principle is outlined, features of rural labour market dynamics that are pertinent to the principle are discussed and key findings from primary research are presented.

Principle 1: Securing the supply of staff

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

This principle forms the essence of the golden thread running through the research. It concerns securing the supply of staff to the health and care system and is about achieving an optimal balance between recruitment and retention. ***Recruitment*** encompasses:

- *new entrants to the health and care workforce (from within the UK)* – whether from new entrants/ returners to the labour market or moves within the labour force from other sectors;
- *returners to health and social care* – attracting back workers who have left the sector; and
- *recruitment from outside the UK* – where activities are shaped by the UK immigration regime and the actions of recruiters.

Retention of existing staff is linked to making health and social care attractive to workers (encompassing issues of job quality, providing opportunities for development, etc. – as covered in Principle 2).

Applying a general (non NHS specific lens) to the issues around this principle four ***features of rural labour market dynamics are pertinent to securing the supply of staff***[3] are identified:

Demographics and population mobility

Rural areas tend to be characterised by an ***older than average population*** (see Figure 1) and an older than average workforce. From a population viewpoint this has knock-on effects on the profile of health and care needs in rural areas. From a workforce perspective it has implications for so-called 'replacement demand' (i.e. job openings resulting from retirement) and the character of the potential workforce on which the NHS and social care employers can draw, taking into account the fact that generally there are fewer younger people in rural than in urban areas. In turn this has implications for recruitment strategies and job design, given variations in work aspirations and expectations of different generations (see Principle 5). In aggregate older workers are less likely to have their qualifications certified than younger workers, so they may be less likely to meet qualification requirements of jobs.

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[3] For further details of rural labour market dynamics see Green A. (2016) 'Changing dynamics of rural labour markets' in Shucksmith M. and Brown D.L. (eds.) *Routledge International Handbook of Rural Studies,* Routledge, Abingdon, 143-153.

Figure 1: Age structure of the population, 2011 – comparison of 'Mainly Rural' and England
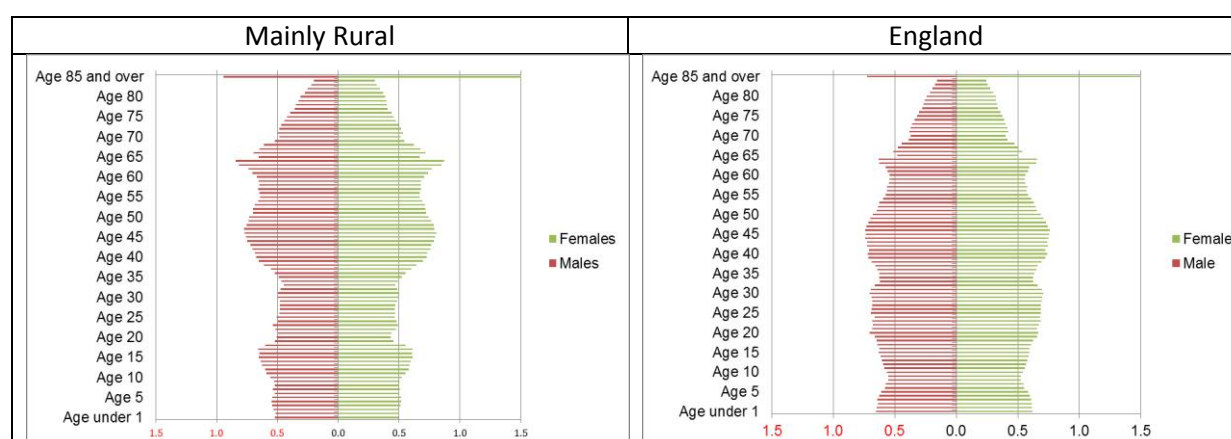
Source: 2011 Census of Population

The older than average population in rural areas suggests that integration of health and social care is particularly important to address more complex and greater interdependence of needs associated with advancing years. It is also plausible that the need to support (unpaid) carers is greater in rural areas than in urban areas given the relative age structures of the population. This has implications for education and training (see Principle 2), broad career pathways (see Principle 3), widening participation (see Principle 4), the need for modern model employment principles (see Principle 5) and the intertwining of service, financial and workforce planning (see Principle 6).

A related key feature of rural labour markets is selective ***out-migration of the most academically qualified young people to larger urban areas***, so reducing the number of qualified young people for recruitment. This might suggest that there is particular scope in rural areas for consideration of how to recruit individuals with fewer formal qualifications (see Principle 4). Rural areas tend to be less attractive than urban areas to new graduates looking to start their careers, especially if they have moved to urban areas for higher education. Hence it may be the case that rural areas need to rely more on returning practitioners (i.e. those who have left roles in the NHS and social care) and recruitment from outside the UK.

Research on internal migration has pointed to a ***decline in internal migration and a rise in secular rootedness*** across several parts of the developed world.[4] While there are variations in this trend between countries, distances and economic cycles, this trend presents an opportunity and a challenge for rural areas, which need to be attractive for individuals and households to be able to stay in one residential location, while still pursuing their careers.

Quantity of labour

A ***limited labour pool in rural areas*** means that there is a smaller potential workforce on which the NHS and social care can draw. This limited pool places a premium on widening participation (see Principle 4) and designing jobs in such a way that workers are inclined to stay (see Principle 5).

In many (but not all) rural areas issues of a limited labour pool are ***exacerbated by remote location and poor public transport***. Workers in rural areas working in the NHS and social care are more likely to need a car to travel-to-work than workers in urban areas and this is likely a limiting factor for

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[4] Champion T., Cooke T. and Shuttleworth I. (2018) *Internal Migration in the Developed World,* Routledge, Abingdon.

labour supply – especially in social care roles requiring home visits and for lower-paid job roles. Remoteness and associated travel issues are also an issue in increasing the incidence of hard-to-fill and skill-shortage vacancies in rural areas across the economy in aggregate.[5]

Partly reflecting their smaller scale (in terms of population and employment) **traditionally rural labour markets have been more reliant on informal recruitment mechanisms** than urban areas. This suggests that existing staff are an important resource for encouraging new recruits to the NHS and social care – so highlighting the need for them to be inclusive modern model employers that current employees would recommend (see Principle 5).

Skills

The so-called '**low skills equilibrium'** (i.e. where low levels of skills in the population are met by a low level of demand for skills from employers[6]) is a feature of some rural labour markets, particularly in peripheral rural areas. There is a danger that use of this term (i.e. 'low skills') creates an image of a lack of career paths in certain sectors – potentially fuelling a lack of attractiveness of such sectors for workers. However, the existence of a set of conditions where employers have increasing demands for low, though flexible, skills (functional flexibility) and a limited number of skilled job opportunities (which in turn makes such areas relatively unattractive for dual career households), tends to create a situation where the local workforce develops fewer skills. The existence of this set of conditions can lead to the persistence of the spiral of decline, and the generation of low expectations and lack of an innovative mind-set among both employers and employees.

This suggests that promotion of opportunities for education and training (see Principle 2) and progression (see Principle 3) may be particularly pertinent in peripheral rural areas.

International migrants

Traditionally rural labour markets have tended to be less reliant on **international migrants** as a source of labour supply than urban labour markets. With the expansion of the European Union (EU) from 2004 the population of rural areas in England has become more diverse as migrants from Central and Eastern Europe took jobs (often below their skills levels) in rural as well as urban areas.[7] International migrants have expanded the supply of labour in rural areas and have also reduced the average age of the population. It is notable that with free movement migrants from the European Economic Area (EEA) have tended to be relatively more mobile than non-EEA migrants, so potentially making rural areas with a relatively high share of international migrants from the EEA disproportionately vulnerable to changes in international migrant flows.

The NHS and social care are to some extent distinctive in that historically in nearly all parts of the country the NHS and social care workforce have relied to varying extents on international migrants in accordance with differences in local demographics, skills needs, relative attractiveness of the area and workforce planning policies. While immigration rules are the same across the UK, the impact of

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[5] Owen D., Li Y. and Green A. (2013) Secondary analysis of employer surveys: Urban and rural differences in jobs, training, and skills', Evidence Report 75, UKCES, Wath-upon-Dearne and London.

[6] See Green (2016) op. cit.; see also Green A. (2016) *Low skill traps in sectors and geographies: underlying factors and means of escape.* https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/593923/LowSkillsTraps-_final.pdf

[7] Bauere V., Densham P., Millar J. and Salt J. (2007) 'Migrants from Central and Eastern Europe: Local Geographies', *Population Trends* 129, 7-19; Green A.E., de Hoyos M., Jones P. and Owen D. (2009) 'Rural development and labour supply in the UK: the role of non-UK migrants', *Regional Studies* 43(10), 1261-1273.

changes in such rules (including immigration rules for non-EEA migrants and the immigration regime for EEA workers post Brexit) will vary depending on the dependence of different local areas (both rural and urban) on migrant workers (see Appendix I for further information on the UK immigration context).

Four key features pertinent to securing the supply of staff emerging from the **findings from the primary research** are highlighted next: first, variations between rural areas; secondly, the relative importance of recruitment versus retention; thirdly, the features of rural labour markets as they relate to the NHS and social care; and fourthly, the issue of enhancing attractiveness to secure labour supply.

Variations between rural areas

Rural areas are heterogeneous – geographically and socio-economically. As indicated by the ONS classification of urban and rural areas[8] there are differences in *settlement structure* which in turn are manifest in different gradations of rurality. This has implications for the viability and provision of transport and other services. Also of particular relevance for securing the supply of labour are variations in the *relative accessibility and remoteness* of rural areas. Remoter (and especially peripheral and coastal) rural areas ceteris paribus are likely to suffer particular issues concerning connectivity (in terms of travel-to-work, travel-to-train and accessibility to other services). *Socio-economically* there are marked differences between rural areas, which are evident in variations in economic position of individuals, in-work poverty, housing affordability, health, etc. Relatively high levels of *deprivation* in some rural areas tend not to be captured by standard deprivation indices which tend to be dominated by characteristics of urban populations.[9]

The attractiveness of rural areas for living varies. The geographic and socio-economic factors outlined above impinge on the attractiveness of rural areas as a place to live for individuals and their families. Accessible rural areas may provide a good quality of life, access to good schools, pleasant countryside, etc., within reach of economic, retail and cultural opportunities associated with metropolitan areas and large urban centres. High house prices and a shortage of affordable rented accommodation mean that living in some of the more accessible and attractive rural areas is beyond the reach of some people. Conversely, the isolation of some more peripheral rural areas means limited access to work and services, cheaper house prices and very limited public transport. There are differences between individuals and population sub-groups in the value they place on these different factors (as discussed in Principle 5).

The precise complexion of labour supply circumstances varies between rural areas. Variations in labour supply circumstances are associated with the factors outlined above. While in aggregate rural areas are characterised by relatively high employment rates and have limited labour force availability in quantitative terms, there are variations between rural areas in the labour supply available and the challenges that the NHS and social care employers face in recruiting and retaining labour. So, in general labour supply is a national problem with different local implications, and those implications vary between rural areas.

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[8] https://www.ons.gov.uk/methodology/geography/geographicalproducts/ruralurbanclassifications
[9] Fecht D., Jones A., Hill T., Lindfield T., Thomson R., Hansell A.L. and Shukla R. (2018) 'Inequalities in rural communities: adapting national deprivation indices for rural settings', *Journal of Public Health* 40(2), 419-425.

Recruitment and retention

Recruitment poses a greater challenge than retention in many rural areas. This reflects a relatively thin labour market and associated more limited possibilities for progression than in metropolitan areas which may make initial recruitment difficult in some rural areas. There is some evidence that doctors tend to stay in the area where they have trained and hence the March 2018 announcement of new medical schools in areas where currently there are none (including Lincoln and Canterbury)[10] may go some way to addressing staff shortages in some rural areas in the medium-term. 'Grow your own' strategies (discussed under Principle 2) were identified in primary research as being one important way forward for rural areas. Another issue raised concerned whether training courses should have a compulsory 'rural' module so that trainees have exposure to a rural environment and rural issues (which in turn might lead some to consider working in a rural area). Once in post (in the NHS particularly) there are more limited opportunities for inter-organisational mobility within the external labour market, so making retention less of an issue. As noted above, however, there are some differences between rural areas, as illustrated by retention difficulties in parts of Kent where job opportunities in London may be physically accessible and more attractive (in terms of pay and progression possibilities).

Achieving an optimal balance between job mobility and immobility is important. Too much churn within a workforce causes difficulties for retention and workforce planning. Conversely, insufficient mobility means lack of exposure to new ideas and learning, with a detrimental impact on capacity for innovation. This issue of relative immobility is a potential problem in rural areas given the need for flexibility and adaptability in the NHS and social care in general (see Principle 2) and the potentially greater scope and need for innovation and collaboration in rural areas given service delivery, financial and labour supply constraints.

'Earn, learn and return' is one means of addressing recruitment problems. Rural areas are potential beneficiaries of the Health Education England (HEE) 'Earn, Learn and Return'[11] jobs drive. This allows workers from outside the UK to come to the UK for a fixed period of time to help address staffing shortages, but also to learn, to earn money, and to take that back to their origin country. It provides a 'stop gap' for addressing vacancies, but also might provide exposure of other staff to new ideas.

A segmented approach is needed to make rural areas attractive to different sub-groups. As noted in discussions of Principle 5 and Principle 3 different sub-groups and generations within the (potential) workforce seek and prioritise different things from the work and non-work elements of their lives, and so may value rural areas differently. These differences need to be taken into account in recruitment and retention campaigns so as to appeal in a more targeted way to different groups and generations. Working in a rural environment may be particularly attractive to those individuals wanting to pursue a 'generalist' (as opposed to a 'specialist') role, and this in turn has implications for training (see Principle 2). This links to enhancing the attractiveness of rural areas (discussed below). Experience in a rural area may be attractive to a younger generation of workers as part of developing a portfolio of experiences.

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[10] Secretary of State, Jeremy Hunt, announced the locations of new medical schools in areas where it "can be hard to recruit and attract new doctors" in Sunderland, Lancashire, Lincoln, Canterbury and Chelmsford.
[11] https://www.earnlearnandreturn.com/ and https://www.rt.com/uk/411279-nhs-jobs-nurses-asia/

Features of rural labour markets

Recruitment and retention policies need to take account of the out-migration of young adults and in-migration of families and older adults. As noted above, the establishment of new medical schools outside the main metropolitan areas might go some way to addressing recruitment issues in rural areas given that some trainees tend to stay in or close to their training location on graduation. The in-migration of families and older adults to rural areas provides a potential source of expertise and more mature recruits into the NHS and social care and for volunteering opportunities in third sector organisations. This has implications for education and training (Principle 2) and career pathways (Principle 3).

High employment rates and relatively low rates of unemployment/ economic inactivity place a premium on widening participation and inclusive modern, model employers. In a tight labour market employers need to be open to including non-traditional sources of labour (as discussed in Principle 4) and also to pay particular heed to issues of job quality (see Principle 5). Primary research emphasised that the cost of locum provision is relatively high in rural areas and so policies that make permanent and fixed-term positions more attractive could be especially beneficial in rural areas.

Opportunities to address challenges posed by 'thin' labour markets need to taken. 'Thick' labour markets associated with agglomeration economies in major urban centres are particularly attractive to highly skilled workers, especially those in dual career households. They offer a greater quantity and quality of opportunities for advancement and specialisation than 'thin' labour markets. Primary research suggested that investments in technology also tended to favour larger urban centres. Rural areas and the rural workforce can glean some of the advantages of these agglomeration economies through staff rotation (i.e. providing opportunities for staff in rural areas to sample specialist developments elsewhere and by bringing staff from urban areas to rural areas to share their knowledge). Lack of a large labour pool in rural areas can provide opportunities for empowerment and more for varied careers (with appropriate training support) (see Principle 2) for those who choose to remain in situ.

There is scope to capitalise on the status of the NHS as a large employer in rural areas. With the decline in employment in local government, in many rural areas the NHS is one of the few large employers remaining. As such it can offer significant benefits to employees with opportunities for progression within the NHS internal labour market, in a context where there is a relative absence of other large employers with such an offer and fewer opportunities for progression in the external labour market compared with urban areas. To capitalise on this it is important that pathways for progression (see Principle 3) are as clear as possible and that appropriate workforce development policies are in place.

There is a need to work in partnership across policy domains to help address workforce issues in rural areas. In general, the sparser infrastructure in rural areas than in urban areas means that it is especially important to work in partnership across policy domains. From a planning perspective transport and housing are of crucial importance in helping to address access to work issues, albeit access to private transport is very important for workers. Primary research highlighted the importance of taking account of social capital and the strength of the voluntary sector in rural areas – from both workforce development and population health and wellbeing perspectives.

Enhancing attractiveness

There is scope to promote non-work related features of rural areas as place to live. Enhancing attractiveness of rural areas as places to live and work involves emphasising non-work and work related attributes. Clearly the appeal of rural areas varies for different sub-groups and generations (as discussed above), so highlighting the need for a segmented approach – emphasising lifestyle issues and environmental benefits, schools, housing, etc., as appropriate. Primary research highlighted that these benefits are distinctive to particular rural areas, so emphasising the benefits of a locally-sensitive approach.

Creating and sustaining 'centres of excellence' is a possible way of attracting and retaining staff in rural areas: Some hospitals in rural areas face difficulties in attracting staff, which in turn can lead to challenges in maintaining quality and safe staffing levels in a vicious circle (see Figure 2). One way of escaping this 'trap' and enhancing attractiveness of rural areas from a work perspective is to develop 'centres of excellence' where staff want to come and work. This might be in one or more specialist areas, but overall provides a positive reason for staff to come to work there.

Figure 2 Vicious cycle of attracting staff in some rural hospitals
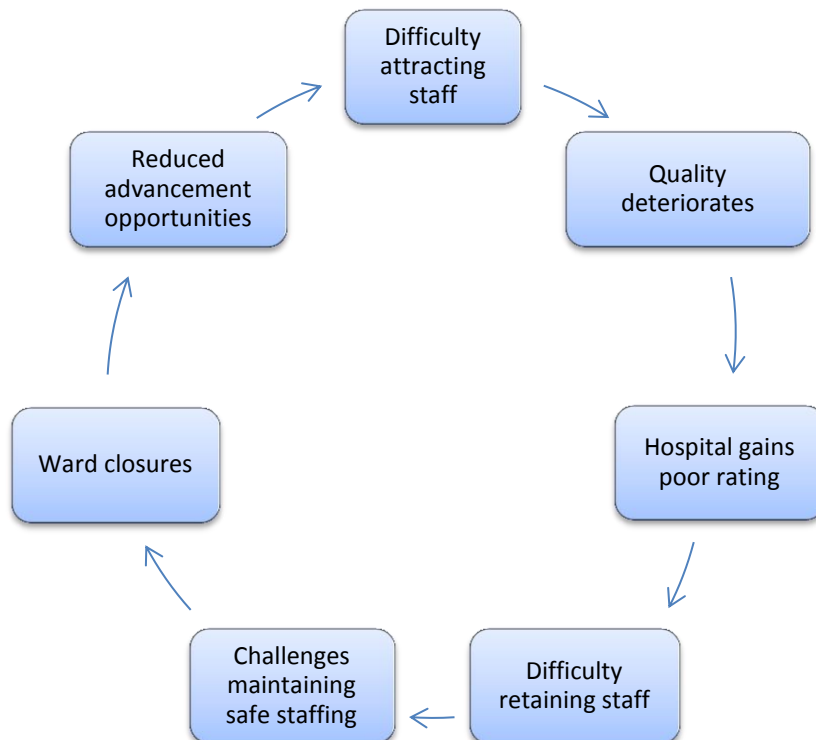
Principle 2: Enabling a flexible and adaptable workforce through our investment in educating and training new and current staff

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

Applying a general (non NHS specific lens) to the issues around this principle three *features of rural labour market dynamics are pertinent to enabling a flexible and adaptable workforce through investment in education and training* are identified:

Cost of training

Across the economy as a whole training is more expensive to deliver in rural than in urban areas – this reflects lower numbers of potential trainees (Principle 1)[12], which can increase costs of training provision. Analysis of NHS Digital workforce statistics suggests there are 45% fewer NHS workers per head in the most rural 11 STP areas (with 33% or more of their population in rural settings)[13]. More information is provided at Appendix B. The operational practicalities and costs of travelling to training are likely to be particularly pertinent for social care and lower-paid, less skilled NHS staff. Delivering training of the current workforce may be more challenging in rural than in urban areas (particularly if necessitating travel to other locations often outside of normal work times). The Lincolnshire STP for example is very large and sparsely populated with 1.2 people per hectare compared to a national average of 2.7 people per hectare. The Cornwall STP area has 0.7 people per hectare[14].

Responses to hard-to-fill vacancies

Increased spending on recruitment and using new recruitment channels are the main responses to hard-to-fill vacancies in urban and rural areas. Across the economy as a whole, *rural establishments are more likely to 'do nothing' in response to hard-to-fill vacancies* than urban establishments. But they are also *more likely to redefine existing jobs* or increase training than establishments in urban areas.[15] So this raises the question of whether rural areas are/ can be in the vanguard of *job redesign* in the NHS and social care.

Relative emphasis on formal qualifications and training

In general rural areas are characterised by a higher proportion of small and medium-sized enterprises (SMEs)[16], lower than average levels of training and *lower emphasis placed on formal qualifications* than in urban areas and *more emphasis on informal training* (Principle 3).

Five key features for flexible and adaptable workforce

Five key features pertinent enabling a flexible and adaptable workforce through investment in education and training emerging from the *findings from the primary research* are highlighted next: first the impact of public attitudes in constraining the acceptance of flexible and innovative working practices (Principle 4), secondly the impact of sparsity on flexible approaches to training and

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[13] NHS Hospital & Community Health Service (HCHS) monthly workforce statistics, NHS Digital March 2018
[14] 2011 Census: Population Estimates by five-year age bands, and Household Estimates, for Local Authorities in the United Kingdom, Office for National Statistics
[15] Owen D., Li Y. and Green A. (2013) Secondary analysis of employer surveys: Urban and rural differences in jobs, training, and skills', Evidence Report 75, UKCES, Wath-upon-Dearne and London.
[16] England's rural areas: steps to release their economic potential, Commission for Rural Communities, May 2008

development, thirdly the enabling effects of technology (Principle 6) in supporting flexible modes of working, fourthly the impact of a largely urban focused planning mentality within the NHS on flexible working approaches within the NHS and finally the impact of the current scale and configuration of the housing stock in rural areas on opportunities for flexible and innovative workforce deployment and development (Principles 4 and 5).

a) Public Attitudes

Rural settings, which find it difficult to attract and/or retain staff, are affected by sparsity which manifests acute challenges in terms of the operation of a traditional model (unchanged in terms of public expectations in some senses in the 70 year lifetime of the NHS). ***Generally people are reported as loathe to support and to explore new models of delivery***, which depart from "received wisdom" about what the NHS should provide. GPs and acute hospitals are the touchstones, which in some senses act as an impediment to workforce flexibility and innovation (Principle 5).

b) Sparsity

Evidence from primary research indicates that notwithstanding the challenges set out above ***sparsity can also be the "mother of invention"***. We found several examples of radical approaches to these issues including:

- Mobile training facilities bringing CPD out into the field in Worcestershire[17].
- A GP surgery operating without a GP in Herefordshire.
- Workforce approaches responding to the character and needs of specific places based on a "whole town model". This approach involves working extensively with all the agencies and initiatives in a settlement which impact on the health and well-being of local people rather than linking just with organisations and initiatives which have a very specifically defined health and or care remit. We found particularly well developed examples of this approach in the Lancashire and South Cumbria STP area in Fleetwood and Millom (Principle 6).
- Rotating workforce[18] (alternating rural an urban settings in the deployment of staff) involving paramedics in pilot sites comprising Derbyshire & Lincolnshire, Newcastle, South East Hampshire and Yorkshire, and involving East Midlands, North East, South Central and Yorkshire Ambulance Services (Principle 3).
- Examples of innovation around the services delivered by pharmacists in rural settings.
- Examples of the contribution of volunteers to effective local services.
- Evidence of "grow your own" strategies in some rural settings taking a long term view about workforce gaps/challenges. (Principle 3).

Innovative workforce and training activities such as those set out above were recognised as providing scope to overcome some of these challenges but their deployment in the areas we looked at in detail overall was relatively limited according to our interviewees.

The new and existing strategic targets set out in the workforce consultation[19] recognise the importance of the recruitment of these roles but do not set any targets for rural areas in terms of:

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[17] Health Education West Midlands Innovation Programme Skills Enhancement in Rural Communities. Health Education West Midlands. July, 2015.

[18] The Rotating Paramedic Pilot - the right response, first time. Health Education England, February 2018

[19] Facing the Facts, Shaping the Future. A draft health and care workforce strategy for England to 2027, Appendix 1. Public Health England.

- Nursing associates.
- Clinical pharmacists.
- Physician associates.

The deployment of individuals, delivering these roles, provides real scope for innovation in rural areas.

There is a workforce planning commitment to publish intelligence reports by profession and geography in the draft workforce strategy. This will provide scope to begin regularly applying a rural lens to the key workforce issues facing health and care providers.

c) Technology

There is a significant strand of discussion *in the context of technology* about *how roles can be performed more flexibly and insightfully* (Principle 6).

Examples of interventions, which provide the scope to address staffing issues include:

- E-medical applications which reduce the number of face to face interactions between patients and health professionals through linking individuals remotely with clinical settings. The Our Digital Future Initiative in Lancashire and South Cumbria is a powerful example of an STP wide approach to addressing this issue[20].
- Equipment which reduces the range and number of health interventions required to support individuals and in some cases help people to remain independent without intensive personal care for longer. Examples range at the least high tech end of the spectrum from residential aids and adaptations supplied by organisations promoting independence for individuals in their own homes, to sophisticated e-enabled dementia management systems at the high tech end of the spectrum.

> *Good Practice Example of provision of digital technology to support integrated care, business intelligence and remote home management of patients with long-term conditions*
>
> *Docobo telehealth[21]* emulates a consultation with a clinician, carried out remotely. It consists of vital sign measurements and symptomatic questions that indicate a patient's health and wellness status – the technology monitors the patient, displaying trends over time and generating alerts when necessary. ARTEMUS-ICS™ provides a population health status radar, where all information relating to patient movements, health status, risk of admission and urgent care among others can be viewed from one location. General Practitioners can track a patient's journey through the healthcare system, and intervene to make the journey more cost-effective for the payer and a better experience for the patient. Commissioners and providers are able to function as 'traffic controllers' viewing and acting upon the results, tracking impacts of new interventions and flag-up emergencies and urgent requirements. Docobo works nationally with acute trusts, carers, CCGs, clinicians, GP practices, patients and residential care providers.

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[20] Our Digital Future. Healthier Lancashire and South Cumbria, 2017
[21] https://www.docobo.co.uk/index.htm

> **Good Practice Example of fostering innovation in e-health**
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> _**ehealth Productivity and Innovation** in Cornwall and the Isles of Scilly (EPIC)_[22] is a collaborative and multidisciplinary project funded by the European Regional Development Fund (ERDF) and the South West Academic Health Science Network (AHSN). The project provides SMEs with funding to test their ideas, develop eHealth products and drive innovation forward in the health sector – up to £5,000 for feasibility and £5,000-£10,000 to tackle challenges.

- Equipment which introduces and element of self-organising into working arrangements, so aiding workforce planning.

> **Good Practice Example of an app to aid worker flexibility and help address workforce needs**
>
> _gogoflo_[23] is a mobile app that healthcare professionals can download for free. They create their profile, upload all their compliance (which is checked by gogoflo) and then set their shift criteria: how much they want to work, how much they want to get paid and how far they are prepared to travel. For hospitals, gogoflo is an online dashboard. They post out a shift vacancy specifying: worker's hourly rate, shift time and date, and skills or specialties required. The algorithm then searches for healthcare professionals that make that match and instantly notifies them. They then book the shift on the app in two taps. The healthcare professional attends the shift and gogoflo pays them on the Friday. Because gogoflo uses technology they only charge a tiny commission compared to traditional agencies and healthcare professionals can manage their shifts on the go, anywhere at any time. This means the hospital makes savings and the healthcare professional gets paid more.

d) Urban Bias

Several of our interviewees asserted that **the universal service and standards approach of the NHS led to a 'one size fits all' tendency**. As the majority of NHS services are provided in urban settings and at large scale this can lead to a default planning position, which applies an urban bias to the delivery of health and care services.

In terms of a traditional urban focused approach to workforce issues the primary research identified examples of:

- A lack of training placements and learning environments in rural areas – driven in most cases by the fact that there are simply fewer people and places in rural areas (Principle 1).
- New entrants to NHS professions reluctant to take on roles in rural practice.
- Increasingly challenging vacancy levels amongst rural GPs.
- High and unmet demand for mental health services in rural settings.
- Travel time as a real barrier to participation in training and development.
- Difficulties around progression arising from a limited number of roles and opportunities in rural geographies. (Principle 3).

e) Housing

We also found **house prices in some rural areas** were **a significant factor in limiting the pool of available workers with a knock on effect into workforce flexibility**. ONS data demonstrates an England wide ratio of house prices to annual wages of 7.8. In Devon the ratio is 9.1 and in Dorset 11.4.[24]

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[22] https://www.plymouth.ac.uk/research/epic
[23] https://gogoflo.com/how-it-works
[24] Ratio of house price to workplace-based earnings (lower quartile and median), 1997 to 2017 Ratio of house price to workplace-based earnings (lower quartile and median), 1997 to 2017 Office for National Statistics

Principle 3: Providing broad pathways for careers in the NHS

> This priority is about enabling staff to contribute more (and earn more) by developing their skills and experience through structured progression opportunities within and between professions. The Draft Strategy emphasises the need to enhance retention and help the NHS become the employer of choice.

Applying a rural (non NHS specific lens) to the issues around this principle, six features of rural labour market dynamics are pertinent to developing structured progression for staff:

- Rural areas are characterised by a *smaller quantity and reduced range and scope of job opportunities*. This serves to constrain career opportunities in-situ relative to urban areas.
- This has links to the *supply of workers* (Principle 1) given the reduced opportunities for job moves – the breadth and depth of different job roles is likely to be greater in urban areas than in rural areas.
- This also links to the *higher proportion of SMEs*, *lower than average levels of training* and have a *lower emphasis on formal qualifications* compared to urban areas, leading to more emphasis on informal training (Principle 2).
- There is a particular issue of *how to provide broad pathways for progression without losing workers from rural areas.* For example, there are often no discernible differences in the caseloads of the medical workforce between urban and rural areas[25], the lower patient volume and smaller peer group can make posts less attractive to staff who want to maintain *specialist* interest and skills.
- However, for workers who wish to remain in situ in rural areas, as a large employer, the NHS provides a potentially greater range of opportunities in terms of progression (in terms of its internal labour market) compared to other employers (Principle 1).

In rural and urban areas alike there is a need to *think of workforce development in terms of an employment pathway[26]* – from employment entry to in-work progression – with training and support along the way:

Get In
opportunities for people to start their career in a support role

Get On
support people to be the best they can be in the job they do

Go Further
provide opportunities for career progression, including into registered professions

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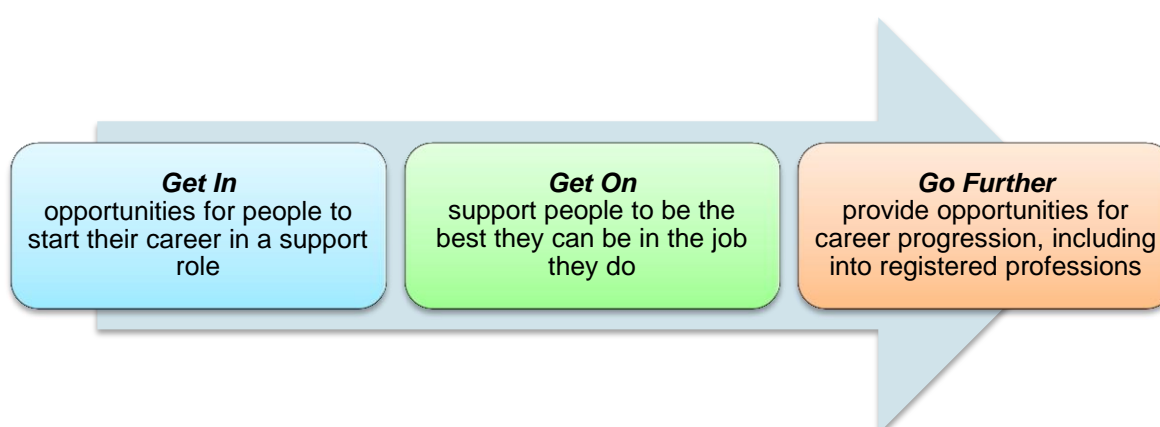
[25] Ball J, Philippou J, Pike G, and Sethi J. (2014) *Survey of district and community nurses in 2013: Report to the Royal College of Nursing.* Kings College London, London.
[26] The employment pathway has been adapted from Health Education England's 'talent for widening participation' programmes. Available online at: https://hee.nhs.uk/our-work/talent-care-widening-participation last accessed 26 July 2018.

Within the pathway, development and progression are based upon a person's merit, ability and motivation and not their social background or social networks, and where the intention is for the NHS workforce to be representative of the communities it seeks to serve (Principle 5).

In rural areas three specific factors affect the likelihood of achieving the goals of this employment pathway:

The capacity and cost of rural healthcare organisations in being able to create, expand and support opportunities for people to develop and progress their careers

There is a growing body of evidence that staff health and wellbeing is associated with a multi-disciplinary approach (Principle 5) that is achieved in a cost effective way by creating teams that serve many trusts. This consolidation of investment and delivery often favours urban areas which have certain efficiencies and economies of scale.

The attractiveness and visibility of health careers information and advice

There is a need to demonstrate the breadth of career openings and progression opportunities available within the NHS and wider health sector in urban and rural places. However, sparse/ remote rural areas may benefit from providing high-quality training and employment compared to accessible rural areas which have to compete with health careers available in metropolitan areas / urban centres. In all rural settings there is an opportunity to engage with staff to act as 'ambassadors' to help people get in, get on and go further.

Having an innovative mind-set

There can be low expectations, aspirations and a lack of an "innovative mind-set" (Principle 1) among some workers in rural areas. This can lead to resistance or difficulty among some staff in adapting to change and new ways of working.

The *findings from the primary research* provide examples from rural areas where workforce development had been conceptualised around a pathway:

Grow your own ("get in")

Growing-your-own workforce means finding ways to recruit, develop, cultivate and retain individuals from with a local community to enter healthcare careers. This approach recognises that individuals from the local community are more likely to remain in and want to serve that community. It is worth noting that this approach does not yield workers immediately who can enter the current health labour market but rather it provides a longer-term strategy in securing the supply of staff.

> *Good Practice Example of an Initiative to Support Grow Your Own and Providing a Climbing Frame*
>
> *The Lincolnshire Talent Academy*[27] was formed in June 2015 by United Lincolnshire Hospitals NHS Trust (ULHT) to support the engagement of younger people into its workforce. It has since evolved and now comprises a wide range of health and care organisations and stakeholders. As employers, they work with students, schools, colleges and universities and other agencies such as the Department for Work and Pensions (DWP) to provide services for individuals from the age of 14 years and above. This includes careers inspiration activities, the delivery of careers guidance, work experience and the management of apprenticeship training and support.

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[27] More information about The Lincolnshire Talent Academy is available online: http://www.lincstalentacademy.org.uk/ last accessed 26 July 2018.

To support the existing workforce, **The Lincolnshire Talent Academy** has a Nursing Workforce Development Pathway[28]. This supports staff to progress their careers through work-based learning. Further career pathways are being developed for Children's Nursing, Midwifery, Theatres and Pharmacy.

Integrated Apprenticeships provide a means of apprentices being employed in one sector and then gaining work experience in placements in a different sector. They vary in their level of integration: from bringing health and social care apprentices together for joint learning through to integrated schemes with dual employers. Integrated Apprenticeships are seen as means of providing workers with a diverse range of knowledge and skills as well as improving partnership working between health and social care. **Staffordshire University** provides an *integrated care* apprenticeship[29] which spans health and social care settings, equipping apprentices to the level of a Band 4 Assistant Practitioner. **Norfolk and Norwich University Hospitals NHS Foundation Trust** worked with social care partners to pilot an integrated apprenticeship model[30]. After a two week clinical introduction, the apprentices undertook two six month placements, one in a community care setting and one on a hospital ward.

A climbing frame rather than a ladder ("get on", "go further")

The NHS as a big employer struggles to main its organisational structure for very long. In practice this means a health career could include side-steps, changes in direction, entry into related or new specialisms / roles and working for longer.

Examples of rotating the workforce (i.e., alternating rural and urban settings in the deployment of staff) are included in Principle 2. In **Cornwall** rotational posts integrate in-patient and out-patient cases, health and social care. This forms and part of an attractiveness strategy which advertises the ability to reach 'work to wave' in 10 minutes and has cost implications in health providers seeking to reduce admissions into acute settings.

In a research context, HEE and the National Institute of Health Research (NIHR) provide an Integrated Clinical Academic (ICA) Programme. Launched in 2014 this provides internships for those with no prior research experience, a grounding in clinical research whilst obtaining a recognised qualification, doctoral research fellowships and lectureships.

Several of the interviewees referenced the desire to **partner with universities** – in providing a pool of people with qualifications wanting a clinical career through to accessing research and continuing professional development opportunities.

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[28] More information about the career pathways being developed by The Lincolnshire Talent Academy is available online: http://www.lincstalentacademy.org.uk/article/talent-academy-launches-range-of-new-career-development-pathways/ last accessed 26 July 2018.
[29] More information about the integrated care apprenticeship led by Staffordshire University is available online at: https://www.staffs.ac.uk/higher-degree-apprenticeships/apprentices/health-integrated-care/ last accessed 26 July 2018.
[30] More information about the Norfolk and Norwich University Hospitals NHS Foundation Trust is available online at: http://www.nhsemployers.org/case-studies-and-resources/2017/03/integrated-health-and-social-care-apprenticeship last accessed 26 July 2018.

Providing clinical support beyond the hospital walls – the need for confident "expert generalists"

Some clinical roles may require a greater range of skills in rural areas because of a lack of ease of referring to a specialist team. The tendency within the existing health system to focus on workforce numbers, gaps and vacancies – leads to an emphasis on the numbers of staff required to meet the shortages in roles. Interviewees suggested there is "a pressing need for confident expert generalists happy to deal with most of what comes their way" as well as hospital clinicians that provide clinical support beyond the hospital's walls. It was noted in some rural areas that is especially hard to attract staff to these roles meaning posts and rotas go unfilled. It was further suggested that such an approach requires the 'de-risking' of any service change from the perspective of individual staff (Principle 5).

Information about recruitment and retention campaigns that appeal in a more targeted way to different groups and generations can be found in Principle 5.

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

> This priority enshrines the public duty to provide equal opportunities for all and will ensure the NHS workforce of the future more closely reflects the population it serves. If delivered successfully it will increase the pool of people available to be recruited into the NHS.

Applying a rural (non NHS specific lens) to the issues around this principle two key features are identified:

Ethnic diversity

Rural areas tend to be less ethnically diverse than urban areas and so on this particular dimension there is likely less scope for widening participation. However, there is room, in particular, for widening participation focusing on gender (i.e. encouraging men into female-dominated roles [e.g. carers] women) and age (i.e. focusing particularly on opportunities for older workers given the age profile of rural areas).

New roles

Developing existing roles/ creating new roles (as in the case of Nursing Associates in the NHS) may be a particularly pertinent means for widening participation in rural areas (this relates to issues outlined under Principle 3 above).

The ***findings from primary research*** emphasised four key issues relating to people with disabilities, health conditions, the scope for the NHS to provide a 'second chance' for people failing in or failed by the education system, an enhanced role for the third sector, and capturing the imagination of young people.

A role for people with disabilities and long-term health conditions

All backgrounds includes individuals with disabilities and long term health conditions who with appropriate adaptions and support could undertake a range of roles in NHS and social care in rural areas. Widening participation might be seen as a lower priority in rural areas where the definition of underrepresented groups in NHS employment often is too narrowly defined in terms of ethnicity. A more inclusive approach would include providing opportunities for individuals with disabilities and long term illnesses to work in the NHS. This could be achieved by making appropriate adjustments to work roles and the provision of practical support. Similarly the NHS can help individuals with long term illnesses re-enter employment.

Providing a 'second chance' and fostering social mobility

The NHS is one organisation in rural areas that can support social mobility and provide a second chance for adults 'failed by the education system'. Being a large employer in rural areas the NHS can offer opportunities for career advancement and examples given included nursing assistant through training to being a nurse and career opportunities becoming a director. There is a significant group of adults who do not do well at school who would like an opportunity for a career. Routes such as further and adult education has been cut back significantly making it more difficult to access training in basic adult skills that are required for entry level posts. There is opportunity for the NHS to sponsor courses that develop adult basic skills and prepare individuals to apply for opportunities available. This is particularly significant in those rural areas where schools have been identified as 'coasting' and have significant pockets of underachievement, particularly in some coastal towns.

An enhanced role for the third sector

The third sector can provide alternative routes into employment in health and social care. Opportunities for work in the third sector can be more appealing than working in the NHS to some – including qualified health and allied professionals – because it is perceived as less bureaucratic, more rewarding and flexible. For example LIVES[31] has more than 70 volunteer doctors, nurses and paramedics who respond to complex or traumatic 999 medical emergencies across Lincolnshire. The third sector, through structured volunteering opportunities, provides a means for individuals – especially in underrepresented and disadvantaged groups –to gain skills to enter employment or further education.

Capturing the imagination of young people

Need to start early to capture the imagination of young people at school of the range of opportunities within the NHS. Young people are not aware of the range of opportunities available to them outside the traditional doctor and nurse roles that might better suit their aptitudes and interests, including the application of new technologies. Rural NHS Trusts could work more closely with schools and career services.

Example linking to widening participation: UCLAN's One Health Strategy for the North West[32]
This strategy sets out how the University of Central Lancashire deploys its expertise and networks to improve the health and wellbeing of people and communities.

UCLAN provides almost the full range of health and social care professional education and therefore is well

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[31] Further information available at: https://lives.org.uk/about-lives-lincolnshire/ [Accessed 30.07.2018]
[32] https://www5.uclan.ac.uk/sites/ImageBank/Marketing_Image_Library/5281_One_Health_June2018_FINAL_WEB.pdf (accessed 14.08.2018)

positioned to facilitate new integrated ways of working, develop new roles and produce graduates that are resilient and ready to meet future demands. UCLAN uses a range of approaches for engaging and empowering people and communities in developing innovative health solutions to transform lives and in improving outcomes through evidence based care.

At the heart of the 'One Health' vision is an understanding and recognition that:

- the reality that prevention and early intervention are more effective and cost-efficient than curing, fixing or improving problems.
- better education, information, advice and guidance about lifestyle have life-changing potential, underpinned by nutrition and physical activity.
- effective progress in tackling inequalities and improving health and wellbeing requires action on social, economic, environmental, cultural and commercial determinants of health.
- 'Making Every Contact Count' (2016, Public Health England) is an opportunity to keep 'individuals' from becoming 'patients', for example, keeping people in their own homes, and helping them recover their health when they are discharged from care.
- empowering people and communities to generate solutions to improve health and wellbeing is at the heart of our approach.

UCLAN's vision is informed by their Corporate Strategy and the Strategy for Lancashire along with regional and national strategies and policies (the Lancashire Local Enterprise Partnership Sector Skills Baseline Study for Health and Social Care; Lancashire and South Cumbria Sustainability and Transformation Plan; West, North and East Cumbria Sustainability and Transformation Plan; NHS Five Year Forward View).

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

This priority is about employment models that sustain the values which drive health professionals every day whilst protecting against burnout, disillusionment or impossible choices between work and home. The Draft Strategy emphasises flexible working patterns, career structures and rewards that support staff now and changing expectations of all generations who work in the NHS. [33]

Applying a rural (non NHS specific lens) to the issues around this principle, seven key features of rural labour market dynamics are pertinent to creating inclusive and modern employment models:

Recruitment
Recruitment poses a greater challenge than retention in many rural areas (Principle 1) - rural areas tend to be more attractive to people established and/or coming towards the end of their career. Rural areas are not always perceived as offering clinically fulfilling and rewarding roles.

Being an 'employer of choice'
With staff resources being finite, there is a need to retain the current workforce as well as attracting new staff in and encouraging people to return to practice. This requires being an ***'employer of choice'*** with good employee engagement, shared values and goals that make the NHS an environment where people want to work. Being an employer of choice is seen as one means of the NHS retaining existing staff.

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[33] NHS employers are committed to diversity and equality (e.g. through the employment of current and former service users, flexible working options, growing their own talent from within the local labour pool so they are representative of the communities they serve).

Large employer benefits

Being part of a large workforce (such as the NHS) brings a portfolio of *rewards and benefits* – in rural areas NHS organisations often provide the most comprehensive and attractive employment packages available (e.g. pension scheme, local discounts, car or cycle to work schemes, childcare vouchers).

Understanding career determinants

Becoming an employer of choice increasingly involves understanding career determinants. These determinants may be professional or directly linked to the work environment (e.g. clinical content of practice, working conditions, wages, job satisfaction and support). Here the *quality of work*, the rise of '*atypical work forms*'[34] (e.g. part-time working and multi-jobs), *flexibility* and *employer engagement with staff* are all viewed as important. Lifestyle or social determinants (e.g. personal characteristics and family circumstances) - the emphasis here is on work-life balance – in the context of an ageing population and understanding the aspirations of different generations of staff. While traditionally women may have exercised different choices from men when choosing their medical career, both men and women now value a balanced life[35]. These determinants may be intrinsic (e.g. characteristics such as self-awareness of skills and attributes) with staff looking for a career that is stimulating and interesting. These determinants may be influenced by external factors (i.e., related to geographical location – whether employment is in accessible or peripheral rural area Principle 1 and how this relates to access to other services and support).

Values and behaviours

From an employer perspective this in turn leads to recruiting and retaining staff with the *right values and behaviours* that can be 'moulded' to fit within the organisation. The principles and values that guide the NHS[36] include: working together for patients, respect, dignity, quality, compassion and everyone counts – these form part of a responsibility for maximising the benefits from NHS resources and should form part of employment models where nobody is discriminated against or disadvantaged.

Good work

All of these determinants are important in providing a lens for thinking about how staff get in, get on and go further (the employment pathway, Principle 3) and how the *future of work* needs to move beyond developing projections about numbers of clinical, non-clinical and allied staff required to consider the trends and drivers of change (e.g. expert generalists, Principle 3). From an employer perspective (the demand side) this means needing to *provide good jobs* (i.e. with pay, security, flexibility, opportunities for progression) and from an employee perspective (the supply side) this means being clear about what they are looking for in a job. Bringing both sides together, to be an employer of choice involves providing opportunities for *co-design in order that staff are supported in their professional lives (job satisfaction) in ways that are beneficial to their wellbeing.*

The *findings from the primary research* provide examples where employers are focusing upon flexible working patterns, career structures and rewards.

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[34] See Green A., Kitsos A. and Riley T. (2018) The nature of work and economic resilience, City-REDI, University of Birmingham, (mimeo).
[35] Peckham S, Marchand C, Peckham A. (2016). General practitioner recruitment and retention: an evidence synthesis. PRU, University of Kent.
[36] A list of the principles and values of the NHS can be found online:
https://www.nhs.uk/NHSEngland/thenhs/about/Pages/nhscoreprinciples.aspx last accessed 27 July 2018.

Flexible career structures and working patterns

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The FlexAbility in Nursing project

The FlexAbility in Nursing project[37] is piloting team based rostering that has been shown to work in similar areas (e.g. social care) with 120 nurses in three hospital trusts (Birmingham Women's and Children's Hospital, Nottingham University Hospital and University Hospital Southampton). This is a team based approach to scheduling rotas with a lead time made up of 8-9 people each of whom represent 4-5 colleagues. For employees it improves work-life balance and for employers it ensures wards are fully staffed without having to pull in agency staff. While the project is taking place in urban settings, in rural areas such an arrangement may encourage a sense of collective responsibility and cooperation, and could bring about change to attract, recruit and keep enough staff.

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Interviewees described the different expectations and aspirations of generations – in Cumbria, for example, some hospitals have more than one generation of the same families in their workforce and trusts are increasingly focusing their attention on millennials as a future workforce. In the South West acute trusts are retaining staff through offering sideways moves i.e., into another team or department as part of job redesign (see Principle 3). This requires segmenting (Principle 1) your offer as an employer to recognise the different expectations of generations. Interviewees highlighted three reasons for doing this: (1) Attracting staff – Cornwall Partnership NHS Foundation Trust, for example advertises the ability to reach 'work to wave' in x minutes; United Lincolnshire Hospitals NHS Trust has an 'excellence in rural healthcare' strapline. (2) Retaining staff – encouraging them to move around and undertake continuing professional development. In Worcestershire a Culture Change programme has been in place since October 2017 to build signature behaviours including 'wisdom in the workplace' and a sense of local pride. (3) To lead to churn – if rural areas are to attract staff employers need to recognise that people may come, stay for 2-5 years and then move on. This is seen as beneficial in rural areas complementing where staff come and stay.

Using informal recruitment ('making every contact count') through word of mouth and using existing staff to act as advocates for how the NHS is a modern employer was also seen as important.

Recognising the voluntary and community sector and local communities

Interviewees highlighted the 'social capital' that exists in rural areas and the need for health workforce development to take this into account. Rural communities are well rehearsed in not expecting or receiving the same level of access to public services as their urban counterparts. This has led communities to look for and develop their own solutions to the issues they face (e.g. developing community transport schemes). Many rural communities are underpinned by volunteers and the work of local voluntary and community sector organisations. These groups often form no part of workforce consideration with interviewees querying how their often informal role around health and social care could be acknowledged and/or further developed, since it impacts on the social care sector and the NHS.

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[37] More information about the project is available online: https://timewise.co.uk/article/flexible-working-nursing-fix-staffing-crisis/ last accessed 27 July 2018.

Rewards

HEE has a Targeted Recruitment Scheme[38] for GPs – this offers a one-off payment of £20,000 to GP trainees committed to working a select number of training places in England that have been hard to recruit to for the past three years.

Targeted Enhanced Recruitment Scheme in England[39]
Provides a list of the hard to recruit training place locations. There are 12 of these and they are nearly all rural. A variety of reasons are provided why these areas find it more difficult to attract trainees. Some areas struggle because they are relatively remote from large towns, and as a result are not routinely used for medical school placement so are unfamiliar to doctors in training. The quality of placements in such areas are at least equivalent to all other placements and are often more highly rated by trainees who work there. As these placements are often in smaller communities where a greater number of services need to be delivered locally rather than relying on large teaching hospitals, doctors working in these areas often receive an increased breadth of training and many more opportunities for diversification. Once you get there, you may well find that the lifestyle is much more relaxed than in our big cities.

Building resilience in General Practice – St Austell Healthcare[40]
In August 2014, the largest practice in St Austell handed back their General Medical Services (GMS) contract, placing significant pressure on the three neighbouring practices. Primary care services were redesigned for the 32,000 patients with an emphasis on upskilling a broad multidisciplinary team (MDT), collaborative working with community (NHS and non-NHS) partners, social care, the local acute trust and an Out-of-hours provider. They have improved access by running an acute care hub (open 8am-8pm Monday to Friday). One of 15 national test sites for the Primary Care Home pilots, St Austell Healthcare has changed the way it works through:
- recruitment and upskilling of the clinical and non-clinical team.
- separating urgent and planned care.
- collaborative working with health and social care providers.
- a pioneering social prescribing scheme.
- staff wellbeing reviews.
- high-level financial modelling and advice from a dedicated finance consultant.
- streamlining back office functioning.
- implementation of SystmOne IT Clinical system across all five sites.
- new ophthalmology secondary care service for macular degeneration and glaucoma.

The offer of flexible working and portfolio careers for salaried GPs has helped with the demands of work and family life. St Austell Healthcare has managed to recruit successfully but their model is based on high patient to whole time equivalent (WTE) numbers (approx. 2,900 patients/WTE), they see investing in their MDT as the key to sustainable general practice in St Austell.

Health and wellbeing of staff

Some interviewees recognised stress and anxiety in staff – with some suggesting the issue was less acute in rural areas compared to urban areas. As employers the importance of investing in staff health and wellbeing was seen as important – with examples given around having a full clinical induction package, mentoring and flexible working options. Building a team ethos across multiple sites rather individualistic silo based working was viewed as particularly important in rural areas – benefitting the professional development and personal wellbeing of staff.

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[38] More information about the targeted recruitment scheme in England is available online at: https://gprecruitment.hee.nhs.uk/Recruitment/TERS/England last accessed 27 July 2018.
[39] https://gprecruitment.hee.nhs.uk/Recruitment/TERS/England (page 33): (accessed 14.8.2018)
[40] Taken from NHS case study available at: https://www.england.nhs.uk/gp/case-studies/st-austell-healthcare/

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

> This principle, through alignment of services and workforce planning, seeks to maximize the impact of resources.

This principle is **pertinent in both rural and urban labour markets**. A number of **nuanced features of rural labour market dynamics** discussed in relation to principles 1-5 above are worth referencing however. These are:

- A limited labour pool in rural areas (Principle 1), exacerbated by remote location, high accommodation costs and poor public transport, is a factor that increases the incidence of hard-to-fill and skill-shortage vacancies in rural areas across the economy. This reduces the scope for dynamic workforce planning.
- A limited pool of local young talented workers in rural areas due to out-migration – affecting the range of talent to deploy in terms of the workforce. (Principle 1)
- An older than average population making it more difficult to fill key roles within workforce strategies as people retire or exit the NHS or Social Care.
- Research on internal migration suggests *a decline in internal migration and a rise in secular rootedness* – this is an opportunity and a challenge for rural areas, which need to be attractive for individuals and households to be able to stay in one residential location, while still pursuing their careers. Where this challenge has not been addressed rural labour markets have limited flexibility and dynamism. (Principle 3)
- The NHS and social care workforce relies to varying extents on *international migrants*. (Principle 1). Changing immigration rules (both a tightening of the immigration rules for non-EEA migrants and the immigration regime for EEA workers post-Brexit – see Appendix I) affect rural and urban areas alike, but will impact particularly on those rural areas most reliant on non-UK labour.[41]
- Across the economy as a whole *training is more expensive to deliver in rural than in urban areas* – this reflects lower numbers of potential trainees, which can increase costs of training provision and reduce the scope for maximizing the use of resources. It threatens to drive up wage costs and increase the number of unfilled vacancies in rural areas reducing the scope for maximizing the impact of resources. (Principle 2)
- There is a particular issue of *how to provide broad pathways without losing workers from rural areas.* (Principle 3) However for workers who wish to remain in situ in rural areas, as a large employer the NHS provides a potentially greater range of opportunities in terms of career opportunities than other employers. Nonetheless a lack of scale and diversity in job roles in rural areas does hamper the recruitment and retention and therefore the opportunities to maximize the impact of workforce planning in rural areas.

Four key features pertinent to the alignment of services and workforce planning to maximize the impact of resources emerging from the **findings from the primary research** are highlighted next: first the lack of a spatial component in workforce planning; secondly the expression of bottom up

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[41] Rural and urban areas alike may be particularly reliant on non-UK labour for some job roles (albeit the identity of these roles may vary within and between urban and rural areas). Both rural and urban areas are likely to be adversely affected by a stricter UK immigration regime in terms of a restricted supply of labour and skills in the short-term.

solutions through local pragmatism in the delivery of services; thirdly structural issues which militate against effective alignment in rural settings, and finally institutional arrangements (Principle 5) which make it very difficult to drive innovation and specificity in the alignment of workforce and service approaches.

The lack of a spatial component in workforce planning

The STP documents, which are where we might expect to see this alignment most significantly manifested do not have any significant consideration of rural as a spatial concept. Where they do rehearse issues and approaches informed by a rural context they do not link them to their workforce strategies. Similarly the Draft Workforce Strategy itself makes no reference to rural issues directly.

As a consequence of this lack of spatial analysis, the generic characteristics of rural labour markets, which militate against "joining up" and resource maximization set out above form no part of a "one size fits all" approach to the drive to maximize the impact of the NHS workforce strategy.

The new drive to Integrated Care Systems is a powerful exposition of this principle working in practice but we can see no spatial component in it in its current form.

Joining up services and workforce planning is made still more difficult in rural areas because there is no current rural cut of key performance data, which enables a spatial component to be built into the planning of more effective planning.

Local pragmatism

Notwithstanding a lack of discrete strategic planning taking account of the importance of the spatial characteristics of settings we did find a number of "bottom up" examples of "joining up" in rural settings.

Consultees identified how a thin and widely distributed range of workforce roles (Principle 1) in rural settings this makes integration and flexibility difficult to achieve, but as set out in our response to priority 2 above this can also be a driver of innovation and flexibility where sparsity means traditional models break down.

Whole population and settlement workforce planning strategies in Lancashire and South Cumbria in settings such as Millom and Fleetwood are good examples of what might be achieved when local services and workforce planning are aligned around the notion of "place". Both these examples are relatively small towns which have a rural hinterland.

Adult social care in some rural areas cannot be flexibly applied due to a lack of suppliers arising from market failure – this could be deemed in some ways to extend into the NHS more widely. We did however find a very powerful example of an antidote to the failing social care market in Somerset delivered through the creation of very local micro-enterprises to provide an alternate source of supply. This has generated wider benefits in terms of employment and reduced travel to care miles in the villages in which it has operated[43].

Structural challenges

The biggest single challenge in terms of workforce and services alignment in rural areas is the significantly smaller number of NHS staff per head of population in rural areas.

Looking at NHS Digital Workforce Statistics for March 2018 this indicates an overall difference in the ratio of NHS staff per head of population (excluding regional ambulance services) in the 11 most rural STP areas compared to England as a whole of 45%. By this we mean compared to the national average rural areas have 45% fewer workers per head of population (Principle 1).The table sets out how these differences manifest themselves across key professions (with the most acute examples set out in red) below:

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[42] https://www.theclic.org.uk/about-us

[43] Releasing Somerset's Capacity to Care – Community Catalysts July 2017

Table 1: NHS staff per head of population ratio All England/Rural

Professional group	NHS staff per head
Total	1.45
Professionally qualified clinical staff	1.48
HCHS Doctors	1.57
Consultant (including Directors of Public Health)	1.52
Associate Specialist	1.31
Specialty Doctor	1.42
Staff Grade	1.72
Specialty Registrar	1.87
Core Training	1.53
Foundation Doctor Year 2	1.45
Foundation Doctor Year 1	1.51
Hospital Practitioner / Clinical Assistant	0.87
Other and Local HCHS Doctor Grades	1.18
Nurses & health visitors	1.45
Midwives	1.60
Scientific, therapeutic & technical staff	1.48
Support to clinical staff	1.39
Support to doctors, nurses & midwives	1.41
Support to ST&T staff	1.34
NHS infrastructure support	1.42
Central functions	1.34
Hotel, property & estates	1.52

Source: NHS Digital Workforce Statistics March 2018

There are relatively limited examples of the joining up of strategies to manage the interface between Health and Social Care – we have identified a number of challenges in this context, which are rural in character through our access to local authority experiences in rural settings[44]. These include:

- Dispersed population patterns lead to higher service provision costs in terms travel to care distances and reduce the contact time that can be allocated to clients. This can be exacerbated by seasonal weather fluctuations.
- In many rural areas there are very few providers of social care to choose from due to the relatively high cost of providing services and the small number of clients. (Principle 1)
- Clients with complex support needs in rural areas are harder to support because of the distance between the agencies involved in providing care.
- The overall demography of rural areas means there is a smaller stock of workers to support those needing adult social care. (Principle 1)
- Low wages and high housing costs make it difficult to recruit and retain care workers in rural areas.
- The high level of replacement demand, linked to a higher proportion of care workers retiring compared with new workers entering the profession is a significant challenge in rural areas.
- Poor broadband and mobile connectivity limit the scope to deploy technological innovations to support people in their own homes for longer. They also limit the potential to deliver cost

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[44] Based on a survey of 13 first tier local authorities for the Rural Services APPG June 2018. See Appendix H)

efficiencies in the management of health conditions by both older people and their support workers accessing and providing services remotely.

- Notwithstanding the practical challenges facing rural areas in terms of connectivity there is a strong consensus that technological solutions provide real, but largely unfilled potential to improve outcomes for adult social care clients.

- Carers in remote settings find it more difficult and expensive to network and support each other in rural settings. (Principle 2)

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

- The housing stock in rural areas often fails to match the needs of the vulnerable older population. There is an acknowledgement of the need for but a lack of adequate provision of extra care housing in many rural settings. The lack of a suitable housing stock puts pressure on smaller rural care homes and leads to the danger of a two-tier system in terms of care choices between local authority and self-funded clients.

- The declining number of rural GPs has a knock on effect in terms of support for vulnerable older people in rural settings and where they have a key role in preventive strategies limits their potential impact. (Principle 1)

- Whilst preventive strategies based on multi-agency working and early intervention offer the potential to reduce rising costs they are more difficult to deliver in rural areas. This is because of the wide distribution of clients and the greater distances, which agencies seeking to work collectively have to overcome in pursuit of integrated care approaches.

- There is a strong feeling amongst respondents that the challenge of supporting people is getting worse. Very few respondents have a long-term plan for overcoming the scale of challenge they face under the current system of providing adult social care. There is a widespread acknowledgement that not only does the funding regime for providing adult social care need to change but so do attitudes about what is expected.

- Respite care is more difficult to provide in rural settings due to sparsity in terms of the number of eligible clients within manageable geographical bounds.

- There is a very acute cost linked to providing support for younger and disabled local authority clients, which is equally as severe as the pressures put on local authority finances by adult social care. Taken together adult social care and these costs are rapidly eroding the financial viability of many local authorities.

- We found evidence of funding formulas which militate against integrated approaches because they fail to recognize the additional cost of delivering services in rural settings.

Institutional Issues

A number of consultees identified that the one size fits all, universal entitlement strategy of the NHS sometimes has negative implications for the provision of adequate but different provision in rural areas, where a gold standard cannot sometimes be achieved due to small population scales. (Principle 1).

Plans to Create an Integrated Health Partnership joining up planning in a largely rural setting[45].

Three Sustainability and Transformation Partnerships (STP) in the North of England have formed a collaboration to develop more joined up planning. The collaboration includes Northumberland, Tyne and Wear and North Durham (NTWD), Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby (DDTHRW), and West, North and East Cumbria (WNEC). This collaboration has identified 14 work streams against which they will jointly on :

- Increasing the impact of public health interventions and preventative services.
- Strengthening health and social care services in communities and neighbourhoods.
- Managing demand for high cost treatments.
- How we will deliver acute hospital services in the future.
- Improving the diagnosis and treatment of cancer.
- Coordinating urgent and emergency care.
- Sustaining good mental health.
- Better outcomes for patients with learning disabilities.
- Workforce development and transformation.
- Digital care.
- Pathology services and diagnostics.
- Estates management.
- Communications.
- System development.

We found evidence that the quality of the estate is a burden to integration in some rural areas and other examples of the innovative use of community facilities to overcome the inflexibility of traditional health sites.

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[45] https://www.ntw.nhs.uk/content/uploads/2018/03/Item-10-STP-paper-for-NHS-Boards.pdf (accessed 14.08.2018)

Conclusions

The **main issues** running through this report are:

Challenges *facing rural areas*:

1. Rural areas are characterised by disproportionate out-migration of young adults and in-migration of families and older adults.
2. This means that the population is older than averag*e* in rural areas - this has implications for demand for health and care services and for labour supply
3. Relatively high employment rates and low rates of unemployment and economic inactivity mean that the labour market in rural areas is relatively tight
4. There are fewer NHS staff per head in rural areas than in urban areas.
5. A rural component in workforce planning is lacking.
6. The universalism at the heart of the NHS can have negative implications for provision of adequate, but different, services in rural areas and also means that rural residents can be reluctant to accept that some services cannot be provided locally.
7. The conventional service delivery model is one of a pyramid of services with fully-staffed specialist services in central (generally major urban) locations – which are particularly attractive to workers who wish to specialise and advance their careers.
8. Rural residents need access to general services locally and to specialist services in central locations to provide best health and care outcomes.
9. Examples of innovation and good practice are not routinely mapped and analysed, so hindering sharing and learning across areas.

Opportunities *for securing workforce supply and maximising impact*:

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

Four main conclusions arise from these main issues and the evidence collected in this research study.

First, **there is systemic lack of 'thinking rurally' in workforce planning in health and care**. This is illustrated by a paucity of references to 'rural' issues, circumstances, challenges and opportunities in Sustainability and Transformation Plans and an absence of specific references to the workforce in rural areas. This gap in thinking is also reflected in a smaller proportion of NHS staff per head of population in rural areas than in urban areas. This poses challenges both for staff development and for access to health services in rural areas. It points to rural disadvantage that remains unacknowledged.

Second, despite having common features **rural areas are diverse**. There is variation amongst rural areas on several dimensions: socio-economically, relative remoteness and accessibility, and in terms of attractiveness for living and working amongst different population sub-groups. There is increasing awareness and recognition amongst policy makers and the general public that 'place matters' (across the whole range of geographical scales from the regional to the neighbourhood area level) in terms of healthy life expectancy. The importance of **sensitivity to local circumstances** also needs to be taken into account in workforce planning in rural areas.

Third, **urban bias** is apparent in the application of the universal service and standards approach of the NHS. It is often easier, and more efficient, for organisations to deal with large entities rather than small ones in introducing scientific and technical innovation and in provision of specialist services. A seemingly **default 'one-size-fits'-all tendency in provision of a universal service** tends to further disadvantage rural areas which can face enhanced challenges relative to urban areas in meeting nationally imposed minimum threshold standards associated with health-related and non-health-related aspects of service delivery. These factors can stifle local innovation and pose barriers to entry for new providers and configurations of service delivery in rural areas (an in urban areas), so limiting bespoke responses to rural health and care issues.

Fourth, there are examples of **good practice** and there has been **innovation in rural areas** (e.g. involving a 'whole place' approach, making use of volunteers in some aspects of service delivery, etc.) alongside centralisation. Good practice and development of centres of excellence in specific aspects of health and care delivery need to be promoted in rural areas, and the key change components and contextual factors underlying them need to be identified to aid replication (as appropriate). Our review has identified at the European, national and sub-national level a number of funding streams and programmes that have supported innovation in health and social care. However, there has been no detailed mapping of programmes and funding streams, nor an analysis of the extent they have supported innovation in rural areas including workforce development in terms of the number of projects funded, spend and relevant case studies to share learning. Where there are case studies these may be lost when programme websites are not maintained or archived.

Recommendations

Four key recommendations follow from these conclusions:

- It would be useful to **'rural proof'** plans, documents, guidance so that key issues relating to the health and care workforce are examined through a rural lens. A recommended way of doing this would be to **introduce an additional 'spatial' component in the HEE workforce planning STAR tool**[46] to support workforce transformation, so helping providers understand their workforce requirements and also providing initial ideas for a range of potential solutions. This provides a starting point in taking account of spatial – including rural – factors. At a more detailed level this rural proofing needs to take account of local differences between and within rural and urban areas.

- **Good practice** and development of **centres of excellence** in specific aspects of health and care delivery need to be promoted in rural areas. These can help raise the profile of, and enhance the attractiveness of, the rural areas concerned to the workforce.

- The diversity of rural areas and of different generations and sub-groups of the (potential) workforce needs to be reflected in a **segmented** approach to recruitment and policies to promote retention and workforce development in health and care.

- It would be useful to **map programmes and initiatives** that have funded innovative approaches to workforce development in the past 15 years and identify projects located in rural areas. One output of a mapping exercise might be capturing of relevant case studies in a single repository subject to necessary permissions from copyright holders. The National Centre for Rural Health and Care would be an ideal host organisation for maintaining and advertising such a repository and fostering associated networking activities.

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[46] https://hee.nhs.uk/our-work/hee-star. The five 'enablers' identified are Supply, Up-skilling, New roles, New ways of working, and Leadership.

Next Steps

A number of follow on actions from these recommendations fit particularly well with the agenda for the new National Centre for Rural Health and Care as follows:

(1) The National Centre for Rural Health and Care (NCRHC) would like Health Education England to consider the findings of the research, and the development of an additional spatial dimension for the Star tool. References within the tool to the way the rural-urban classification distinguishes between types of rural place to encourage a 'nuanced' approach to workforce planning in rural areas.

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

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

Appendix A: Literature Review

Overview

- Many of the studies commissioned by government bodies and undertaken by think tanks related to workforce issues have tended to focus on social care and do not specifically mention rural areas.

- A recent opinion piece in the BMJ summarised the issues the issues relating to provision of health care in rural areas.

- An international comparison study of eight affluent countries noted that only Italy had a national strategy for rural health, though sparsely populated countries like Canada and Australia have regional policies.

- A recent NAO report summarised the issues facing the provision of adult social care and calls for the development of more effective workforce planning. This report provides useful recent background statistics.

- There has been increasing age segregation between rural and inner urban areas.

- Travel distance affects the development and delivery of alternative entry level routes in care work, as well as the length of the working day for existing care workers in rural areas.

- Working and engaging with patient groups can be more difficult for rural trusts, which can lack the resources to do so. This can lead to poorer relationships between NHS managers and patient groups.

- The requirement for registered care managers may be difficult to fulfil for providers because the level of legal accountability is very high compared to pay they receive.

- Employers need to be more creative in the recruitment and retention of their staff.

- There is literature on the difficulty of recruiting and retaining GPs focusing on rural and remote practices.

- The Local Government Association, while noting that health outcomes have been better for rural residents in the past, identify that there are now factors that will potentially make this less so in the future.

- Community and district nurses in rural areas have greater travel demands – but still have the same workload – than those based in urban areas.

- Our searches found reports on the use of telecare and lessons might be learnt from its use in more sparsely populated regions in North America and Australia.

- The use of shared electronic records could support more mobile working within rural areas.

- There is little evidence on which incentives work best for retaining health staff in rural areas, though a tentative framework of incentives has been developed based on the literature.

- Stage of education of children of male GPs in Australia has been identified as a factor for whether they likely to work in rural and remote areas.

- There is limited research on the effectiveness of distance learning to support CPD for allied health professional in remote rural areas.

- Rural placements during medical training totaling more than a year increase the likelihood of graduates working in rural location three to five years after graduation in one Australian teaching programme.

- The European Regional Development Fund has supported projects to tackle issues related to recruitment and retention of healthcare staff in remote areas, which subject to information being still being available may merit further investigation.

Age segregation in England and Wales			
Author	Kingman (2016)	**Reference to Rural**	✓
Key Findings and Conclusions			
Found that rural areas have aged nearly twice as rapidly as urban ones over the past 25 years, as cities have become magnets for young people. He found that during the 24 years between 1991 and 2014, the median age of rural areas rose almost twice as rapidly as the median age of urban ones. Places with the highest median ages are predominantly in rural parts of the country, particularly around coastal areas. He argued that it was necessary to encourage older people to stay in their urban communities by creating suitable homes for them to downsize into.			
Kingman, D (2016). Generations apart? The growth of age segregation in England and Wales. Intergenerational Foundation (IF), Available: http://www.if.org.uk/wp-content/uploads/2016/09/Generations-Apart_Report_Final_Web-Version-1.pdf			

Travel is a barrier to providing apprenticeships			
Author	Fox et al (2017)	**Reference to Rural**	✓
Key Findings and Conclusions			

Research for Health Education England (West Midlands) who wanted to develop the concept of Integrated Apprenticeships. They commissioned Skills for Care and Skills for Health to carry out a scoping exercise to assess the level of activity in integrated Apprenticeships across the health and social care sectors between March and May 2017. In their report they mention Staffordshire County Council which undertook a project in 2015/16 to scope the market to determine the appetite for an integrated health and social care Apprenticeship pathway. They developed the pathway in partnership with health partners to ensure it was fit for purpose. The Local Authority highlighted the key benefits from the project as:

- New links with health partners
- Development of a clear suggested pathway for a fully Integrated Apprenticeship (as a joint pathway does not exist, this is only a draft pathway)
- Inspired by the new challenge, most partners did agree it would be a good pathway
- A new strategy for recruitment into the sector in Staffordshire.
- Supports sustainable recruitment

Challenges faced included:

- Partnership working – getting everyone around the table
- Every partner who engaged shared similar concerns around who would be the actual employer of these apprentices and who they would report to
- Partnership trusts would only offer placements if it was financially viable for their business plan
- The travel logistics for the candidates, as parts of Staffordshire are very rural, means the learning provider would have to be very flexible in their learning approach

Fox, Margaret et al (2017). Scoping integrated apprenticeships in health and social care. Skills for Health. Available at:
http://learning.wm.hee.nhs.uk/sites/default/files/ICT_Integrated%20Apprenticeships%20Final%20Report%2012%20June%202017.pdf

Rural hospitals

Author	Oliver 2017	Reference to Rural	✓

Key Findings and Conclusions

A recent opinion piece in BMJ makes the following points about providing care in rural areas:

- The UK is densely populated compared to Canada or Australia. Even Scotland, with only 62 people per square kilometer, pales in sparseness next to, whose densities are 3.2 and 2.6, respectively.
- Rural areas face distinct challenges, and the problems facing urban health systems are exacerbated in the countryside: less car ownership, worse public transport, longer travel times to GP surgeries.
- General Practices are smaller in rural areas and have more difficulty attracting GPs.
- Attending hospital often involves a long round trip from patients' homes. Distance makes access to moderate level urgent and ambulatory care crucial, as is rehabilitation or end of life care at or close to home, as well as family and social networks.
- Community hospitals, where they exist, can be used as a hub. GPs, paramedics, allied professionals, and nurse practitioners with enhanced skills and roles are invaluable.
- Rural areas are not homogeneous. Alongside bucolic idylls, much rural deprivation exists: social isolation, single occupier households, and unfit housing stock are more prevalent.
- Rural and coastal communities have a high proportion of older residents, compounded by "urban drift" in younger people.
- Much rural deprivation exists: social isolation, single occupier households, and unfit housing stock are more prevalent
- It is harder to attract a workforce to low paid caring jobs.
- Community practitioners and teams spend longer travelling to and between patients' homes. Funding formulas don't reflect these additional costs, further disadvantaging rural areas.
- And reconfiguration of health services based on urban models risks leaving whole regions without a hospital. Some specialised services clearly benefit from centralisation, but a smaller rural hospital should be able to do a great deal, including level 2 urgent care.
- In sparsely populated countries such as Australia, hospitals much smaller than the UK's can provide a wide range of services.
- The lower patient volume and smaller peer group can make posts less attractive to subspecialists who want to maintain specialty interest and skills.
- Parallel rotas for acute, internal, and geriatric medicine, for example, may be unviable.
- There is a pressing need for confident expert generalists happy to deal with most of what comes their way and for peripatetic hospital clinicians providing clinical support beyond the hospital's walls. It's especially hard to attract consultants to these roles, so substantive posts and rotas go unfilled.
- Doctors tend to settle in the region where they complete specialist training, often with a family base in the town.
- Medical school places are disproportionately concentrated in big cities, limiting trainees' exposure to rural medicine.
- Doctor-patient ratios and applications for training posts are higher in the metropolis.
- If we want to ensure fair access to care in rural populations, tailored to their unique circumstances, we need plans to tackle these issues. And we have to start by recognising that their needs are the same but different

Oliver, D (2017): Challenges for rural hospitals—the same but different. BMJ 2017;357:j1731

Labour pool and recruitment

Author	Figgett (2017)	**Reference to Rural**	✓

Key Findings and Conclusions

Operating in an urban area often has advantages for employers as there's typically a wider pool of potential employees to recruit from, compared with those operating in rural areas, and staff are able to use public transport links to travel more easily between locations if they cannot drive. However, employers may also face increased competition from other sectors or may find that people are being priced out of the housing market, particularly in more central areas; factors which are beyond their control.

Employers suggested that this can be mitigated to some extent by being creative with advertising. Recommendations included casting the net wide, encouraging people with the right values and behaviours that they can 'mould' (not necessarily experienced care workers) and making use of social media. Adverts should include the advantages of working

in adult social care and for the particular employer.

Operating in a rural area can also pose challenges for employers in relation to the number of people available to recruit and also in relation to logistical issues such as availability of public transport and travel times between visits. Employers suggested that offering good mileage rates can be beneficial for some staff, as can ensuring that staff are paid for the time they are travelling.

Figgett D (2017). Recruitment and retention in adult social care: secrets of success
Skills for Care https://www.skillsforcare.org.uk/Documents/Recruitment-and-retention/Secrets-of-success/Recruitment-and-retention-secrets-of-success-report.pdf

Local Government Association Report on Health and Wellbeing in Rural Areas (2017)			
Author		**Reference to Rural**	✓
Key Findings and Conclusions			

The Local Government Association published a report which compared social and economic factors' impact on people's health. The key messages from the report was whilst rural areas may historically enjoyed certain advantages in terms of health outcomes these are being eroded by changes in demographics. 15 per cent of households in rural areas live in relative poverty after housing costs are taken into account, as compared with 22 per cent in urban areas. House prices tend to be higher in rural areas and more households experience deeper fuel poverty. In 2015 77 per cent of working age people in rural areas were in employment, as compared with 73 per cent in urban areas: household incomes in rural areas can be lower due to part-time or seasonal working. Rural populations have poorer access to transport with rural residents travel longer distances than their urban counterparts and spend longer travelling.

The health of people in rural areas is on average better than that of urban areas with higher life expectancy and infant mortality and a lower number of potential years of life lost (PYLL) from cancers, coronary health disease and stroke. However, as the rural population is older, the prevalence of these conditions is higher. Those living in town and fringe settlement types have higher mortality rates than those living in village and dispersed areas. Overall, around one sixth of areas with the worst health and deprivation indicators are located in rural or significantly rural areas.

The LGA contends that, indicators currently in use to assess poverty and deprivation may not reflect cost of living and other wellbeing issues in rural areas. A place-based approach in which all local partners work together is important in addressing the multi-factorial determinants of the health of rural populations. For example, as the largest employers in many rural areas, councils and the local NHS can model healthy employment practices and work with the many small enterprises located in rural communities.

Many of the factors contributing to health risks in rural communities relate to the wider social determinants of health as well as to access to health and care services.

- **Changing population patterns:** Changing population patterns, including outward migration of young people and inward migration of older people, are leading to a rural population that is increasingly older than the urban population, with accompanying health and care needs.

- **Infrastructure:** Sparsity and the increasing scarcity of public transport links have a significant impact both on daily living costs of rural households and on access to services.

- **Digital access and exclusion:** A combination of the older demographic and the unavailability of high speed broadband and mobile phone networks are leading to an increasing digital gap between urban and rural areas. This is made more serious by the growing number of important services, such as job search opportunities, banking and increasingly, health-related services, that are available online.

- **Air quality:** Pollution from traffic is increasing in rural areas where levels of ozone are generally higher and where there are a significant number of Air Quality Management Areas (AQMAs). Air quality remains a serious health risk.

- **Access to health and related services:** Rural areas have worse access in terms of distance to health, public health and care services. Longer distances to GPs, dentists, hospitals and other health facilities mean that rural residents can experience 'distance decay' where service use decreases with increasing distance. Different models of service delivery may be needed for rural areas, including new models of workforce development. These also include the development of rural hubs providing a range of services, and more services provided on and through the internet.

- **Community support, isolation and social exclusion:** Rural social networks are breaking down with a consequent increase in social isolation and loneliness, especially among older people. The fact that social isolation influences health outcomes in its own right suggests that this and the emotional and mental wellbeing of people in rural areas is an important and hitherto neglected area in the promotion of public health.

- **Housing and fuel poverty:** Affordability, poor quality housing and significant fuel poverty in the most rural areas are threatening the wellbeing and sustainability of communities. House prices are 26 prices

higher in rural areas and there is much less housing association and council housing. There is a much higher proportion of 'non-decent' homes and of houses which are energy inefficient and many areas are not on the gas grid which leads to higher prices.

- **Employment and under-employment:** Unemployment and under-employment are taking younger people away from their families and work is low paid and intermittent.

Local Government Association (2017). Health and wellbeing in rural areas
https://www.local.gov.uk/sites/default/files/documents/1.39_Health%20in%20rural%20areas_WEB.pdf

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Community and district nursing

Author	Ball et al 2013	Reference to Rural	✓

Key Findings and Conclusions

Ball et al's 2013 survey of community and district nurses for the Royal College of Nursing, of which 40 per cent were based in rural areas found:

- Services in urban environments are more likely to be available 24 hours a day (72% reporting 24 hour services available compared to 62% of respondents working in primarily rural settings).
- The average distance to furthest point to travel was 17 miles for nurses working in rural areas compared to 10 miles in urban areas. Advanced and specialist nurses cover larger areas – a mean of 17 miles to the furthest point as opposed to a mean of 10 miles across the other job categories.
- There were no differences in typical caseloads between nurses working in rural or urban environments, those in areas with large or small populations, or between different employer groups. There is however differences in the number of patients seen per day according to job title/role.

Ball J, Philippou J, Pike G, Sethi J. (2014) Survey of district and community nurses in 2013: Report to the Royal College of Nursing. Kings College London. https://www.kcl.ac.uk/nursing/research/nnru/publications/Reports/DN-community-RCN-survey-report---UPDATED-27-05-14.pdf

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Striking a balance between in-person care and the use of eHealth in older rural population

Author	Roberts et al (2015)	Reference to Rural	✓

Key Findings and Conclusions

Roberts et al (2015) report variability in how ready the current generation of older people in remote and rural locations are to deal with opportunities for digital care to enhance face-to-face interaction in terms of acceptability, a physical ability to use technology, and having access to the IT infrastructure necessary to use digital care options. Readiness, at present, should be assessed at an individual level and will inevitably change as the older population become even more technologically able and connectivity issues improve. Overall, the findings show that the potential recipients of eHealth are open to the use of such technologies, that eHealth may provide opportunities to sustain and enhance these interactions but that in-person care is likely to remain an important element of caring for older people with chronic pain in the future.

Roberts A, Philip L, Currie M, Mort A. (2015). Striking a balance between in-person care and the use of eHealth to support the older rural population with chronic pain. International Journal of Qualitative Studies in Health and Wellbeing, Vol 10. (2015)

State of Rural Services Report (2017)

Author	Rural England (2017)	Reference to Rural	✓

Key Findings and Conclusions

This report published in 2017 provides contextual information in terms of the following services in rural areas:

- Local buses and community transport
- Welfare services
- Access to cash
- Further education
- The retail sector
- Mental health services
- Older people services
- Public health services
- Community assets

Rural England (2017)State of Rural Services 2016. Available:
https://www.rsnonline.org.uk/images/files/SORS2016-FinalFullReport-Jan17.pdf

Service user involvement			
Author	Rose et al (2014.	**Reference to Rural**	✓
Key Findings and Conclusions			
The ENSUE study included a rural area and two metropolitan areas. The study looked at how managers and leaders in the National Health Service and social care respond to service user involvement in mental health services. It is difficult to extrapolate from this study but it appeared that the rural NHS trust because it lacked resources was less able to field representatives leading to poorer relationship with the local Patient Advice and Liaison Service.			
Rose, D et al (2014). How do managers and leaders in the National Health Service and social care respond to service user involvement in mental health services in both its traditional and emergent forms? The ENSUE study, Health Services and Delivery Research, Vol 2 No 10 Apr 2014 https://www.ncbi.nlm.nih.gov/books/NBK259692/pdf/Bookshelf_NBK259692.pdf			

International comparisons on rural health care policies			
Author	Rechel et al (2016)	**Reference to Rural**	✓
Key Findings and Conclusions			
Rechel et al (2016) reviewed policies in eight high-income countries (Australia, Canada, United States, Italy, Spain, United Kingdom, Croatia and Estonia) in Europe, Australasia and North America with regard to hospitals in rural or remote areas. They explored whether any specific policies on hospitals in rural or remote areas are in place, and, if not, how countries made sure that the population in remote or rural areas has access to acute inpatient services. They found that only one of the eight countries (Italy) had drawn up a national policy on hospitals in rural or remote areas. In the United States, although there is no singular comprehensive national plan or vision, federal levers have been used to promote access in rural or remote areas and provide context for state and local policy decisions. In Australia and Canada, intermittent policies have been developed at the sub-national level of states and provinces respectively. In those countries where access to hospital services in rural or remote areas is a concern, common challenges can be identified, including the financial sustainability of services, the importance of medical education and telemedicine and the provision of quick transport to more specialized services.			
Rechela B, Dzakulab Al, Antonio Duranc A et al. (2016) Hospitals in rural or remote areas: An exploratory review of policies in 8 high-income countries. Health Policy, Vol. 120, No 7. pp. 758-769			

General practitioner recruitment and retention			
Author	Peckham et al 2016	Reference to Rural	✓
Key Findings and Conclusions			
Peckham et al 2016 reviewed the available evidence, noting much of the evidence related to rural areas:			

Peckham et al 2016 reviewed the available evidence, noting much of the evidence related to rural areas:

> *Overall, the published evidence in relation to GP recruitment and retention is limited and most focused on attracting GPs to underserved rural areas. However, this literature does suggest that there are some potential factors that may support the development of specific strategies for the recruitment and retention of GPs. There are also clear overlaps between strategies for supporting increased recruitment and retention.*

They concluded that studies that examine specific recruitment strategies for the GP workforce were scarce, but still provided useful insights in into the factors that affect attractiveness of general practice.

- **Promoting general practice:** There is a lack of evidence that supports positive marketing of general practice and GP, but there is some evidence that positive role models (for example highlighting GPs in leadership roles could provide positive role models), a stronger emphasis on general practice in medical school, and enhancing the status of general practice among the general population as compared with other specialisations were predictors of career choice

- **Career determinants are mainly intrinsic and idiosyncratic to the individual and factors related to the home and work environment**. Intrinsic factors include self-awareness of skills and attributes. For example, they suggest that medical graduates primarily look for a career that is stimulating and interesting. Since there is a negative view of the general practice field, as it is not perceived as intellectually stimulating, it is possible that medical graduates may reject general practice as a result. Gender is also important. Traditionally, women may have exercised different choices from men when choosing their medical career but now, it appears that both men and women value a more balanced lifestyle.

- Cites Petchey et al (1997) who identified **three key themes that influenced career choice: clinical content of practice, lifestyle and the organisational context of practice.** They found that the interviewees had a strong preference for 'traditional' or 'biomedical' forms of medical practice. Most of them identified general practice as intellectually less challenging and less intrinsically satisfying. A

minority of interviewees, however, referred to general practice as the 'real' medicine but acknowledged that their views were different from those of the average junior doctor. The second determinant is lifestyle and the authors refer to it as an extrinsic factor. In fact, in this study general practice was envied for its lifestyle when compare to hospital medicine. More precisely, while some saw general practice as a 'nice career life' they perceived that this lifestyle was achieved at a cost of clinical content and self-fulfilment. Lastly, the third determinant is the organisational context, seen by the authors as intermediate between intrinsic and extrinsic satisfaction factors. Team, team support and teamwork as opposed to isolation and professional autonomy were presented as important factors when considering the organisational context.

- The study by Hemphill and Kulik (2011) suggest **two strategies for future recruitment to rural and urban practices.** Indeed, the authors emphasized the importance of recognising the different preference attributes in general practice and suggested that recruitment activities and publicities should be aligned with the type of GP a practice wants. They identified two options. The first option is to aim recruitment at one specific group of criteria (either family- focused, job-focused or practice-focused) and to direct all recruitment strategies towards this goal. The second option would be "to diversify their recruitment strategies to target all three cohorts" (p.122). To do so, would mean developing various recruitment strategies such as multiple advertisements highlighting specific elements of the family, job and practice- focused GPs alongside more general cross category recruitment campaigns.

- Landry et al (2001) examined the **effect of exposure to the same location** as the student's place of origin in New Brunswick, a rural province of Canada. They analysed the effects of length, timing and frequency of exposure to a student's region of origin during medical training on the likelihood that the junior doctor or the newly graduate doctor will return and practise medicine in that region. They differentiated between exposures during undergraduate and graduate training and identified two main results regarding exposure during undergraduate training. The first is that an additional month of clinical rotation increases the odds of practicing in the province by 30%. The second is that cumulative exposure to the region during undergraduate training is an important determinant influencing whether or not the graduate will return to the area to work as a family doctor. As for graduate training, they were more likely to practice in the Province if they had undertaken a residency programme in the region. In fact, family and speciality doctors who undertake residency in the province were respectively five and four times more likely to subsequently work in the Province.

- **The development of training hubs** - where groups of GP practices could offer inter-professional training in primary care – are aimed at extending the skills base and developing a workforce able to meet challenges of new way of working. While we did not find specific evidence of the effect of training hubs on the recruitment of GPs, it is possible that the evidence on rural training is relevant here. Training hubs have been found to have a positive effect on attraction of practitioners to rural areas. Barnett et al (2012) noted that in Australia, the General Practice Training program involves "multiple small training sites across a wide geographical area"(p.88). Factors that support recruitment are a familiarity with community health resources, a sociocultural awareness in patient care, community participation and assimilation, and the capacity to intervene in the communities' health problems. However, they found that junior doctors felt isolated from their peers, friends and family and developed a virtual community to reduce the effects of isolation.

- Lee and Nichols (2014) suggest that the **decentralisation of medical schools to rural areas and curricula with a rural focus would provide exposure to a rural learning experience and could be most successful to attract doctors to practice in rural areas.** They also suggest that students with a rural background and a year practising primary care as a freshman for example, are more likely to choose to practice in a rural area. In other words, medical school staff should develop strategies to increase rural applicants who wish to practice family medicine, general practice or any primary care specialties. While Lee and Nichols paper is about attraction and retention in rural practice, some of the ideas presented are also relevant to general practice. Early linking of students to general practice may increase students' propensity to choose general practice training but also their propensity to return to the geographic location that they trained in. Recruiting students from these specific under- doctored areas may also influence them to return back to the community especially if local training was also available. From this perspective, it is clear that training hubs and breadth of training are closely related.

- **In non-UK settings there is evidence that choice of career in primary care is positively linked to loan forgiveness, funding in primary care research, increased and guaranteed funding for fellowship training in primary care, and direct training funds to schools with track records of producing graduates in primary care (**Schwartz et al 2005). Shadbolt and Bunker (2009) suggest that remuneration seems less important for younger doctors than for more senior doctors but while the level of remuneration is less important, school debt remains a major concern for many junior doctors (Lee & Nichols 2014). Campos-Outcalt et al (1995) showed evidence that **higher levels of national**

- **health research funding reduces the proportion of students choosing to become family physicians and generalist physicians.**
- **Targeted support could also be given to support GP teaching.** Harding et al (2015) highlighted that the financial support for undergraduate general practice teaching seems low, given its importance. They identified a significant disparity between teaching delivery and payment received, while these measures are inadequate to provide enough education (in term of quantity) or to improve its quality. Funding is important since the quality of the teaching and the reputation of the school are two important elements and determinants of specialisation choice. Furthermore, insufficient financial support can have a negative effect on GPs motivation to teach and result in a reduction of time committed to teach. Finally, the authors strongly suggested that the payment mechanisms be simplified in line, for example, with payments made to hospitals.
- Humphreys et al's (2001) **review of the rural medical workforce identified three main factors pertinent to retention and turnover: professional issues, social factors, and external contextual factors.** Professional issues are related to the work content, vocational satisfaction, support and remuneration. The social factors are related to personal characteristics and family circumstances. Lastly, the external factors are related to the community and its geographical location. While these factors might be important for rural practices, they may also influence GPs retention of all contexts.
- Buciuniene et al (2005) looked at healthcare reform in Lithuania and job satisfaction of primary healthcare physicians. The authors found that **autonomy at work, social status and workload were the main determinants of job dissatisfaction among primary healthcare physicians.** Job satisfaction is also related to Humphreys et al's identification of the factors that lead doctors to remain in rural practice although professional satisfaction (variety of work, autonomy of practice, and a feeling of doing an important job) were identified as the main reasons.

Peckham S, Marchand C, Peckham A. (2016). General practitioner recruitment and retention: an evidence synthesis. PRU, University of Kent.
https://kar.kent.ac.uk/58788/1/PRUComm%20General%20practitioner%20recruitment%20and%20retention%20review%20Final%20Report.pdf

Authors cited by Peckham:

Barnett, S., Jones, S.C., Bennett, S., Iverson, D. and Bonney, A. (2012) General practice training and virtual communities of practice - a review of the literature, BMC Family Practice,13, pp. 87.

Buciuniene, I., Blazeviciene, A.and Bliudziute, E. (2005) Health care reform and job satisfaction of primary health care physicians in Lithuania, BMC Family Practice, 6(1), pp. 10

Campos-Outcalt, D., Senf, J., Walkins, A.J. and Bastacky, S. (1995) The effects of medical school curricula, faculty role models, and biomedical research support on choice of generalist physician careers: a review and quality assessment of the literature, *Academic Medicine*, 70(7), pp. 611-619.

Harding, A., Rosenthal, J., Al-Seaidy, M., Gray, D.P., McKinley, R. (2015). Provision of medical student teaching in UK general practices: a cross-sectional questionnaire study, British Journal of General Practice, 65(635), pp. e409-e417.

Hemphill, E. and Kulik, C.T. (2009) Defining a process for segmenting the general practitioner market for rural practice recruitment, *Social Marketing Quarterly,* 15(2), pp. 74-91.

Humphreys, J., Jones, J., Jones, M., Hugo, G., Bamford, E. and Taylor, D. (2001) A critical review of rural medical workforce retention in Australia, *Australian Health Review,* 24(4), pp. 91-102.

Landry, M., Schofield, A., Bordage, R., & Bélanger, M. (2011). Improving the recruitment and retention of doctors by training medical students locally. Medical education 45(11): 1121-1129.

Lee, D. M. & T. Nichols (2014). Physician recruitment and retention in rural and underserved areas. International Journal of Health Care Quality Assurance 27(7): 642-652.

Petchey, R., Williams, J., & Baker, M. (1997). Ending up a GP: A qualitative study of junior doctors' perceptions of general practice as a career. Family Practice 14(3): 194-198.

Schwartz, M. D., Basco, W. T., Grey, M. R., Elmore, J. G., & Rubenstein, A. (2005). Rekindling student interest in generalist careers. Annals of Internal Medicine 142(8): 715-724.

Shadbolt, N. & J. Bunker (2009). Choosing general practice: A review of career choice determinants. Australian Family Physician 38(1-2): 53-55.

Modelling family effects on whether GPs work in rural and remote areas			
Author	McGrail et al (2017)	Reference to Rural	✓
Key Findings and Conclusions			

McGrail et al (2017) undertook an analysis of 4,377 GPs who completed at least two consecutive annual surveys of the Medicine in Australia Balancing Employment and Life (MABEL) longitudinal study between 2008 and 2017. The main outcome variable was GP work location and was categorized by population size and remoteness. Each

GP was binary coded for the following categories: no children, only preschool children (0-4), at least one primary school child (2-11), at least one secondary school child (12-18) and all children older than school age (>19). Partner was classified as being in/looking for work or not in work.

Male GPs with children in secondary schools were significantly less likely to work rurally than those with primary school children. Location of female GPs was not affected by educational stage of their children. Whether or not male GP worked in rural location was not affected by employment status of their partner, whereas female GPs were significantly less likely to work in rural and remote areas if they had a partner in the workforce.

The authors conclude their research supports the need to develop opportunities for strong secondary school and partner employment opportunities. This study is based on Australian GPs and similar research in the UK may produce similar findings.

McGrail MR et al (2017). Family effects on the rurality of GP's work location: a longitudinal panel study. Human Resources for Health, 15:75

Transforming social care through the use of information and technology

Author	LGA 2016	Reference to Rural	✓

Key Findings and Conclusions

This report was commissioned by the LGA and published in 2016 and looks at five areas of innovation and two enablers of innovations. These being:

- integrating services and information for children, families and adults
- enabling people to interact with care services through digital channels
- promoting independence and wellbeing through the use of digital services and technology
- integrating commissioning through the improved use of information and analysis
- enabling care professionals to work from any base at any time

The enablers were strategy and leadership engagement and collaborations and recommendations.

There were two specific references to rural areas which were:

- There are ongoing pressures in rural areas where mobile reception and internet access may be limited. The LGA has been calling for the Government to re-affirm its commitment to a national minimum broadband speed (the Universal Service Obligation) and improved phone coverage in rural areas.
- Access to faster and more reliable broadband is a key way of enabling residents who are housebound, to live independently and helps to reduce social isolation, particularly in rural areas.

Anon. (2016). Transforming social care through the use of information and technology. Local Government Association (LGA). Available: https://ipc.brookes.ac.uk/publications/Transforming%20social%20care%20through%20the%20use%20of%20information%20and%20technology%20November%202016.pdf

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TSA report 'A digital future for technology enabled care'

Author		Reference to Rural	✓

Key Findings and Conclusions

The regional variation in digital connectivity, such as that between urban and rural areas, poses significant challenges, where data download speeds can vary enormously

Telecare Services Association (TSA) (2017) A digital future for technology enabled care? Available at: https://www.tsa-voice.org.uk/sites/default/files/TSA301664%20Whitepaper_Oct17%20120917_ONLINE%20VERSION%20ONLY.pdf

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Delivering sustainability and transformation plans

Author	Ham et al (2017)	Reference to Rural	✓

Key Findings and Conclusions

Ham et al (2017) undertook an analysis of sustainability and transformation plans. While their report names partnerships that can be considered to rural it does not provide a separate analysis of the issues facing rural STPs and how they are addressing. There was one specific reference to rural areas sharing patient records electronically across organisation: *Some STPs emphasise the **ability of shared records to facilitate greater mobile working**. This is particularly the case in STPs that cover rural areas – for example, Bath and North East Somerset, Swindon and Wiltshire*. Generic key messages from their report were:

- The NHS five year forward view set a direction for the future of the NHS that has been widely supported.
- Sustainability and transformation plans (STPs) – the local plans for delivering the Forward View based on 44 geographical 'footprints' in England – offer the best hope for the NHS and its partners to sustain and transform the delivery of health and care.
- The context in which STPs have emerged is much more challenging than when the Forward View was published, with the NHS now facing huge financial and operational pressures.
- The changes outlined in STPs could help address these pressures, but there is a risk that work to sustain services will crowd out efforts to transform care.
- Proposals set out in the 44 STPs submitted in October 2016 need to be developed into coherent plans, with clarity about the most important priorities in each footprint.
- A high priority is to use existing services in the community more effectively to moderate demand for hospital care, which is a major cause of current NHS pressures.
- New care models being developed by the vanguards and in related initiatives demonstrate how services are being transformed, and need to be supported and spread to other areas.
- Proposals to reconfigure hospitals could improve the quality and safety of care, and need to be considered on their merits to ensure that a convincing case for change has been made.
- Proposals to reduce capacity in hospitals will only be credible if there are robust plans to provide alternatives in the community before the number of beds is cut.

Cuts in social care and public health and a lack of earmarked funds to support transformation will affect the ability of NHS organisations and their partners to implement their plans.

Ham C. et al (2017). Delivering sustainability and transformation plans. From ambitious proposals to credible plans. Kings Fund. Available at:
https://www.kingsfund.org.uk/sites/default/files/field/field_publication_file/STPs_proposals_to_plans_Kings_Fund_Feb_2017_0.pdf

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Incentives for retaining health workers in rural areas

Author	Buykx et al (2010)	Reference to Rural	✓

Key Findings and Conclusions

Buykx et al (2010) undertook a systematic review of the international literature on retention incentives for rural health workers over the period 2000-2009 that was considered relevant to Australian context. 142 unique references were identified, of which 14 meet the inclusion criteria. The review found:

- Little evidence on the effectiveness of any specific retention strategy. The most commonly used strategies were financial incentives despite some evidence suggesting these may not be the main consideration or the only factor. Financial incentives might assist with recruitment and short term retention. There is evidence to suggest that non-financial incentives and housing have greater potential influence decisions around length of stay. Overall the evidence on financial incentives is inconclusive.
- Strategies involving some form of health worker obligation such as visa conditions might be effective for the duration of the agreement.
- Bundling of strategies is necessary given the causes of retention include multiple personal and work related factors.
- HR monitoring of retention insufficiently captures relevant information and more research is therefore needed.

Buyke and colleagues propose a six part retention framework based on their analysis.

Maintaining an adequate and stable staff	- Appropriate recruitment – selecting the right person - Adequate relief / avoiding staff burnout
Providing appropriate and adequate infrastructure	- Good access to ICT and technical support - Access to transport - Adequate housing
Maintaining realistic and competitive remuneration	- Packaging benefits - Retention bonuses
Fostering an effective and sustainable workplace organisation	- Good communication - Leadership management role - Employee induction and orientation - Leadership - Management and supervision
Shaping the professional environment that recognizes and rewards individuals	- Mentorship programme - CPD and conference opportunities

	- Engaging in research and scholarship for academic pursuits - Opportunities for promotion and career pathway
making significant contributions to patient care	
Ensuring social, family and community support	- Childcare and family support

Adapted from Table 2 (p.106)

Buykx P et al (2010) Systematic review of effective retention incentives for health workers in rural and remote areas. Aust. J. Rural Health, 18, 102-109

Effectiveness of distance learning strategies for CPD of allied health professionals			
Author	Brendt et al (2017	**Reference to Rural**	✓
Key Findings and Conclusions			

Brendt et al (2017) undertook a systematic review that attempted to answer what distant learning strategies are currently being used to provide CPD for rural AHP and how effective are these strategies for improving rural AHP outcomes. Outcomes of interest were change in practitioner knowledge, confidence and satisfaction with CPD distant learning model. 3964 unique references were identified of which 14 meet the inclusion criteria published over the period 1997 to 2016. Early studies tended to focus on the technology being used rather than educational outcomes. Only 3 of 14 studies reported on changes in practice. Those studies that compared delivery with face-to-face interaction found similar level of learner satisfaction and outcomes. None of the studies assessed the impact on workforce retention.

Berndt A et al (2017). Effectiveness of distance learning strategies for continuing professional development (CPD) for allied health practitioners: a systematic review. BMC Medical Education, 17:117

The effect of rural placements during medical training on location of graduates three to five years after graduation			
Author	May et al 2018	Reference to Rural	✓
Key Findings and Conclusions			

May et al 2018 investigated the influence of extended rural clinical school placements and rural origin on the rural principal place of practice of three graduate cohorts (2012-2014) completing a joint medical programme delivered by two universities in northern New South Wales.

426 graduates were included in their analysis. Multivariate analysis was used to control for covariates. Their analysis suggests that graduates who had a rural placement lasting a year or more were significantly more likely to be working in rural locality in their first 3 to 5 years after graduation and this effect was much greater than graduates who resided in rural locations prior to their studies returning to work in rural area. Bonding students to work for a specific period of time as a condition of their studies had no effect on whether graduates worked in rural areas. There is some indication that older students may be more likely to work in rural areas.

Characteristic	Odds Ratio (95% CI)	p
Originated from rural area (v non-rural area)	3.613 (1.752-7.450)	0.001
Rural clinical school placement at least one year (v. less than a year)	6.07 (2.716-13.591)	<0.001
Bonded (v unbounded)	0.589 (0.272 – 1.275)	0.179
Female (v male)	1.794 (0.851 – 3.783)	0.125
Aged 25+ at graduation (v ≤ 24y)	2.550 (1.252 – 5.194)	0.010

May J et al (2018). In Place Training: Optimizing Rural Health Workforce Outcomes through Rural Based Education in Australia. Education Sciences, 8, 20.

Recruit and Retain Solutions Project			
Author	NPP	Reference to Rural	✓

Key Findings and Conclusions

The European Regional Development Fund supported the Northern Periphery Programme (NPP) Recruit and Retain Project that supported the identification and development of good practices in recruiting and retaining public sector staff in remote areas of Northern Europe. Eight countries took part in the project which included Canada, Greenland, Iceland Ireland, Northern Ireland, Norway, Scotland and Sweden. In 2014 the project produced a series of factsheets on products and services developed by its partners grouped under advertising and marketing, administration and organization, professional support including service delivery, infrastructure, education and training, career development and support, domestic and social support and the web tool they developed. Specific products and services of potential interest include:

- Introduction to rural medicine for students and interns (Sweden)
- Presentation to interns (Sweden)
- Exchange programme for general practitioners in remote rural areas (Sweden)
- The yearly wheel to describe recruitment activities (Norway)
- Relocation Officer Business Case (Scotland)
- Rotation Scheme (Greenland)
- Clinical expertise to rural areas through tele-robots (Ireland)
- Scientific projects database (Sweden)
- Career Framework (Scotland)
- Buddying programme (Scotland)
- Couple Recruitment (Sweden)
- Focus on young family members (Sweden)

It should be noted that since funding for the project has ceased detailed information on individual initiatives may not be readily available, through some are likely to continue under different arrangements.

General Practice Forward View			
Author	NHS England	Reference to Rural	✓ (limited)
Key Findings and Conclusions			

Policy paper that lists a number of initiatives

- New funding formula to better reflect practice workload, including deprivation and rurality.
- GP Access Fund supporting wider range of healthcare professionals in GP practices and network of locality primary care access hubs.
- £40 million GP practice resilience programme over 4 years
- £206 million for workforce development
- £246 million to support practices in redesigning services.
- £20,000 bursaries of 109 GPs
- £1.75 million for practice development
- Increase in funding for Better Care Fund to support innovation at local level.
- Recruitment campaign to encourage doctors to be GPs with 35 National ambassadors and advocates
- International recruitment campaign
- 250 new post certificate of completion of training (CCT) fellowships to provide training opportunities in areas with poorest GP recruitment
- Simplify return to work routes and targeted financial incentives.
- £3.5 million for 13 new multidisciplinary training hubs (Community Provider Education Networks) support the development of the wider workforce in general practice, including placement in general practices, development for current staff and workforce development
- National induction and refresher (returner) scheme offering £2300 bursary to doctors looking to return to general practice.

NHS England (2016). General Practice: Forward view. April 2016

Retaining clinical staff: a practical improvement resource			
Author	NHS Improvement	Reference to Rural	Limited to case studies of NHS Trusts that include rural rather than specific references to rural
Key Findings and Conclusions			

Sets out seven steps:
    1.   Develop and refine your retention strategy
    2.   Understand your data and insights
    3.   Engage and empower staff
    4.   Development and career planning
    5.   Tailor offer to staff depending on staff of their career
    6.   Reduce variation and standardize working environments
    7.   Collaborate with neighbouring organisations
 	
Two case studies are from HNS Trusts that serve rural areas – Norfolk and Suffolk ran listening events around what makes a good or bad day at work listed under step 3 and Buckinghamshire on tailoring their offer to the over 50s. Most of the case studies are from Trusts that serve urban areas and there are no specific references to rural in the document.			

NHS England (2017). Retaining your clinical staff: a practical improvement resource. December 2017.			

Evaluation of the Better Care Fund			
Author	Forder J et al (2018).	**Reference to Rural**	One reference to rural in report
Key Findings and Conclusions			
'Related to the issue of workforce recruitment and retention were fears about the longer term capacity and sustainability, and short term resilience to cope with proposed changes set out in BCF plans…. This seemed to be a particular issue for smaller sites and in rural areas who explained they had a limited number of care providers.' (p.43)			
Forder J et al (2018). A system level evaluation of the Better Care Fund: Final Report. QORU. July 2018			

Reports on workforce issues reviewed that do not refer to rural

The following reports reviewed did not make specific reference to rural:
- Marangozov, R et al. Beyond Brexit: assessing key risks to the nursing workforce in England. Institute for Employment Studies (IES). Available: https://www.employment-studies.co.uk/system/files/resources/files/hrp12.pdf
- Johnston, L et al (2017). Building the future social care workforce: a scoping study into workforce readiness, recruitment and progression in the social care sector. Social Care Institute for Excellence (SCIE). Available at: https://www.scie.org.uk/files/future-of-care/care-workers/building-the-future-social-care-workforce-a-scoping-study-into-workforce-readiness.pdf
- Social Care Institute for Excellence (SCIE) (2016). Care workers: building the future social care workforce. Available at: https://www.scie.org.uk/files/future-of-care/care-workers/care-workers-building-the-future-social-care-workforce.pdf
- Social Care Institute for Excellence (2016). Evaluation of the care assistant development programme: learning from early implementation. Available at: https://www.scie.org.uk/files/care-providers/hc-one/care-assistant-development-programme.pdf

- Consilium Research and Consultancy Ltd.(2016). Study into the impact of a values based approach to recruitment and retention. Available at: https://www.skillsforcare.org.uk/Documents/NMDS-SC-and-intelligence/Research-evidence/Values-based-recruitment-Final-evaluation-report.pdf
- Nuffield Trust (2016).Reshaping the workforce to deliver the care patients need https://www.nuffieldtrust.org.uk/files/2017-01/reshaping-the-workforce-web-final.pdf

Sustainability of adult social care sector			
Author	National Audit Office	**Reference to Rural**	None
Key Findings and Conclusions			

Summarises the state of adult social care provisions and issues facing the sector. In 2016-17 the adult social care sector employed 1.34m workers in England with local authorities spending £16.8b being spent by Local Authorities (£14.8bn directly LA and £2bn from the NHS through the better care fund). Staff turnover was 27.8% across all care jobs and the median salary was £7.50 per hour for care workers in the independent sector. There was 11.3% vacancy rate for registered managers and 16% of registered nurses were of non-British European Economic Area nationals. The Centre for workforce intelligence projects 2m fulltime staff will be required by 2035. (NAO, 2018).

Key findings of the NAO 2018 report were:
- Turnover and vacancy rate across the social care workforce is high
- Growth in the number of jobs has fallen behind growth in the demand for care
- Care Quality Care Commission stated in October 2018 that the sustainability of the care market remains precarious
- Recruitment and retention challenges include:
  - Care work is viewed by the public as low skilled and offering limited opportunities for career progression
  - Providers and commissioners of care have raised concerns that low pay for care workers is contributing to high vacancy and turnover rates
  - The vacancy rate for nurses more than doubled between 2012-13 and 2016-17
  - In 2016-17, 7% of the care workforces were non-British EEA nationals. Wide regional variation from 2% in NE to 13% in London
  - Since 2010 CQC has required all adult social care establishments to have registered managers to ensure a safe service. The RM along with the care provider is legally accountable. Vacancy rate is highest for RM at 11.3% because of the low number of care workers willing to seek promotion because of the high level of responsibility compare to level of pay
- The Department does not have an up-to-date care workforce strategy and roles and responsibilities of bodies involved in delivering care are not clear.
- Local and regional bodies and partnerships are not taking the lead on workforce strategy planning in the absence of a national strategy
- The department cannot demonstrate that the sector is sustainably funded which makes workforce planning difficult
- Four-fifths of LAs are paying fees to providers that are below the benchmark costs of care. The Competition and Market Authority (2017) estimated if LA paid the full costs of home placements for all residents they fund the additional cost would be £1bn.
- The department is not doing enough to support the development of a sustainable care workforce. Only £21.5m has been made available to Skills for Care to oversee and administer workforce initiatives equivalent to £14 per worker.
- Integration of health and social care is not expected to significantly reduce the number of care jobs required

The NAO makes a number of recommendations
   A) **The Department should produce a robust national workforce strategy to address the major challenges currently facing the care workforce**. The Department has policy responsibility for the care workforce, and should involve other key stakeholders, principally the Ministry of Housing, Communities & Local Government. The strategy should be consistent with reforms stemming from the planned green paper. If a strategy is combined with health, care must receive equivalent prominence.
   B) **The Department needs to understand and plan long-term for the effect on the workforce that integration of health and care, and other potential changes to how care is delivered, will bring.** The Department should set out clearer career pathways for workers in care that link with roles in health.

	The Department should consider how best to address differences in pay and conditions across the health and care sectors, in relation to supporting recruitment and retention in care.
C)	**The Department should encourage local and regional bodies to produce workforce strategies that complement the national strategy.** The Department should gain assurance that every area has a clear plan, aligned with the national strategy and local NHS plans. Local areas should plan how to work effectively with other statutory bodies, such as local Jobcentre Plus offices. The Department should gain assurance that local or regional bodies are holding providers to account for delivery.
D)	**The Department should assess whether current initiatives, both national and local, to support recruitment, retention and development are sufficient.** The Department should identify ways to boost the impact of these initiatives and consider increasing the scale of those shown to be successful.
E)	**The Department should establish how much funding the sector will need over the long term and make the consequences of any funding gap clear**. The Department should consider sharing its modelling of cost and demand pressures on the care sector to help commissioners set appropriate fees for providers; this includes the costs arising from future changes to the National Living Wage.

National Audit Office (2018). The adult social care workforce in England.

Availability of affordable housing

Author	Wheatley and Beswisk (2018)	Reference to Rural	Does not specifically refer to rural areas.
Key Findings and Conclusions			
Provide an analysis of the sale of surplus NHS property under the Government public land sales programme. They found that 20 per cent of homes built on former NHS sites would be affordable to a nurse on average salary and only 10 per cent offered at genuinely affordable social rent. The report provides multiples of earnings required to purchase properties built on former NHS land.			
Wheatley, H., Beswick, J. (2018). No homes for nurses: how NHS land is being sold off to build unaffordable homes. New Economics Foundation Available : http://neweconomics.org			

Appendix B: Analysis of Sustainability and Transformation Plans

Spatial Footprint of Sustainability and Transformation Plans and Distribution of NHS Employees across STPs

Overview

This section sets out the percentage of the population of each Sustainability and Transformation Plan areas, which is rural, excluding those STP areas in Greater London which are deemed to be overwhelmingly urban. It has been produced by matching STP boundaries with NUTS 3 data showing the distribution of rural and urban populations (using the 2011 rural-urban classification) across England[47].

Background

The 2016 (March) Five Year Forward View on STP footprints identifies five factors taken into account in "forming footprints" for STPSs:

- Geography
- Scale
- Fit with existing footprints of change programmes
- Financial sustainability of organisations in the area
- Leadership capacity and capability to support change

22 of the 44 STPs have a population shire equal to or greater than the England average (17%) There is no indication in this document or the STPs about how this process has been applied in detail. It has led to a number of anomalies, which emasculate rural geographies by lumping them together with urban settings:

- Dorset on this basis has only 16% rural
- Lancashire and South Cumbria 16%
- Northumberland, Tyne and Wear 12%

The Most Rural STP Areas

Box B1 below sets the areas with highest populations living in living rural areas. All of these areas have at least double the share of rural population than England as a whole.

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[47] Rural Urban Classification (2011) of NUTS 3 (2015) in England. Office for National Statistics- The 2011 rural-urban classification (RUC) of 2015 NUTS 3 (Nomenclature of Territorial Units for Statistics) in England is based on the 2011 RUC of Output Areas (OA) published in August 2013, and allows users to create a rural/urban view of local authority district level products.

Box B1: The top 10 rural STP areas by population (percentage)

1. Cornwall and Isles of Scilly (62%)
2. West, North and East Cumbria (54%)
3. Norfolk and Waveney (50%)
4. Lincolnshire (48%)
5. Somerset (48%)
6. Cambridgeshire and Peterborough (39%)
7. Shropshire, Telford and Wrekin (39%)
8. Suffolk and North East Essex (38%)
9. Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby (35%)
10. Devon (34%)

Table B1 below shows the percentage of rural and urban dwellers in each STP area in scope. The rows shaded green show those STP areas with a population share above the England average population share of rural residents:

Table B1: STPs rural population

STP	Rural Population 2011	Urban Population 2011	%Rural
1. Cornwall and Isles of Scilly	328,885	205,591	62
2. West North East Cumbria	267,819	232,039	54
3. Norfolk and Waveney	428,713	429,175	50
4. Lincolnshire	343,265	370,388	48
5. Somerset	255,263	274,709	48
6. Cambridgeshire and Peterborough	314,385	490,456	39
7. Shropshire Telford and Wrekin	186,646	286,124	39
8. Suffolk and NE Essex	445,603	740,766	38
9. Durham, Darlington, Tees, Hambleton, Richmondshire and Whitby	627,981	1,146,428	35
10. Devon	384,793	748,949	34
11. Herefordshire and Worcestershire	248,290	501,356	33
12. Northamptonshire	220,625	471,327	32
13. Gloucestershire	177,017	419,967	30
14. Bath, Swindon and Wilts	356,271	965,215	27
15. Kent and Medway	433,557	1,294,108	25
16. Coast Humber and Vale	270,223	845,475	24

STP	Rural Population 2011	Urban Population 2011	%Rural
17. Leicester, Leicestershire and Rutland	224,979	792,718	22
18. Coventry and Warwickshire	180,662	681,772	21
19. Derbyshire	208,184	810,254	20
20. Sussex and East Surrey	395,122	1,593,120	20
21. Staffordshire	206,527	890,970	19
22. Hampshire and IoW	333,151	1,564,840	18
23. Dorset	168,952	575,089	16
24. Herts and West Essex	226,003	1,176,105	16
25. Lancashire and South Cumbria	274,360	1,388,761	16
26. MK, Bedfordshire and Luton	299,613	1,680,331	15
27. Mid and South Essex	126,069	854,629	13
28. Nottinghamshire	83,972	555,867	13
29. South Yorkshire and Bassetlaw	231,431	1,563,813	13
30. Berkshire, Buckingham and Oxfordshire	486,069	3,465,312	12
31. Northumberland, Tyne and Wear	177,509	1,243,344	12
32. Surrey Heartlands	89,636	661,444	12
33. West Yorkshire	224,835	2,001,223	10
34. Greater Manchester	204,526	3,074,986	6
35. Birmingham and Solihull	20,951	1,258,768	2
36. Cheshire and Merseyside	178,295	2,028,375	1
STPs (excluding Greater London) rural population using "best fit" of NUTS 3 data to STP boundaries- England rural population 17% overall (9.3 million)			

Distribution of NHS Employees Across STPs

Overview

This section analyses the aggregate number of NHS employees[48] in the top 11 STP areas by rural population (see table above) as a proportion of the aggregate overall population of the 11 STP areas. All STPs chosen have approaching twice the number of rural dwellers as the national average and provide therefore a good starting point for a differentiation between rural and more urban STP geographies.

Table B3 below compares the ratio of NHS employees to population of these STPs as a group to the ratio of NHS employees to the population across England as a whole. Our analysis excludes ambulance services as they are distributed at a regional level of geography. The workforce categories with the greatest divergence from the England ratio are set out in red.

Table B3: **NHS staff per head of population ratio All England/Rural**

Professional Group	NHS staff per head
Total	1.45
Professionally qualified clinical staff	1.48
HCHS Doctors	1.57
Consultant (including Directors of Public Health)	1.52
Associate Specialist	1.31
Specialty Doctor	1.42
Staff Grade	1.72
Specialty Registrar	1.87
Core Training	1.53
Foundation Doctor Year 2	1.45
Foundation Doctor Year 1	1.51
Hospital Practitioner / Clinical Assistant	0.87
Other and Local HCHS Doctor Grades	1.18
Nurses & health visitors	1.45
Midwives	1.60
Scientific, therapeutic & technical staff	1.48
Support to clinical staff	1.39
Support to doctors, nurses & midwives	1.41
Support to ST&T staff	1.34
NHS infrastructure support	1.42
Central functions	1.34
Hotel, property & estates	1.52

The employers included in the analysis within the STPs chosen are set out in Box B2 below:

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[48] NHS Hospital & Community Health Service (HCHS) monthly workforce statistics: HCHS Staff by Health Education England area, Organisation and Main Staff Group - Full Time Equivalent. NHS Digital March 2018. These statistics are updated monthly and have a six month time lag between the date of compilation and the date of publication.

Box B2

• 2Gether NHS Foundation Trust	• NHS South Tees CCG
• Cambridge University Hospitals NHS Foundation Trust	• NHS South West Lincolnshire CCG
• Cambridgeshire and Peterborough NHS Foundation Trust	• NHS South Worcestershire CCG
• Cambridgeshire Community Services NHS Trust	• NHS Telford and Wrekin CCG
• Cornwall Partnership NHS Foundation Trust	• NHS West Norfolk CCG
• County Durham and Darlington NHS Foundation Trust	• NHS West Suffolk CCG
• Cumbria Partnership NHS Foundation Trust	• Norfolk and Norwich University Hospitals NHS Foundation Trust
• Devon Partnership NHS Trust	• Norfolk and Suffolk NHS Foundation Trust
• Ipswich Hospital NHS Trust	• Norfolk Community Health and Care NHS Trust
• James Paget University Hospitals NHS Foundation Trust	• North Cumbria University Hospitals NHS Trust
• Lincolnshire Community Health Services NHS Trust	• North Tees and Hartlepool NHS Foundation Trust
• Lincolnshire Partnership NHS Foundation Trust	• North West Anglia NHS Foundation Trust
• NHS Cambridgeshire and Peterborough CCG	• Plymouth Hospitals NHS Trust
• NHS Durham Dales, Easington and Sedgefield CCG	• Queen Elizabeth Hospital King's Lynn NHS Foundation Trust
• NHS Great Yarmouth and Waveney CCG	• Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust
• NHS Hambleton, Richmondshire and Whitby CCG	• Royal Cornwall Hospitals NHS Trust
• NHS Herefordshire CCG	• Royal Devon and Exeter NHS Foundation Trust
• NHS Kernow CCG	• Royal Papworth Hospital NHS Foundation Trust
• NHS Lincolnshire East CCG	• Shrewsbury and Telford Hospital NHS Trust
• NHS Lincolnshire West CCG	• Shropshire Community Health NHS Trust
• NHS North Cumbria CCG	• Somerset Partnership NHS Foundation Trust
• NHS North Durham CCG	• South Staffordshire and Shropshire Healthcare NHS Foundation Trust
• NHS North East Essex CCG	• South Tees Hospitals NHS Foundation Trust
• NHS North Norfolk CCG	• Taunton and Somerset NHS Foundation Trust
• NHS Northern, Eastern and Western Devon CCG	• Tees, Esk and Wear Valleys NHS Foundation Trust
• NHS Norwich CCG	• Torbay and South Devon NHS Foundation Trust
• NHS Shropshire CCG	• United Lincolnshire Hospitals NHS Trust
• NHS Somerset CCG	• West Suffolk NHS Foundation Trust
• NHS South Devon and Torbay CCG	• Worcestershire Acute Hospitals NHS Trust
• NHS South Lincolnshire CCG	• Worcestershire Health and Care NHS Trust
• NHS South Norfolk CCG	• Wye Valley NHS Trust
	• Yeovil District Hospital NHS Foundation Trust

Appendix C: Application of a Rural Lens to the Draft Health and Care Workforce Strategy

The draft health and care workforce strategy for England to 2027 entitled *Facing the Facts, Shaping the Future to 2027* identifies six principles to support better workforce planning. These principles are presented in Table C1 below and comments regarding their relevance and specific pertinence to rural areas are set out.

Table C1: Draft Health and Care Workforce Strategy principles and their specific relevance to rural areas

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Principle 1: Securing supply of staff

- A key feature of rural labour markets is selective *out-migration of the most academically qualified young people to larger urban areas* – this reduces the number of qualified young people for recruitment. It might suggest that there is particular scope in rural areas for consideration of how to recruit individuals with fewer formal qualifications. Rural areas tend to be less attractive than urban areas to new graduates looking to start their careers;[49] hence it may be the case that rural areas need to rely more on returning practitioners (i.e. those who have left roles in the NHS and social care) and recruitment from outside the UK.

- Rural areas tend to be characterised by an older than average population and an *older than average workforce* – which has implications for replacement demand (i.e. job openings resulting from retirement). In aggregate older workers are less likely to have their qualifications certified than younger workers, so they may be less likely to meet qualification requirements of jobs.[50] Given the older than average population in rural areas it is plausible that integration of health and social care is particularly important to address more complex and greater interdependence of needs associated with advancing years. It is also plausible that the need to support (unpaid) carers is greater in rural areas than in urban areas given relative age structures of the population.

- The so-called '*low skills equilibrium'* has been identified as a feature of rural labour markets, particularly in peripheral rural areas. Although there is a danger that use of this term creates an image of a lack of career paths in certain sectors – potentially fuelling a lack of attractiveness of such sectors for workers, the existence of a set of conditions where employers have increasing demands for low, though flexible, skills (functional flexibility) and a limited number of skilled job opportunities, the local labour force tends to develop fewer skills. The existence of this set of conditions can lead to the persistence of the spiral of decline, and the generation of low expectations among both employers and employees

- A *limited labour pool in rural areas, exacerbated by remote location and poor public transport*, is a factor that increases the incidence of hard-to-fill and skill-shortage vacancies in rural areas across the economy in aggregate – workers in rural areas working in the NHS and social care are more likely to need a car to travel-to-work than workers in urban areas and this is likely a limiting factor for labour supply.

- *Traditionally rural labour markets have been more reliant on informal recruitment*

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[49] This is important given that new graduates are an important source of new labour for the NHS.
[50] There may also be a case for revising recruitment and selection requirements (whilst maintaining quality standards) to help attract/ secure a supply of older workers. (Note that older workers may be suited to care jobs and other roles where life experience is a particular asset.)

mechanisms than urban areas. This suggests that existing staff are an important resource for encouraging new recruits to social care and the NHS.

- *Doctors tend to stay in the area where they are trained* – this suggests a need for training to take place in rural areas.[51]

- Research on internal migration suggests *a decline in internal migration and a rise in secular rootedness* – this is an opportunity and a challenge for rural areas, which need to be attractive for individuals and households to be able to stay in one residential location, while still pursuing their careers.

- The NHS and social care workforce rely to varying extents on *international migrants*. Changing immigration rules (both a tightening of the immigration rules for non-EEA migrants and the immigration regime for EEA workers post-Brexit) affect rural and urban areas alike, but will impact particularly on those rural areas most reliant on non-UK labour.[52]

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

- Across the economy as a whole *training is more expensive to deliver in rural than in urban areas* – this reflects lower numbers of potential trainees which can increase costs of training provision. Issues of the operational practicalities and costs of travelling to training are likely to be particularly pertinent for social care and lower-paid and less skilled NHS staff. Delivering training of the current workforce may be more challenging in rural than in urban areas (particularly if necessitating travel to other locations often outside of normal work times).

- Increased spending on recruitment and using new recruitment channels are the main responses to hard-to-fill vacancies in urban and rural areas. Across the economy as a whole, *rural establishments are more likely to 'do nothing' in response to hard-to-fill vacancies* than urban establishments. But they are also more likely to redefine existing jobs or increase training than establishments in urban areas.[53] Can rural areas be in the vanguard of *job redesign* in the NHS and social care?

- In general rural areas are characterised by a higher proportion of SMEs, lower than average levels of training and *lower emphasis placed on formal qualifications* than in urban areas and more emphasis on informal training.

Principle 3: Providing broad pathways for careers in the NHS

- Rural areas are characterised by a *smaller quantity and reduced range and scope of job opportunities*. This serves to constrain career opportunities in situ relative to urban areas.

- This has links to the supply of workers (see Principle 1) given the reduced opportunities for job moves – the breadth and depth of different job roles is likely greater in urban areas than in rural areas.

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[51] The announcement in March 2018 of the locations of new medical schools in areas where it "can be hard to recruit and attract new doctors".(Secretary of State, Jeremy Hunt) in Sunderland, Lancashire, Lincoln, Canterbury and Chelmsford represents a recognition of this issue and should go some way to address it.
[52] Rural and urban areas alike may be particularly reliant on non-UK labour for some job roles (albeit the identity of these roles may vary within and between urban and rural areas). Both rural and urban areas are likely to be adversely affected by a stricter UK immigration regime.
[53] Owen D., Li Y. and Green A. (2013) Secondary analysis of employer surveys: Urban and rural differences in jobs, training, and skills', Evidence Report 75, UKCES, Wath-upon-Dearne and London.

- There is a particular issue of *how to provide broad pathways without losing workers from rural areas.*

- However for workers who wish to remain in situ in rural areas, as a large employer the NHS provides a potentially greater range of opportunities in terms of career opportunities than other employers.

- In rural and urban areas alike there is a need to *think of workforce development in terms of an employment pathway* – from employment entry to in-work progression – with training and support along the way:

Get In opportunities for people to start their career in a support role	**Get On** support people to be the best they can be in the job they do	**Go Further** provide opportunities for career progression, including into registered professions
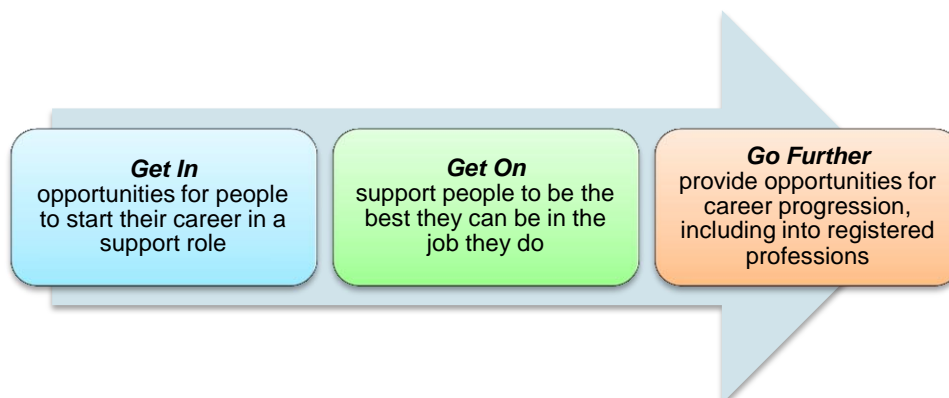
Principle 4: Widening participation in NHS jobs – to include people from all backgrounds

- *Rural areas tend to be less ethnically diverse* than urban areas; hence on this particular dimension there is likely less scope for widening participation. However, there is scope, in particular, for widening participation focusing on gender (i.e. encouraging men into carer roles currently dominated by women) and age (i.e. focusing particularly on opportunities for older workers given the age profile of rural areas

- *Roles such as Nursing Associates* may be a particularly pertinent means for widening participation in rural areas (this relates to issues outlined under Principle 3 above).

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

- This seems pertinent to rural and urban areas alike

Principle 6: Ensuring that service, financial and workforce planning are intertwined

- This seems pertinent to rural and urban areas alike

It is notable that **technology** does not feature explicitly in the *Draft Health and Care Workforce Strategy* principles. However, given issues of travel time for carers and challenges associated with travel in rural areas, it may be the case that technology can play a particularly important role in supporting the workforce (and population) in rural areas.

Selected issues of interest and knowledge gaps:

1. How do vacancies for particular job roles vary by area? Are there systematic rural/ urban variations?
2. What is the experience of employment of Nursing Associates in rural areas?[54] Is it any different from urban areas?
3. Are rural areas more reliant on non-UK workers – at least in some job roles?
4. What are the specific challenges that the NHS and social care face in developing the current workforce in rural areas? And are there rural- urban differences?
5. How can carers in rural areas be supported better?

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[54] It is early to be asking this question given that the role was only introduced in September 2016. The nursing associate role is an opportunity to provide support to nurses and improve care.

Appendix D: Rural Workforce Research – Context

The purpose of this Appendix is to provide a context for a more detailed analysis of the rural dimensions of health and care workforce to be explored. It is divided into three sections covering: (1) spatial context – definitions of rural; (2) organisational context – how health and care as a system is divided into different categories and units; and (3) workforce context – national headcounts, statistics and research covering recruitment, retention and development.

1) Spatial context

The Rural Urban Classification[55] is an official statistic used by Government to distinguish rural and urban areas. The Classification defines rural areas as those with less than 10,000 resident population. Built from clusters of postcodes, Output Areas are statistical units which have similar population sizes. There are some 171,372 OAs for England. Output Areas are assigned to one of four urban or six rural categories. The six rural categories: town and fringe (D1), town and fringe in a sparse setting (D2), village (E1), village in a sparse setting (E2), hamlets and isolated dwellings (F1) and hamlets and isolated dwellings in a sparse setting (F2). This is set out in Figure 1.

Figure 1: England and Wales 2011 Census Output Areas by Rural Urban Classification

ONS et al., 2013 page 8
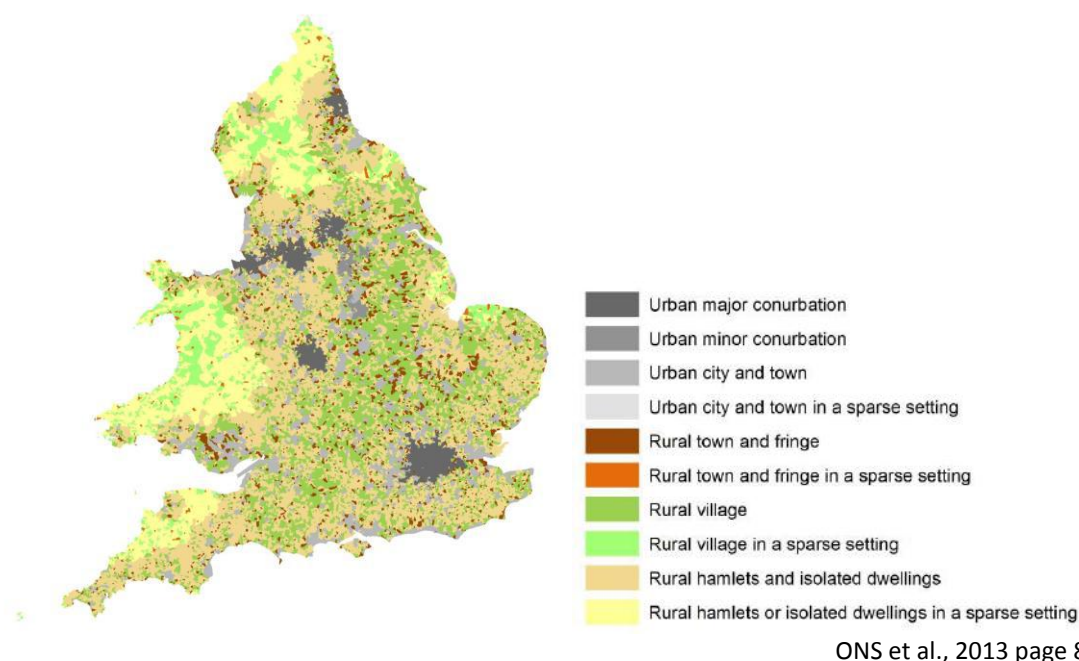
The Classification is an examination of both the physical character of the settlements in which residents typically live and of population sparsity.

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[55] Information about the Rural Urban Classification is available on the Defra website at:
https://www.gov.uk/government/collections/rural-urban-classification

In 2014 Defra commissioned the University of Sheffield to further develop the Classification by identifying 'built-up area hub towns'. This uses the following criteria:

- Settlements with populations between 10,000 and 30,000 people.
- A residential ratio (density of residential dwellings within 2 kilometres).
- A non-residential ratio (the number of businesses and services within 2 kilometres).

This classification incorporates service provision, employment and businesses in considering settlements which 'have an enduring though not unchanging role as a service hub of some sort for their rural hinterland.'[56] 183 settlements have been classified as 'built-up area hub town.'

Defra's Statistical Digest of Rural England is a collection of official statistics on a range of social and economic matters. In relation to health, the Digest reveals:

- Average life expectancy was higher in mainly rural areas – on average, people born in mainly rural areas in 2013-2015 are expected to live two years longer than people born in urban with minor conurbation areas.
- The average life expectancy in 2013-2015 was 79.4 years for men and 83.1 years for women.
- Potentially years of life lost (PYLL) from all causes of death was lower in predominantly rural areas than predominantly urban areas: 2012-2014 the PYLL was 475 years per 10,000 population compared to 372 years per 10,000 population in mainly rural areas.
- In 2016-2017 on average people living in predominantly rural areas rated their wellbeing as slightly higher than those in predominantly urban areas.

2) Organisational context

The NHS in England includes the following key organisations:

- NHS England and Clinical Commissioning Groups: commission NHS services.
- NHS Improvement: responsible for overseeing foundation trusts, NHS trusts and independent providers that provide NHS-funded care.
- The Care Quality Commission (CQC): registers care providers; monitors, inspects and rates health and social care services; and takes action to protect people who use services.
- Health Education England (HEE): provides leadership in education, training and workforce development in the health sector.
- Public Health England (PHE) and Local Authorities with public health duties: improving people's health and wellbeing and reducing health inequalities.
- Health and Wellbeing Boards: bring together NHS, public health, adult social care and children's services, elected representatives and Healthwatch to plan how best to meet the needs of local populations and tackle local inequalities.
- The National Institute for Health and Care Excellence (NICE): provides resources/evidence, national guidance, advice, standards and information for health, public health and social care providers.

Health provision delivered by the NHS is often categorised into units known as Authorities or Trusts. For secondary care this encompasses:

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[56] Quote taken from a description of the research by Peter Biddy, principal investigator, on the University of Sheffield website: https://www.sheffield.ac.uk/usp/research/projects/ruc

- NHS trusts: foundation, acute, ambulance, mental health, strategic clinical networks or special health authorities.
- CCGs: commission services from primary and secondary care – planned hospital care, rehabilitative care, urgent and emergency care including out-of-hours and NHS 111, most but not all mental health services, most but not all learning disability services, and some GP services.
- NHS England: 5 regional teams covering North, Midlands and East, London, South East and South West. NHS England works with CCGs and GP practices on finance, nursing care, medical care, specialised commissioning, patient information, HR, organisational development, assurance and delivery.
- Other NHS services that cross-cut the above i.e., pharmacy, dental, eye care, sexual health and pathology.

Adult social care may be delivered by the NHS, health providers and/or funded and arranged by other means. This includes:

- NHS Continuing Healthcare and NHS Funded Nursing Care: where an individual is assessed and eligible as having a 'primary health care need.' Here care is funded and arranged solely by the NHS.
- Universal and preventative services delivered by Local Authorities available without an assessment of need.
- Packages of care for individuals assessed as having high needs and limited funds: based on assessment undertaken by the Local Authority who then commissions providers from the voluntary, community or private sector to provide care and/or may offer a personal budget following assessment enabling an individual to have full control over how their needs are met.
- Informal care provided in an unpaid and voluntary capacity by family members, friends and community members.

Health and care services in England have traditionally been funded, administered and accessed separately: with health provided free at the point of use through the NHS and Local Authorities means-testing social care. Policies to promote health and social care integration include: the creation of Health and Wellbeing boards, the Better Care Fund, new care models programme, LGA Care and Health Improvement Programme and the establishment of a new central-local partnership as part of the NHS Five Year Forward View. At the same time, Government is seeking to focus delivery on being as close to the patient as possible (at home or in their community) as a way of improving outcomes and reducing costs.

In January 2018 the Department of Health was renamed the Department of Health and Social Care. The Secretary of State has overall financial control and oversight of NHS delivery and performance and oversight of social care policy. In March 2018 the Health and Social Care Secretary set out seven principles[57] that will 'guide the Government's thinking ahead of the social care green paper:

- Quality and safety embedded in service provision.
- Whole-person, integrated care with the NHS and social care systems operating as one.
- The highest possible control given to those receiving support.
- Better practical support for families and carers.

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[57] Taken from the transcript of a speech delivered by The Rt Hon Jeremy Hunt MP on 20 March 2018 titled 'we need to do better on social care'. Transcript available online at: https://www.gov.uk/government/speeches/we-need-to-do-better-on-social-care

- A sustainable funding model for social care supported by a diverse, vibrant and stable market.
- Greater security for all – for those born or developing a care need early in life and for those entering old age who do not know what their future care needs may be.

Under 'a valued workforce', the Secretary of State described how "it is time to do more to promote social care as a career of choice and to ensure there are better opportunities for progression into areas like nursing which span both the health and social care sectors. And we need coherent workforce planning that is better aligned with that now being undertaken by the NHS. Alongside social workers, occupational therapists and nurses in social care we have many care workers who could benefit or be inspired by new progression ladders similar to those that are being developed in the NHS including roles such as associate nurses and nurse degree apprenticeships. These must be as available to those working in social care as in the NHS. We need to recognise that people move between the NHS and social care systems - and will do more so as the 2 systems join up. So part of our thinking must be to think about health and care workforce issues in a joined up way. I can therefore confirm today that later this year we will not now be publishing an 'NHS 10 year workforce strategy' – it will be an 'NHS and social care 10 year workforce strategy' with the needs of both sectors considered together and fully aligned."

3) Workforce context

NHS Workforce Statistics[58] uses the NHS's HR and Payroll system to determine headcount and full-time equivalents of NHS Hospital and Community Health Service (HCHS) staff groups working in Trusts and CCGs in England. These statistics exclude primary care staff. This information is compiled by NHS Digital. The latest statistical bulletin[59] was published on 24 April 2018 and includes monthly figures from January 2018. The headline figures show:

- The headcount was 1,205,949 in January 2018. This is 7,711 (0.6 per cent) more than the previous month (1,198,238) and 21,068 (1.8 per cent) more than in January 2017 (1,184,881).
- The full time equivalent (FTE) total was 1,064,810 in January 2018. This is 6,910 (0.7 per cent) more than the previous month (1,057,900) and 19,252 (1.8 per cent) more than in January 2017 (1,045,559).
- Professionally qualified staff make up over half (54.0 per cent) of the HCHS workforce (based on FTE).

NHS England is working with Health Education England (HEE), the Royal College of General Practitioners (RCGP) and British Medical Association (BMA) to increase the number of doctors in general practice by 5,000 and increase the number of other health professionals (e.g. pharmacists, physician associates) by 5,000 as part of The General Practice Forward View[60]. NHS England has commissioned two independent pieces of research to support the development of the GP Forward View.

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[58] NHS Workforce Statistics – a series/collection of data collated by NHS Digital showing provisional monthly numbers of NHS Hospital and Community Service (HCHS) staff groups working in Trusts and Clinical Commissioning Groups. Information about the series and data is available online at https://digital.nhs.uk/data-and-information/publications/statistical/nhs-workforce-statistics
[59] NHS Workforce Statistics January 2018 (published 24 April 2018) – the Statistical Bulletin is available for download here: https://files.digital.nhs.uk/DD/AD006C/NHS%20Workforce%20Statistics%2C%20January%202018%20Bulletin.pdf
[60] The GP Forward View was published in April 2016 and commits an extra £2.4 billion a year towards supporting general practice services by 2020-2021. More information about the review is available online here: https://www.england.nhs.uk/gp/gpfv/

The first piece of research, an evidence synthesis of General practitioner recruitment and retention was undertaken by the Policy Research Unit in Commissioning and The Healthcare System (PRUComm) and published in February 2016 (see Peckham et al 2016). The evidence synthesis[61] revealed how GP recruitment and retention "is limited and most focused on attracting GPs to underserved rural areas (page 2). Four factors were found to improve recruitment in rural areas: (1) positive marketing of general practice and GP careers; (2) improving the breadth of training for candidates by providing opportunities for candidates to specialise in a second related specialty of interest or develop skills and competencies in management; (3) the development of training hubs where groups of GP practices offer inter-professional training in primary care; and (4) financial targeted support and time-limited incentive schemes.

The second piece of research, carried out by Ipsos MORI and published in December 2015 examined the drivers and barriers that affect student doctors taking up GP specialism; the factors that lead to GP disaffection; ideas for encouraging GPs to stay in or return to the specialty and consider a range of incentives to recruit and retain GPs. The report[62] (see Worsley & Cook 2015)sets out a number of task around getting GPs on-side, tackling professional identity, new ways of working, service design and future proofing but makes no direct reference to rural.

Health Education England provides national leadership and coordination for education and training across the health sector. HEE currently has 100+ programmes to recruit and develop health care staff in healthcare and community settings. There are 300+types of jobs provided by the NHS. HEE is currently developing a system wide workforce strategy 'facing the facts, shaping the future.' This is the first workforce strategy for the health service in England for 25 years. The draft strategy describes the current state of the health and care workforce (since 2012) and decisions that will impact on the future workforce (through to 2027). It is intended the final strategy be published in July 2018 and updated annually thereafter.

HEE has 4 LETBS (Local Education Training Boards) that are responsible for the training and education of NHS staff – clinical and non-clinical – within their area. Each LETB is overseen by a committee comprising representatives from local providers of NHS services. The health education system also includes:

- Universities: who provide the principal setting for the early years of medical education before registration and training and qualifications for non-medical roles; and
- Healthcare providers: who provide a setting for the later years of medical training e.g. placements, CPD.

The Professional Standards Authority (PSA) oversees 9 health and care regulators, in England they include: Nursing & Midwifery Council, Health & Care Professions Council, General Pharmaceutical Council, General Osteopathic Council, General Optical Council, General Medical Council, General Dental Council and General Chiropractic Council.

[61] Evidence Synthesis available for download here: http://blogs.lshtm.ac.uk/prucomm/files/2016/11/PRUComm-General-practitioner-recruitment-and-retention-review-Final-Report.pdf
[62] The research report from Ipsos MORI is available for download here: https://www.england.nhs.uk/commissioning/wp-content/uploads/sites/12/2015/01/gp-retention-return-imp-summary-rep.pdf

There are a number of professional bodies which support clinical and non-clinical professions throughout their career. In England they include: the Royal College of General Practitioners (RCGP) and the British Medical Association (BMA). NHS Employers aims to be the voice of employers in the NHS and work on behalf of the health service in England on four priority areas: pay and regulations, recruitment and planning the workforce, healthy and productive workplaces and employment policy and practice. A number of these professional bodies commission and/or undertake work on issues relating to the education, training and ongoing development of the health workforce.

Some considerations for primary research, analysis & report / toolkit

Spatial

Do workforce challenges and opportunities vary according to physical settlements (i.e., between sparse and less sparse rural settings) and/or their economic functions (i.e., proximity to urban settlements, hub towns)?

Primary research area	Built up area hub towns
Cornwall	Bodmin, Helston, Newquay, Penzance, St Austell and Truro
Cumbria	Kendal, Penrith, Ulverston, Whitehaven and Workington
Kent and Medway	Faversham, Minster, Sheerness and Sevenoaks
Herefordshire & Worcestershire	Herefordshire: Leominster and Ross-on-Wye Worcestershire: Droitwich, Evesham, Stourport-on-Severn and Tewkesbury
Lincolnshire	Bourne, Gainsborough, Louth, Mablethorpe, Market Deeping, Skegness, Sleaford, Stamford,
Northumbria	Ashington, Berwick-upon-Tweed, Consett*, Hexham, Morpeth and Prudhoe NB: Northumbria Healthcare NHS Foundation Trust covers Northumberland and North Tyneside * part of Consett located in County Durham

The indicators currently in use do not necessarily reflect all of the health and wellbeing issues in rural areas e.g. distance to health and care services (the notion of "distance decay" where service use decreases with increasing distance; transport) digital/technology; fuel poverty. The indicators currently in use do not always reflect the different types/variations of rural and coastal places. If/how do health and care organisations 'think rural' in reflecting upon the issues in the countryside?

Organisational

Although the NHS is sometimes perceived as a system that is difficult to change, it has continuously adapted since its formation in 1948. It involves a number of organisations working together to meet the population's health and care needs – in moving from an illness and provider-led system towards a preventative model where care is provided closer to the home (as per the Five Year Forward View). For patients, moving between health and care settings, having assessments, being looked at by multiple different professionals etc. can be confusing (for them and their families/caregivers).

In thinking about secondary care for the primary research: how are health and care organisations finding ways of reducing clinical pressures and improving quality of care for rural patients? If/how is health and social care being integrated in rural settings –how is this delivering benefits for patients,

the NHS and/or Local Authorities? Is the workforce there and trained to provide a more joined-up experience for those with health and care needs in rural settings?

Workforce

The table below contains figures extracted from Table 1: NHS Hospital & Community Health Service (HCHS) monthly workforce statistics, January 2018 monthly data (NHS Digital).

It contains workforce data (clinical and non-clinical) in each of the primary data areas included in the research. It is for Acute Trusts only – other Authorities and Trusts also cover these areas. NB: North Cumbria Hospitals NHS Trust serves Cumbria, parts of Northumberland and Dumfries and Galloway.

The overall CQC rating for each trust has been sourced from the CQC website. Individual services within each Trust may rank higher or lower than the overall rating.

Supply: how does the HCHS total and the numbers of professional (clinical), support and infrastructure relate to the number of vacancies, number of new entrants, the number of staff leaving, number of roles filled by EU and non-EU staff ?

Education and training: which of these acute trusts are part of University and Teaching hospitals (HE) and does this have any impact on the supply of health and care staff? How are the Trusts taking up new clinical/medical roles to address workforce issues?

What activities have these Trusts undertaken to recruit, retain and return staff across all roles (e.g. workload, training and development, hubs, CPD, work-life balance)?

While primary care is not directly in scope (e.g. GPs, dentists, independent sector – some are for profit and some are not-for-profit), the preventative/care closer to the home means primary and secondary care increasingly overlap. How is this taken into account in workforce planning?

Acute Trust	Total HCHS	Professionally qualified clinical staff	HCHS doctors	Nurses and health visitors	Midwives	Scientific, therapeutic and technical staff	Support to clinical staff	NHS infrastructure support e.g. central functions, estates, managers	Overall CQC rating (report published)
Northumbria Healthcare NHS Foundation Trust	8,004	4,323	643	2,276	164	1,242	2,451	1,177	Outstanding May 2016
United Lincolnshire Hospitals Trust	7,589	3,797	824	1,934	234	806	2,737	1,066	Inadequate April 2017
Royal Cornwall Hospitals Trust	5,318	2,936	712	1,302	180	743	1,688	671	Inadequate October 2017
North Cumbria University Hospitals NHS Trust	4,100	2,117	387	1,147	159	405	1,297	686	Requires Improvement October 2017
East Kent Hospitals University NHS Foundation Trust	7,743	4,249	975	1,955	274	1,045	2,533	894	Requires Improvement December 2016
Worcestershire Acute Hospitals NHS Trust	5,971	3,342	646	1,659	250	786	1,930	683	Inadequate January 2018

References

Department for Environment, Food and Rural Affairs (Defra) (2018). *Statistical Digest of Rural England April 2018 Edition*. London: Government Statistical Service.

Department for Environment, Food and Rural Affairs (Defra) (2014). *2011 Rural-Urban Classification of Local Authority and other higher level geographies for statistical purposes. Interim results identifying rural hub towns to be used in the classification.* London: Defra.

Health Education England (HEE) (2018). *Facing the Facts, Shaping the Future. A draft health and care workforce strategy for England to 2027.* London: HEE

Office for National Statistics (ONS), Department for Environment Food & Rural Affairs (Defra), Department for Communities and Local Government (DLCG) & Welsh Government., (2013). *The 2011 Rural-Urban Classification for small area geographies: a user guide V1.0* London: Government Statistical Service.

Peckham, S, Marchand, C & Peckham, A., (2016). General practitioner recruitment and retention: An evidence synthesis. Centre for Health Service Studies, University of Kent.

Universities UK., (2012). *A picture of Health and Education*. London: Universities UK

Worsley, R & Cook, C., (2015). Looking to the future: the recruitment, retention and return of GPs. Summary and next steps report for NHS England. London: Ipsos MORI.

Appendix E: Topic Guide – Interviews

Information about informant

Name:

Date:

Job title / role:

Contact details: Email: Phone:

Affiliated to and or employed by (*some of this can be prepopulated prior to the interview*):

	Employed by	Affiliated to / member of	Notes
Health Education England	☐	☐	
Local Authority commissioning adult social care	☐	☐	
Adult social care provider	☐	☐	
Local Workforce Action Board	☐	☐	
Sustainability and Transformation Partnership	☐	☐	
Clinical Commission Group	☐	☐	
Professional body	☐	☐	
Voluntary Sector	☐	☐	
Higher Education (training)	☐	☐	
Higher Education (research)/Think tank/ other organisation undertake research	☐	☐	
Primary care / General Practice	☐	☐	
Secondary care	☐	☐	
Community of interest or practice in rural health care	☐	☐	

Broad questions

(1) Please briefly describe the rural area(s) within which you work and your role in the planning and delivery of health and social care?

(2) What do you consider to be the current main challenges and future challenges that need to be considered?

(3) In your opinion are there specific, or more particularly prevalent, factors that need to be considered when delivering health and social care services in rural areas/ the rural area where you work?

(4) Have you identified potential opportunities for improving health and social care services? – including the training, recruitment, development and retention of health and allied professionals in the rural areas you work?

Questions by themes identified in the strategy

Securing the supply of staff the health and care system needs to deliver high quality care in the future

(5) Do vacancies for particular job roles vary by local area? Are you aware of any systematic rural/ urban variations?

(6) Please describe the situation regarding recruiting and retaining staff from your organisational perspective.

(7) To what extent is your current situation determined by factors specific to, or of different magnitude, to those in urban centres?

(8) Are you reliant on non-UK workers in some job roles? If so, which? Do you think rural areas tend to be more reliant on non-UK workers for some job roles than urban areas? (If so, please describe)

(9) What do think are the main:

(a) Opportunities and Barriers in your local area (and for rural areas generally) to:

- Recruit, retain and develop staff
- Make use of Apprenticeships
- Make use of Nursing Associates (if applicable, please describe your use of Nursing Associates to date)
- Deliver high quality care in the future

(b) Approaches that might help to take advantage of opportunities/ address challenges

Enabling a flexible and adaptable workforce through investment in educating and training new and current staff.

(8) How is provision for educating and training, new and current, staff currently configured in your local area? How representative do you think this is of rural areas within England? Do you think there are specific challenges in developing the health and social care workforce in rural areas relative to urban areas? – if so, please describe

(9) How might training and education be reconfigured to?

    (a) meet the needs of potential recruits

    (b) meet the needs of existing staff

    (c) meet the needs of returning staff

    (d) enable the provision of a flexible and adaptable workforce that meets the health and care needs of your local area and rural areas generally within England?

    (e) engage groups currently under-represented in the workforce

(10) How can carers/ volunteers in rural areas be supported better? Are you aware of examples of good practice and/or new developments in your local area/ elsewhere? If so, please describe

Providing broad pathways for staff so they have careers, not just jobs (in the NHS and social care)

(11) What is the scope for career progression in your rural area? How does this vary between job roles? Would say this is typical of the NHS/ social care as a whole?

(12) What career development issues (*offer examples*) should be considered from a rural perspective? How are these different from urban areas?

(13) How would you like opportunities to change for health and social care staff to allow them to have a better career?

(14) Can you provide an example of where action is already being taken that might represent good practice - and why is this?

(15) What role is/ can technology (in health/ care) play in helping workers/ providing a better service for users – especially in rural areas? How do job roles need to be redesigned to maximize benefits?

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

(16) What approaches might be used to increase recruitment and retention from specific groups/backgrounds which are representative of the population of your rural area?

(17) Are there any particular groups / demographics you think could be targeted as part of a recruitment campaign?

(18) What do you consider (if any) to be the wider benefits to individuals and communities, the NHS and Social Care more widely of widening participation and creating new routes/opportunities?

Ensuring the NHS and other employers in the system are inclusive modern model employers

(19) What factors need to be considered in rural areas to ensure NHS and other employers are inclusive modern model employers? How do these factors differ in terms of priority and magnitude from urban areas?

(20) How might recruitment and employment practices be adapted to reflect the make-up and characteristics of a rural workforce?

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

(21) What are the main pressures that need to be considered? To what extent are these different in scope and magnitude in rural areas compared with urban areas?

(22) What mechanisms / fora are currently in place and how do they need strengthening?

(23) What impact do you think Brexit will have on the workforce issues you currently face? What can be done in the short-, medium- and long-term to ameliorate any negative impacts?

(24) Overall what would a successful recruitment and retention strategy look like for the NHS /adult social care in a rural setting?

Thank you and wrap up

Are there any points you like to add that you feel have not been covered in this interview?

[Thank interviewee, etc]

Appendix F: Selected Data Analyses: Key socio-demographic and economic indicators for rural and urban areas

This appendix presents selected key features of rural and urban areas (using the 2011 rural urban classification[63]), before secondly presenting some economic statistics for specific rural areas. It provides:

- An overview of the *demographic profile* of different areas – highlighting the older age profile of rural areas compared with the England average. Ceteris paribus this highlights the fact that there is likely to be particular competition amongst employers for young workers with a certain threshold of formal qualification achievement and employability skills in rural areas, as well as a need to recruit and retain other individuals throughout their working lives.

- A recent snapshot of *employment rates* and *inactivity rates* and trends in *unemployment rates* – emphasising that labour markets tend to be tighter (on average) in rural areas in comparison with urban areas. So before considering rural-specific issues such as travel difficulties, this highlights that, in aggregate, rural areas display particular labour supply constraints.

- A recent snapshot of the *qualification profile* and *occupational profile* of rural and urban areas. A key feature here is a lower than average share of the population of conventional working age with degree level qualifications in the mainly rural and largely rural categories. This suggests that attracting in-migrants to these areas may be important in filling some territorially-specific medical roles requiring higher level qualifications. The occupational profile data confirms a smaller share of employment in professional occupations in these areas.

- *Earnings* data for specific rural LEP areas shows that median earnings tend to be lower than the England average, particularly in more peripheral locations. This feature is more marked for workplace-based earnings than for residence-based earnings, suggesting that (at least some) rural residents may gain in monetary terms by taking jobs outside rural areas.

- *Employment projections* data highlight the fact that 'replacement demand' dominates 'expansion demand' in total projected requirements for labour over the medium-term. A focus on replacement demand emphasises that the need for labour in particular occupations/ sectors is (much) larger than statistics on net employment change (i.e. 'expansion demand' would indicate).

- Across the economy as a whole, data for selected rural LEP areas reveals a slightly higher incidence of skill-shortage vacancies and skill gaps than nationally.

The **demographic profile of the population** has implications for the size and age structure of the working population as well as for medical and care needs. Figure F1a presents population pyramids show the age structure of the population in 2011 (with males in red and females in green).

Figure F1a: Population profiles, 2011, for rural and urban areas

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[63] https://www.gov.uk/government/statistics/2011-rural-urban-classification

England

Relative to the England picture the rural areas display a lower share of residents in their twenties and thirties, with this being particularly apparent from the age of nineteen and in the early twenties. By contrast the two most urban categories display larger than average population shares in the younger working age groups. The shape of the pyramids that the *population is relatively older in rural areas* than the England average.

Mainly Rural

Largely Rural

Urban with significant rural

Urban with City and Town

Urban with Minor Conurbation

Urban with Major Conurbation

Source: Census of Population, 2011

Figure F1b shows population estimates by age for rural and urban areas.

Figure F1b: Changing Population and Age Profiles

(Source: Population Estimates by local authority)

Mean age – showing increasing mean age – especially in rural areas
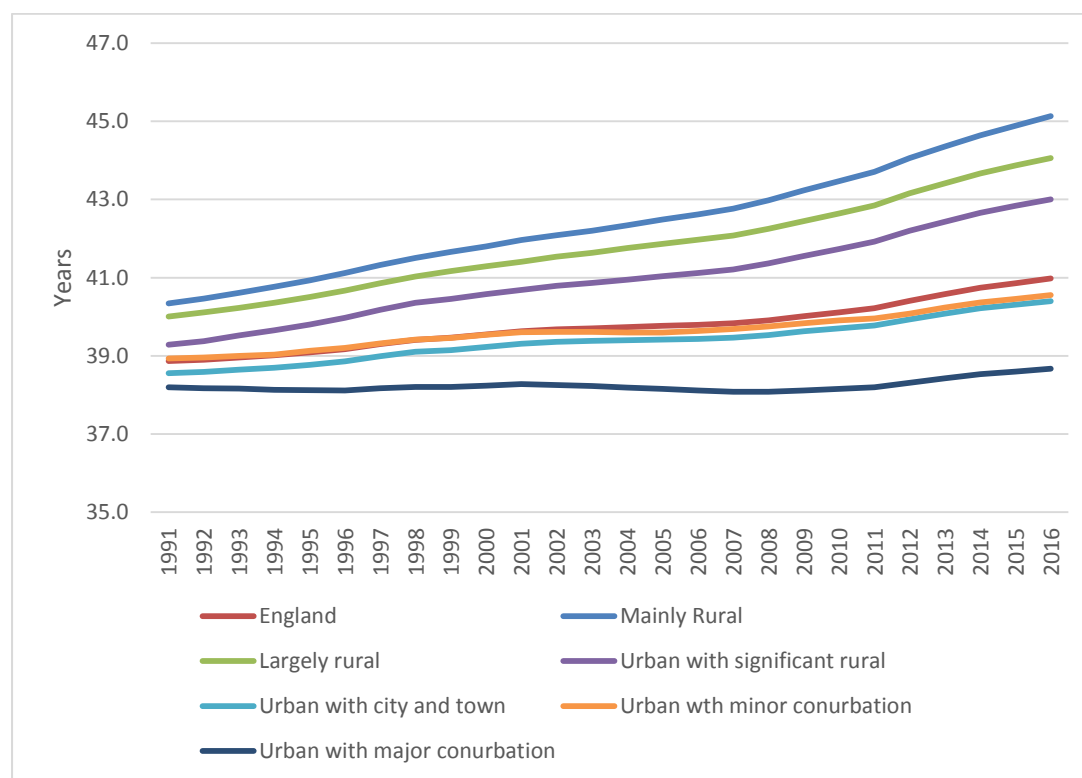
Total population – showing population growth over time, especially marked in the most rural categories
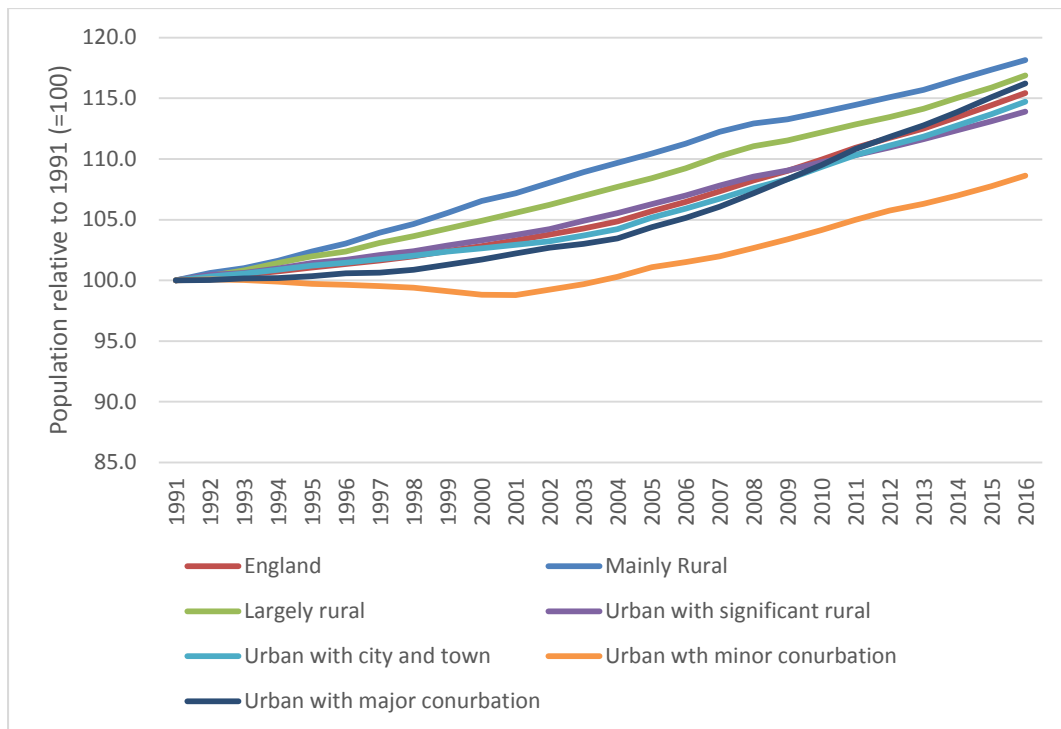
Age 0-15 – showing upturn in this age group in recent years, especially in the urban with major conurbation category
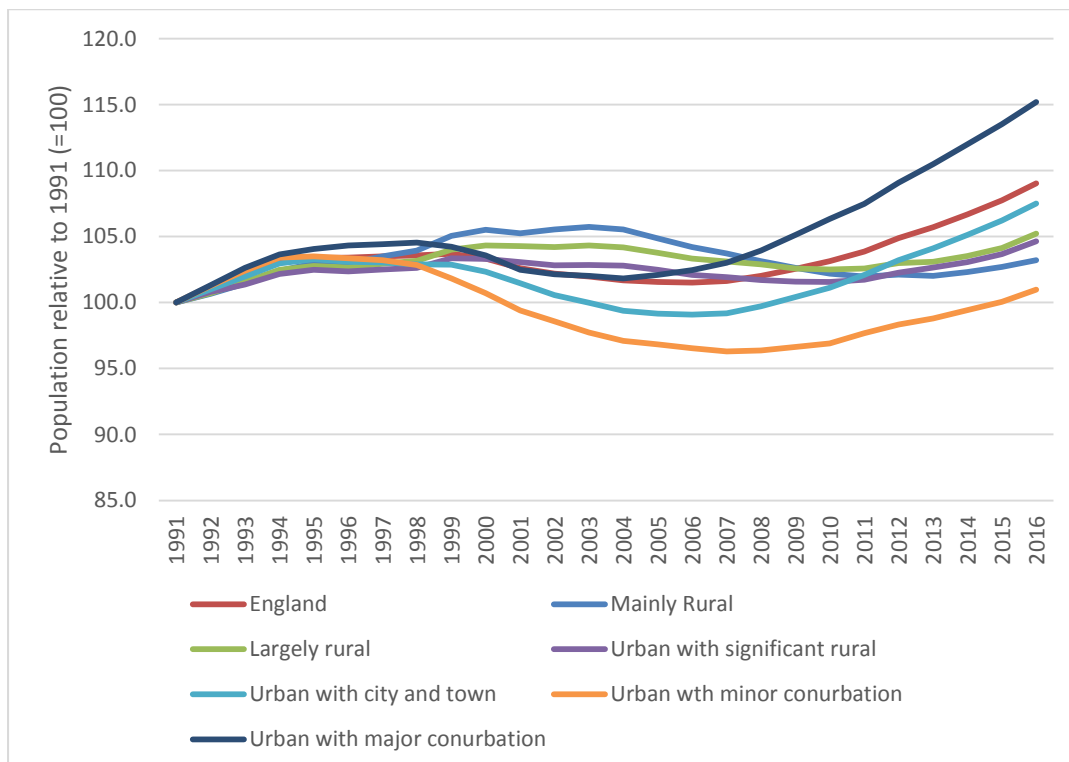
Age 16-24 – showing a reduction in numbers in this age group in rural categories
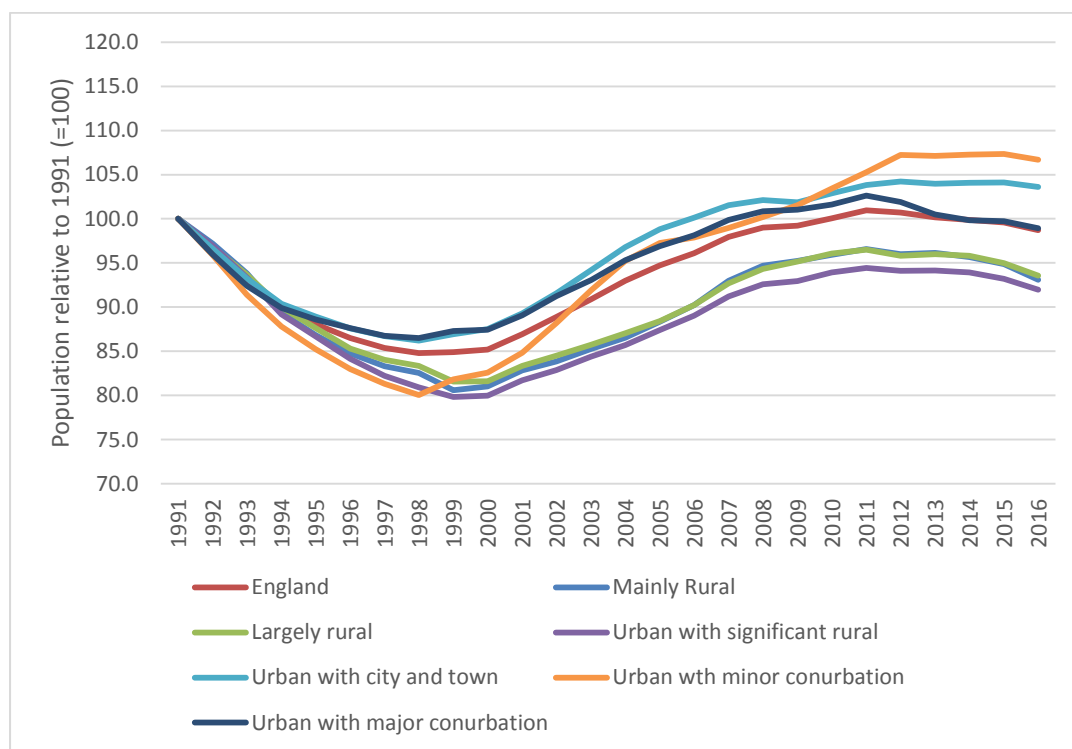
Age 25-49 – showing little change in this age group for rural categories, compared with a relatively large increase in the urban with major conurbation category
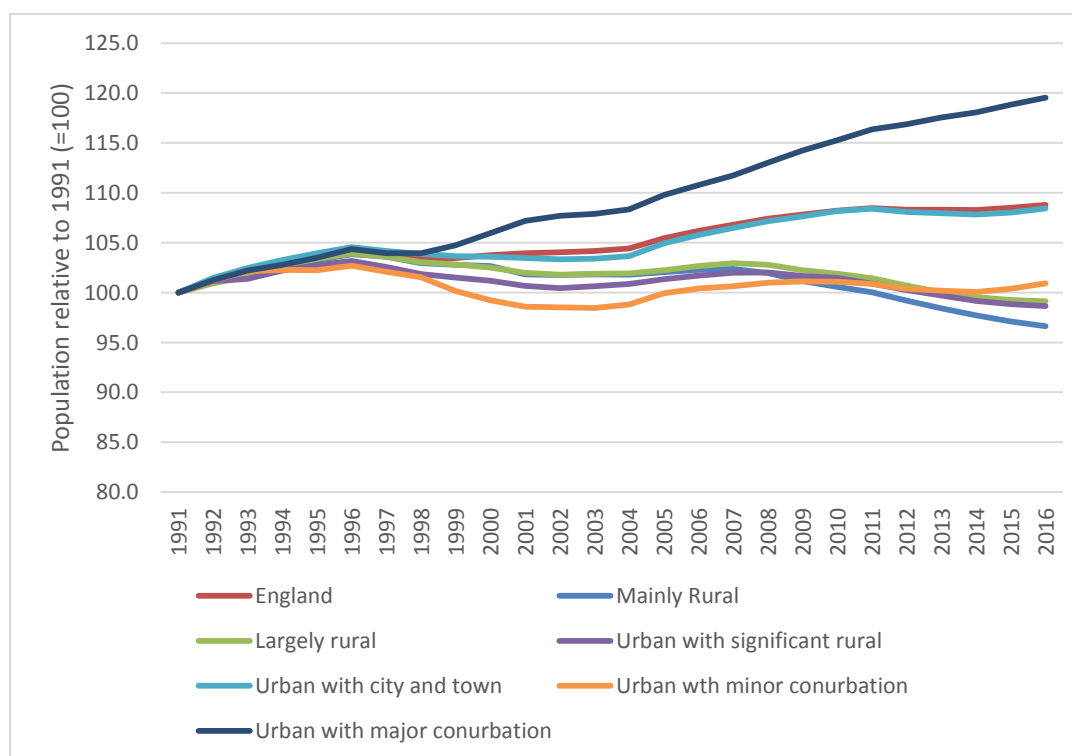
Age 50-64 – showing population increase in all categories, with this being most marked in the rural categories
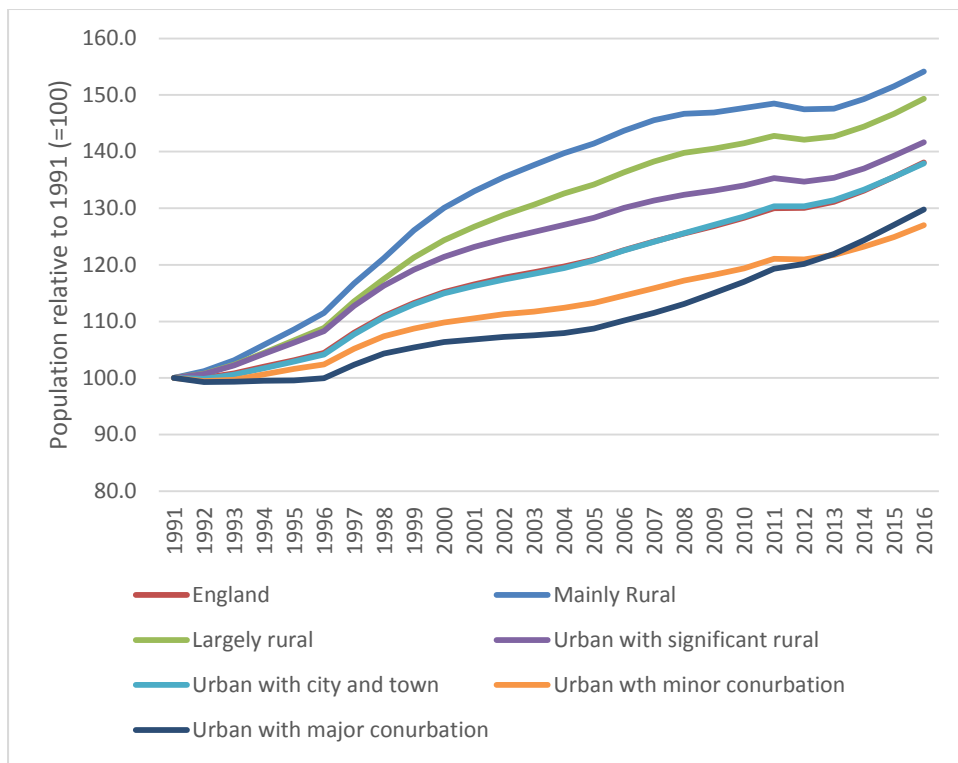
Age 65 and over –showing most marked population increase in rural categories
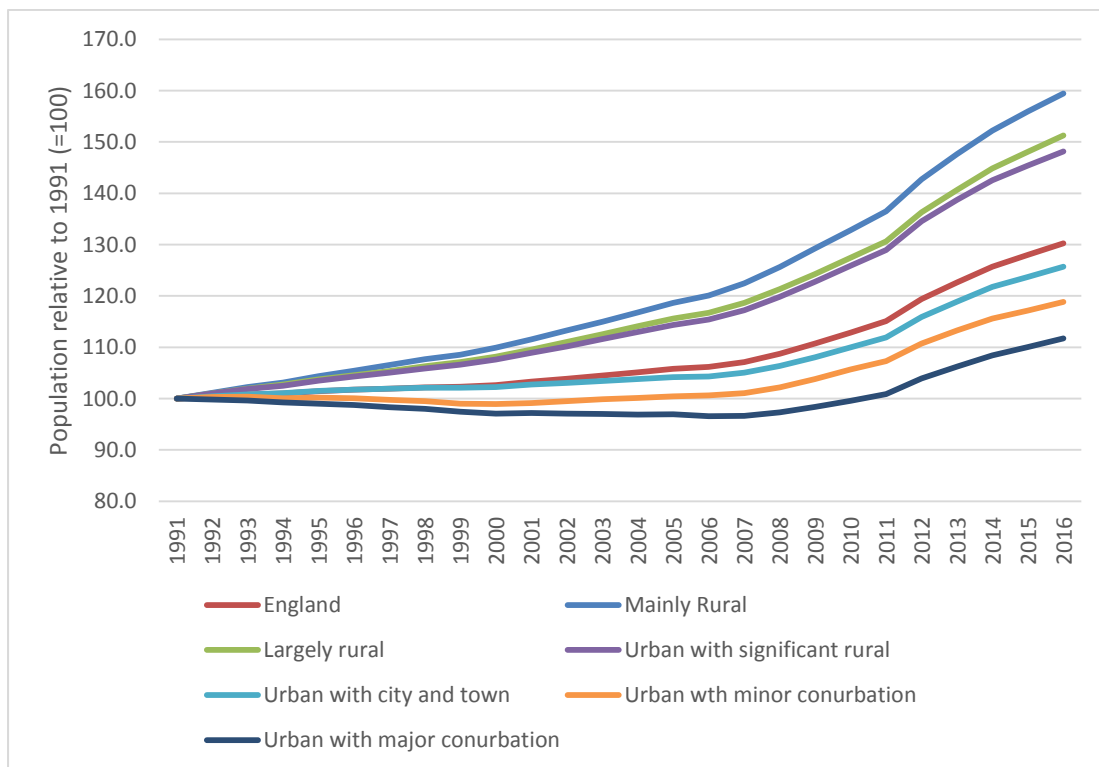
A key indicator of the ***relative tightness/ slackness of labour markets*** are employment rates (measuring the percentage of the population in employment), unemployment rates and economically inactivity rates (i.e. the percentage of the population not in employment or seeking employment.

Table F1 shows the ***employment rate*** for the conventional working age population (i.e. those aged 16-64 years) and for those in different age groups. The figures presented are for 2017 but the trend in recent years has been for an increase in employment rates, indicating a tightening of the labour market. Employment rates are lower in younger and older age groups than for those aged 25-49 years. Across all age groups ***employment rates are consistently higher in rural than in urban areas***.

***Table F1: Employment rates (%) by age group, 2017***

	Age group				
	16-64	16-24	25-49	50-64	65+
England	*75.1*	*53.9*	*84.0*	*71.4*	*10.5*
1 Mainly Rural	77.7	59.7	87.3	73.7	13.2
2 Largely Rural	78.4	60.4	87.2	74.2	11.9
3 Urban with Significant Rural	78.6	59.5	88.2	73.4	11.0
4 Urban with City and Town	75.4	55.1	84.5	71.4	9.3
5 Urban with Minor Conurbation	71.1	52.7	80.4	67.5	6.5
6 Urban with Major Conurbation	72.6	48.6	81.5	69.2	10.0

Source: Annual Population Survey, 2017

Figure F2 shows ***unemployment rates***[64] for rural and urban areas over the period from 2004 to 2017. There was a rise in unemployment in the recession, followed by a marked decline.

Figure E2 Unemployment rates, 2004-2017, for rural and urban areas
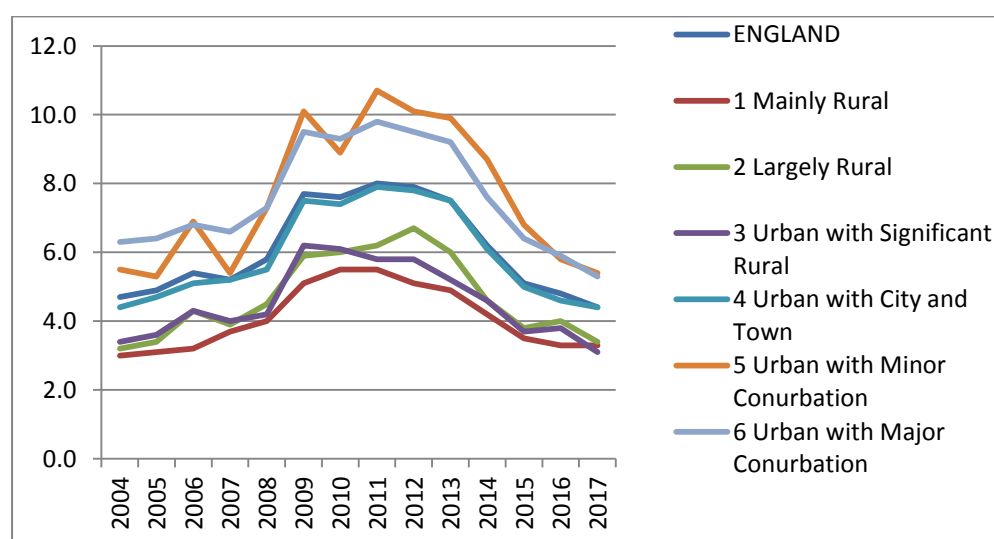
Source: Annual Population Survey, 2017

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64 Using the ILO definition.

Unemployment rates are consistently lower than the England average *in rural areas*.

Figure F3 shows economic inactivity rates for people of conventional working age. People in this category include those in full-time education and training, those with full-time caring responsibilities, early retirees and those who are sick. There is some potential for bringing some of the economically inactive into the workforce.

Figure F3: Percentage of those aged 16-64 who are economically inactive, 2004-2017, for rural and urban areas
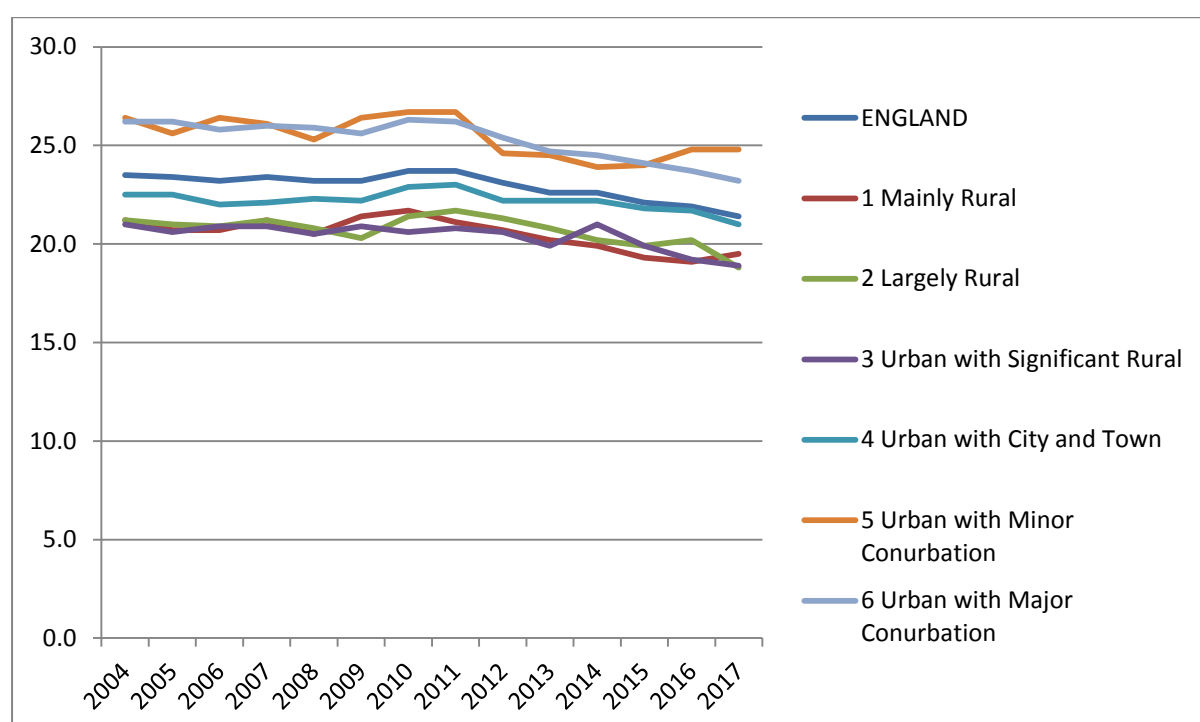
Source: Annual Population Survey, 2017

Rural categories are characterised by a l*ower than England average proportion of 16-64 year olds who are economically inactive*. The more urban categories have a higher than average proportion economically inactive. In recent years economically inactivity rates have declined, indicating a tightening labour market.

The Annual Population Survey provides information on a number of features of employment. Table F2 provides information by of formal *qualification levels* of the working age population.

Table F2: Percentage of 16-64 year olds with different qualification levels, 2017

	NVQ 4+	NVQ 3+	NVQ 2+	NVQ 1+	Other quals	No quals
England	*27.2*	*57.1*	*63.2*	*85.5*	*6.9*	*7.6*
1 Mainly Rural	26.9	57.1	66.5	88.9	5.2	5.9
2 Largely Rural	27.0	56.8	66.2	87.7	5.8	6.5
3 Urban with Significant Rural	28.1	57.6	66.0	88.8	5.4	5.9
4 Urban with City and Town	25.5	55.5	63.0	85.5	7.1	7.4
5 Urban with Minor Conurbation	22.7	52.6	59.7	84.0	6.9	9.1
6 Urban with Major Conurbation	28.7	58.6	60.9	83.1	8.1	8.8

Source: Annual Population Survey, 2017

In the rural categories a higher share of the population aged 16-64 has qualifications at NVQ levels at Levels 1 and 2 (i.e. at GCSE grades A-C or below) than the England average and a similar proportion have qualifications at Level 3. In Mainly Rural and Largely Rural Areas the proportion with qualifications at degree level (i.e. NVQ Level 4+) is lower than the England average). In Urban Areas with Significant Rural the share with such qualifications is higher than the England average; only the Urban with Major Conurbations category displays a higher share. The share of the population aged 16-64 with no qualifications is lower than the England average in the rural categories. Figure F4 shows the ***occupational profile*** of employment in rural areas across all sectors.

Figure F4: Occupational profile of employment by SOC Major Group, 2017
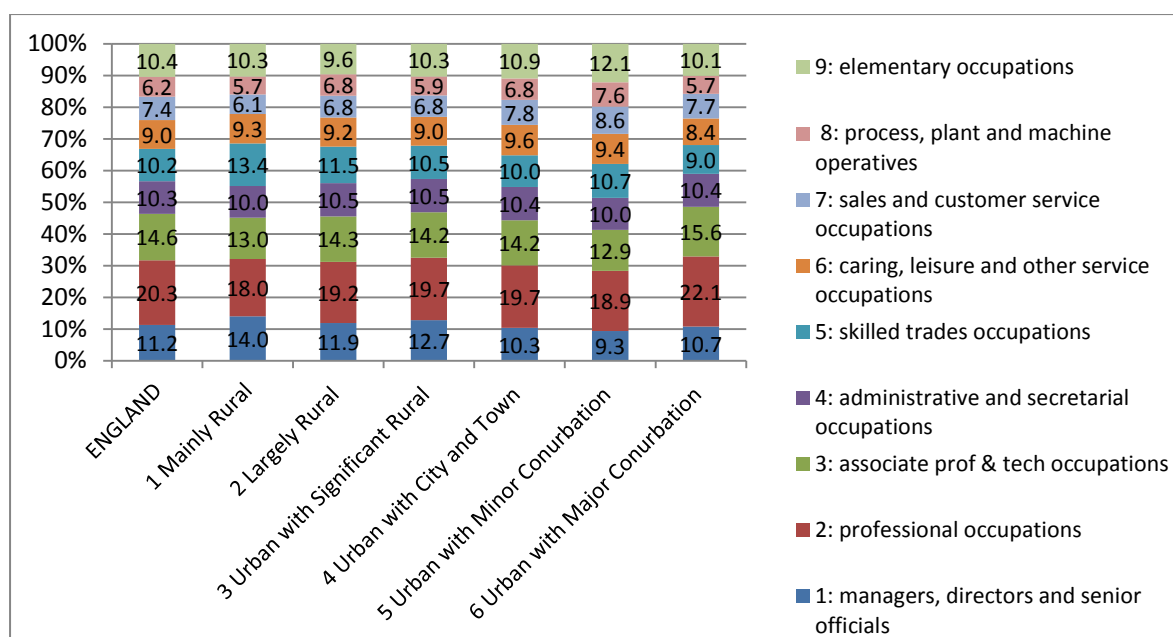
Source: Annual Population Survey, 2017

In general, the differences in the occupational profile of the rural-urban categories are not particularly marked. The Urban with Major Conurbation category has the most distinctive occupational structure, with a higher than England average share of the population in 2: professional occupations and 3: associate professional & tech occupations. All other rural-urban categories have

slightly lower than England average shares of employment in these occupations. Mainly rural and largely rural areas have higher than England average shares of employment in skilled trades occupations and in caring, leisure and other service occupations.

Selected statistics for selected local areas

Some insights into circumstances in specific local areas using selected other statistics are presented for three areas classified as more 'rural' than the England average: Cornwall & Isles of Scilly (IOS), Lincolnshire and Coventry & Warwickshire are used as exemplars here. The two former are amongst the most rural areas in England, while the latter is only slightly more rural the England average. Table F3 presents information on **median gross hourly earnings** in 2017. A distinction is made between residence-based and workplace-based statistics.

Table F3: Median gross hourly earnings, 2017 – selected areas

	England	Cornwall & IOS	Lincolnshire	Coventry & Warwickshire
Residence-based				
Male	14.00	11.50	11.98	14.73
Female	11.24	9.69	9.63	10.87
Total	12.59	10.51	10.82	12.64
Full Time Workers	14.17	11.73	11.79	14.15
Part Time Workers	9.15	8.56	8.46	9.09
Workplace-based				
Male	14.00	11.00	11.63	14.41
Female	11.24	9.50	9.47	10.57
Total	12.59	10.16	10.54	12.46
Full Time Workers	14.17	11.40	11.46	13.88
Part Time Workers	9.13	8.55	8.37	9.10

Source: Annual Survey of Hours and Earnings, 2017

In all three local areas **median gross hourly earnings are lower than the England average**. This is most marked in the most rural areas: Cornwall & Isles of Scilly and Lincolnshire, whereas in Coventry and Warwickshire workplace earnings are close to the England average. Indeed, in the latter area male median earnings are slightly higher than the England average. It is also apparent that **workplace-based median earnings are lower than residence-based median earnings**. This indicates that gross median earnings in workplaces in rural areas are lower than in urban areas. Some rural residents work in urban areas where, on average, they can earn more.

Projected employment change

Working Futures labour market projections provide information on projected employment changes over the medium-term. The latest available projections provide information for the period from 2014 to 2024.[65]

Table F4 shows the ***changing occupational profile*** (measured at the Standard Occupational Classification Major Group level) of employment across ***all industries*** in ***England***. Key features of change are:

- A projected overall increase in employment over the ten-year period of nearly 6 per cent.
- Occupations with a larger than average percentage increase in employment (i.e. net change) are managers, directors and senior officials; professional occupations; associate professional & technical occupations and caring, leisure & other service occupations.
- There are projected net employment losses for administrative & secretarial occupations and process, plant & machine operatives.
- Importantly, total requirements for labour over this period are evident for all occupations because replacement demands[66] are positive for all occupations. This means that even in occupations experiencing a net decline in employment the total requirement is positive.

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[65] *Working Futures 2014-2024* is the latest in a long series of labour market assessments produced by the Warwick Institute for Employment Research in collaboration with Cambridge Econometrics; (a further update is expected in 2019). The full report and associated Annexes can be found at https://www.gov.uk/government/publications/uk-labour-market-projections-2014-to-2024
[66] *Expansion demand* is the term used to describe the net change in the number of job openings as a result of growth/ (decline) in an occupation/sector. *Replacement demand* is the number of openings created by people leaving the labour market (measured here using retirements, although inter-occupational mobility also creates job openings). The total requirement is the sum of expansion demand (i.e. net change in employment) and replacement demand.

Table F4: Occupational employment projections – all industries, England

Employment Levels (000s)

	1994	2004	2014	2024	Net Change, 2014-2024	Replacement Demands	Total Requirement
1. Managers, directors and senior officials	1,765	2,342	2,904	3,345	441	1,221	1,661
2. Professional occupations	3,387	4,453	5,652	6,402	750	2,250	3,000
3. Associate professional and technical	2,758	3,459	4,040	4,508	468	1,504	1,972
4. Administrative and secretarial	3,427	3,323	3,004	2,663	-341	1,268	927
5. Skilled trades occupations	3,224	3,164	2,989	2,931	-58	1,076	1,018
6. Caring, leisure and other service	1,432	2,046	2,675	3,030	355	1,184	1,540
7. Sales and customer service	1,829	2,099	2,195	2,203	8	798	805
8. Process, plant and machine operatives	1,984	1,840	1,733	1,624	-109	656	547
9. Elementary occupations	2,876	3,156	3,044	3,158	114	1,215	1,329
Total	*22,683*	*25,882*	*28,235*	*29,862*	*1,627*	*11,172*	*12,799*

Percentage Shares	**1994**	**2004**	**2014**	**2024**	**% change, 2014-2024**		
1. Managers, directors and senior officials	7.8	9.0	10.3	11.2	15.2	42.0	57.2
2. Professional occupations	14.9	17.2	20.0	21.4	13.3	39.8	53.1
3. Associate professional and technical	12.2	13.4	14.3	15.1	11.6	37.2	48.8
4. Administrative and secretarial	15.1	12.8	10.6	8.9	-11.4	42.2	30.8
5. Skilled trades occupations	14.2	12.2	10.6	9.8	-1.9	36.0	34.0
6. Caring, leisure and other service	6.3	7.9	9.5	10.1	13.3	44.3	57.6
7. Sales and customer service	8.1	8.1	7.8	7.4	0.3	36.3	36.7
8. Process, plant and machine operatives	8.7	7.1	6.1	5.4	-6.3	37.9	31.6
9. Elementary occupations	12.7	12.2	10.8	10.6	3.7	39.9	43.7
Total	100	100	100	100	5.8	39.6	45.3

Source: Working Futures 6.

Table F5 presents similar information focusing solely on the *health and social work sector*. In England this sector is projected to see net declines in employment for administrative & secretarial occupations, elementary occupations, skilled trades occupations and process, plant and machine operatives (albeit in the latter two cases the projected decreases are modest and from a small base. Replacement demand accounts for the majority of the projected total requirement for labour over the projection period. In absolute terms the projected net requirements are largest for caring, leisure and other service occupations; professional occupations and associate, professional and technical occupations. Together caring, leisure and other service occupations and professional occupations account for more than two-thirds of employment in the health & social work sector.

Table F5: Occupational employment projections – health and social work, England

Employment Levels (000s)

	1994	2004	2014	2024	Net Change, 2014-2024	Replacement Demands	Total Requirement
1. Managers, directors and senior officials	54	101	156	161	5	62	67
2. Professional occupations	610	778	1,061	1,149	88	419	507
3. Associate professional and technical	244	327	439	472	33	163	196
4. Administrative and secretarial	413	345	338	231	-107	131	24
5. Skilled trades occupations	71	61	44	32	-12	18	6
6. Caring, leisure and other service	681	980	1,311	1,472	161	563	724
7. Sales and customer service	21	27	44	40	-4	15	12
8. Process, plant and machine operatives	19	20	19	15	-4	7	3
9. Elementary occupations	191	131	91	60	-31	31	0
Total	*2,304*	*2,772*	*3,502*	*3,631*	*129*	*1,409*	*1,539*

Percentage Shares	**1994**	**2004**	**2014**	**2024**	**% change, 2014-2024**		
1. Managers, directors and senior officials	2.3	3.6	4.5	4.4	3.4	39.8	43.2
2. Professional occupations	26.5	28.1	30.3	31.6	8.3	39.5	47.8
3. Associate professional and technical	10.6	11.8	12.5	13.0	7.5	37.2	44.7
4. Administrative and secretarial	17.9	12.5	9.7	6.4	-31.6	38.7	7.0
5. Skilled trades occupations	3.1	2.2	1.2	0.9	-27.7	40.5	12.8
6. Caring, leisure and other service	29.6	35.4	37.4	40.5	12.3	42.9	55.2
7. Sales and customer service	0.9	1.0	1.3	1.1	-8.2	35.1	26.9
8. Process, plant and machine operatives	0.8	0.7	0.5	0.4	-20.1	36.2	16.1
9. Elementary occupations	8.3	4.7	2.6	1.6	-34.5	34.5	-0.1
Total	*100*	*100*	*100*	*100*	*3.7*	*40.2*	*43.9*

Source: Working Futures 6.

Focusing specifically on occupations most associated with the health and social care sectors, Figure F5 provides insights into projected net requirements for three more detailed occupational groups: health professionals, health & social care associate professionals and caring personal service occupations. In all instances replacement demands are greater than expansion demands.

Figure F5: Components of projected net employment requirements, 2014-2024, England

Health professionals

thousands

| | Expansion demand | Replacement demand | Net requirement |

Health and social care associate professionals

thousands

| | Expansion demand | Replacement demand | Net requirement |

Caring personal service occupations
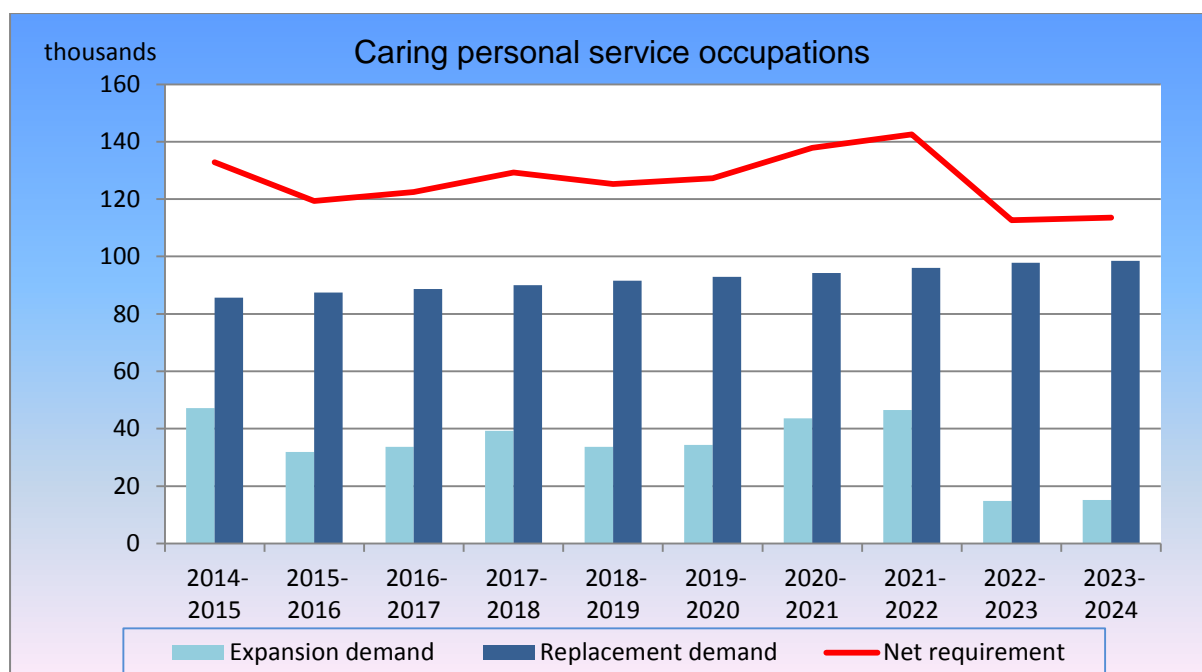
Source: Working Futures 6.

There are Working Futures projections at LEP are level.[67] As an illustrative insight into one of the local areas – **Greater Lincolnshire**[68], Table F6 shows the changing occupational profile (measured at the Standard Occupational Classification Major Group level) of employment across all industries, while Table F7 displays the same information for the health & social care sector. The general patterns of occupational change are similar to those evident at the England scale.

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[67] It should be noted that projections are less robust at local than at national level, and hence should be interpreted with caution.
[68] Note that these projections are for Greater Lincolnshire (i.e. including North Lincolnshire and North East Lincolnshire as well as the Lincolnshire County Council area).

Table F6: Occupational employment projections – all industries, Greater Lincolnshire

Employment Levels (000s)	1994	2004	2014	2024	Net Change, 2014-2024	Replacement Demands	Total Requirement
1. Managers, directors and senior officials	30	39	46	51	6	19	25
2. Professional occupations	51	63	79	88	9	31	40
3. Associate professional and technical	41	48	56	62	6	20	26
4. Administrative and secretarial	52	51	47	42	-5	20	15
5. Skilled trades occupations	62	62	54	52	-3	20	17
6. Caring, leisure and other service	28	39	54	61	8	24	32
7. Sales and customer service	32	39	39	40	1	15	15
8. Process, plant and machine operatives	46	44	42	40	-2	15	13
9. Elementary occupations	55	56	57	59	2	23	25
Total	*396*	*441*	*473*	*494*	*21*	*186*	*207*
Percentage Shares	*1994*	*2004*	*2014*	*2024*	*% change, 2014-2024*		
1. Managers, directors and senior officials	7.5	8.8	9.7	10.4	12.5	41.3	53.8
2. Professional occupations	12.8	14.2	16.6	17.7	11.2	39.0	50.2
3. Associate professional and technical	10.3	10.9	11.8	12.5	10.5	36.3	46.9
4. Administrative and secretarial	13.0	11.6	9.9	8.5	-10.0	42.9	33.0
5. Skilled trades occupations	15.6	14.1	11.5	10.4	-5.3	35.9	30.6
6. Caring, leisure and other service	7.2	8.9	11.4	12.4	14.1	44.4	58.5
7. Sales and customer service	8.1	8.9	8.2	8.0	1.9	37.7	39.6
8. Process, plant and machine operatives	11.7	9.9	8.9	8.1	-5.3	36.9	31.6
9. Elementary occupations	13.9	12.8	12.0	11.9	3.7	39.6	43.3
Total	*100.0*	*100.0*	*100.0*	*100.0*	*4.5*	*39.3*	*43.8*

Source: Working Futures 6.

Table F7: Occupational employment projections – health and social work, Greater Lincolnshire

Employment Levels (000s)

	1994	2004	2014	2024	Net Change, 2014-2024	Replacement Demands	Total Requirement
1. Managers, directors and senior officials	1	2	3	3	0	1	1
2. Professional occupations	12	14	17	18	1	7	8
3. Associate professional and technical	5	6	7	7	0	3	3
4. Administrative and secretarial	8	6	5	3	-2	2	0
5. Skilled trades occupations	1	1	1	0	0	0	0
6. Caring, leisure and other service	15	21	26	30	4	11	15
7. Sales and customer service	0	0	1	1	0	0	0
8. Process, plant and machine operatives	0	0	0	0	0	0	0
9. Elementary occupations	4	3	1	1	-1	1	0
Total	*47*	*53*	*60*	*63*	*3*	*24*	*27*

Percentage Shares	*1994*	*2004*	*2014*	*2024*		*% change, 2014-2024*	
1. Managers, directors and senior officials	2.1	3.5	4.2	4.1	1.8	40.1	41.9
2. Professional occupations	25.2	26.7	27.6	28.5	7.4	39.4	46.8
3. Associate professional and technical	10.0	10.9	11.2	11.4	6.5	37.5	44.0
4. Administrative and secretarial	16.7	11.1	8.5	5.5	-32.7	38.4	5.6
5. Skilled trades occupations	3.2	2.1	1.1	0.7	-37.3	40.0	2.7
6. Caring, leisure and other service	32.2	39.3	43.3	47.1	13.6	43.0	56.6
7. Sales and customer service	0.9	0.9	1.1	1.0	-8.3	35.2	26.8
8. Process, plant and machine operatives	0.8	0.6	0.5	0.3	-38.8	34.5	-4.3
9. Elementary occupations	8.9	5.0	2.5	1.5	-38.8	34.0	-4.8
Total	*100*	*100*	*100*	*100*	*4.3*	*40.5*	*44.8*

Source: Working Futures 6.

Vacancies and skills gaps, 2015

Insights into vacancies (on the external labour market) and skills gaps (in the internal labour market are presented in Table F8.[69] The statistics relate to all industries; (the position for the health and care sectors could be different).

A greater proportion of establishments in Coventry & Warwickshire display vacancies than nationally (this could reflect the greater incidence of manufacturing establishments in this local manufacturing establishments are more likely than average to record vacancies). There is also a greater than average share of skill-shortage vacancies in this local area. Although Cornwall & the Isles of Scilly and Greater Lincolnshire both display slightly lower proportions of establishments with vacancies than the England average, the share of all vacancies that are skill-shortage vacancies is slightly higher than nationally.

In all three of the selected local areas the percentage of establishments reporting skills gaps within the existing workforce is slightly greater than average.[70] This highlights an ongoing need for workforce development for employees – and underlines the need to address any rural-specific structural barriers placing challenges to this.

Table F8: Summary of vacancies and skills gaps, 2015

	England	Cornwall & IOS	Greater Lincs	Coventry & Warks
Unweighted row	*75129*	*963*	*1746*	*1287*
Total	*1488201*	*18654*	*29003*	*23552*
Vacancies				
Establishments with any vacancies	20%	17%	18%	25%
Have at least one vacancy that is hard to fill	8%	8%	7%	12%
Have a skills shortage vacancy (prompted or unprompted)	6%	5%	6%	8%
Number of vacancies	797440	6504	11976	14092
Number of skill-shortage vacancies	180159	1723	2889	3621
Number of vacancies as a % of all employment	3%	3%	3%	4%
% of all vacancies which are SSVs	23%	26%	24%	26%
Skills gaps				
% of establishments with any staff not fully proficient	14%	16%	15%	19%
Number of skills gaps (absolute figures)	1184701	8424	18669	25580
Number of staff not fully proficient as a % of employment	5%	4%	5%	6%

Base: All establishments

Source: Employer Skills Survey, 2015

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[69] The data presented here relates to 2015. Information from the Employer Skills Survey 2017 is due for publication in 2018.

[70] It should be noted that skills gaps may occur amongst new staff who are not fully proficient, as yet. Skills gaps also occur when workers' roles change and they do not have all of the skills necessary to perform them.

Appendix G: Qualitative Findings from Interviews, Sandpits and Group Discussions

Interviews

Theme	
Lack of awareness of rurality	• The UK is very different to Australia (more sparsely populated) where rural health care is taken very seriously in terms of the challenges it presents.
Proximity to large urban centre is a factor in terms of labour market	• Access to large labour market within an easy commute affects the attractiveness of local opportunities for NHS and social care workers. For example, Kent is close to the London labour market which is much bigger and provides more opportunities for advancement. London weighting is attractive to staff and the commute to London is often no longer a deterrent with HS1 having significantly cut journey times. Similarly, HS1 has also resulted in highly qualified clinicians moving into the area because journey times into London are shorter than travelling within London on the tube.
Affluence and deprivation are strong factors	• More remote rural areas are often more deprived because of lack of employment opportunities, especially where traditional industries such as fishing and coal mining have declined. • Deprivation drives demand for services in a number of ways. It can lead to increases demand areas due to higher levels of morbidity, and populations in deprived area more likely to exhibit unhealthy behaviours. • Deprivation can affect the pool of potential NHS workers due to poorer educational outcomes in less affluent areas. There has also been recently been a prevalence of coasting schools in rural areas leading to under attainment, lower skills that reduces the supply of potentially qualified workers. However, NHS potentially provides a second chance for adults poorly served by education system to build meaningful careers, • House prices are significant multiples of average earnings and rents can make up a significant proportion of household income. • In more affluent rural areas (commuter belt) being a carer is not seen as having a proper job. • Some rural areas (coastal towns) demand is being driven by asylum seekers who are being housed in cheap accommodation or because they near the port of entry.
Accessibility and travel times	• Isolation is significant factor, for example, some parts of coastal Kent are really difficult to get to. Coastal towns are described as being bordered by the sea often with only one way in and having significant pockets of deprivation. • Travel distances and times are an issue for both staff and patents. While specialist centres may only be 20 to 30 miles away journeys can be nightmare for patients. There is a lack of public transport with large specialist centres tending not to be near rail stations. Similarly, access to training can be limited because of travel and drug distribution and access to pharmacists are more problematic. Distance people prepared to travel to work is a significant workforce issue with rural areas generally lacking infrastructure.
Reliance on old staffing and delivery model which is reflected in targets	• The NHS delivery model has not changed much in 70 years. There are unrealistic targets based around traditional job roles set by the centre. • Some areas are looking locally how they might do things differently if they use different workforce, professional training or competencies. • There is the need to acknowledge the importance of' appropriately trained and unqualified staff' in delivering care. The focus is too much on doctors and nurses and [the system] needs to consider and value other roles such as nursing assistants working alongside nurses.
More modern workforce	• A modern workforce would involve greater integration of skills sets and working in networks to provide services. It would involve new roles such as nurse associates, physician associates that currently are limited in what they can do by regulation and require supervision. In some rural areas in the South West, Trusts have no choice but to employ these new roles because they are so short of staff – and these roles are working well.
Quality work environment	***Estate***

	• The provision of rural healthcare is hampered by underinvestment resulting in buildings that are not fit for purpose - many district hospitals are dated and in poor condition, poorly equipped to provide modern healthcare
	• Where improvements have been made through public finance initiative such as PFI Hospitals the cost of servicing contracts has been significant proportion of Trusts incomes.
	• There is anecdotal evidence that where there is modern fit for purpose buildings recruitment and retention is not an issue especially when combined with MDT working and modern service delivery
	Reduce stress level to improve retention
Safe staffing levels	• Not possible to have A&E in every town
Increase training places	• Not always possible to fill
NHS Planning	• There is view that there is a <u>one size fits all policy</u> when it comes to planning.
	• One interviewee felt that <u>size of units made no difference</u> to quality of planning. Larger units resulted in larger geographer but did not significantly reduce costs or improve services. Planning had been significantly affected by fragmentation caused reorganisation of NHS. That there was the <u>need to free up people in the health system to be able to work on the forward planning</u> of workforce and to build momentum around workforce issues
	• <u>Non demographic changes such as new housing estates</u>: NHS financial planning does not take account of new housing developments taking place in rural areas, or local housing targets. It is only when new residents are on GP roles that additional funding is made available.
STP workforce planning across health and social care	• The workforce plan is across health and care. There's a really tricky issue with the <u>care sector where the jobs are low paid</u> and the providers have to compete with other sectors with better paid jobs. We're looking at developing <u>career pathways from the care sector into the health sector</u> e.g. you could start as a care assistant but there would be a pathway into training as a nurse.
	• We are looking at being an <u>Integrated Care Partnership</u> – with passports so people can work flexibly between health and care and have flexibility too in terms of rotation, department, location etc.
	• In Cornwall this workforce planning works because it is all NHS / public sector so we can manage it. Where community services are outside of the NHS this can make it difficult to share and rotate staff between NHS and private companies. For example, we're looking to rotate in the care home sector as we think that will make the most impact in reducing hospital admissions.
	• We're developing <u>place based models of care</u> – what are the needs and what are the facilities in localities? We're doing a piece of work with the AHSN on travel and access times to health and care.
	• We're currently developing a <u>3-year financial allocation</u> as part of the plan.
The extent to which recruitment vs retention is more challenge varies by area reflecting local context	• There were differences in the areas included in this study in terms of whether recruitment or retention was more challenging. Recruitment was less of an issue in Kent. This is because providers have been willing to invest the effort in lots of initiatives like open days, keeping perspective candidates warm and making them feel welcome that have been very successful. The issue was more retention, as recruits can move into London labour market once they are experienced. Providers need to be model employers to keep staff – <u>best place to work model</u> employer type of approach based on research. People leave managers not employers and middle managers are forced to focus on delivery rather than pastoral care. Cannot solve shortages by increasing university places in rural areas, as there is not enough young people to fill the vacancies, who have many other options due to low employment.
	• Whereas, retention less of an issue than recruitment in Herefordshire as travel times were much greater to the nearest conurbations. There was a view that recruits 'once they get the work don't want to leave the NHS'.
	• It is acknowledged that everywhere has shortages in all roles. In Kent there is particular acute shortage of GPs.
	• HEE has a Targeted Enhanced Recruitment Scheme (TERS) for GPs in England which offers a one off payment of £20,000 to GP trainees committed to working in places where it has been hard to recruit in the last 3 years. For some GPs this is attractive but

	often they don't stay on. We're spending money on moving the problem around rather than tackling the underlying issues i.e., by moving GPs to hard to recruit areas the places they are moving from may then find it harder to recruit. There is an infinite staff resource. The recruitment envelope we have is not meeting supply • The recruitment gaps in Cornwall mirror national capacity gaps. • Workforce growth needs to be via new graduates, retention of staff and returning staff to practice. • We need to keep current staff in the workplace – by offering flexible working, incentives such as career sideways moves into another team or department. NHS Improvement is writing the retention section of the HEE workforce strategy and I'm led to believe they recognise this is the one thing we have control over here and now. • The public sector here is well paid and an attractive employer compared to the private sector. Once people work here they don't tend to move as they are well paid. • We're all looking for supply and it's not there and you can turn on the taps to generate more doctors and nurses but that takes time and we're still haemorrhaging then. Right now securing the supply of staff in all areas means holding onto our current workforce and helping them to stay in health and social care for longer. • We need a flexible and streamlined approach to the health and care workforce • While we have data on retention and turnover there are no standard records on where staff go (e.g. to agencies, bank, locum). There's also no standard national vacancy system making it more difficult to see where the vacancies and gaps in the workforce are. • We need better data and modelling to understand supply of healthcare workforce, social care workforce, local authority workforce (e.g. learning disabilities, health visitors, children's services) and general practice. • The social care workforce needs consideration.
Attractiveness of working in rural areas	• Rural areas tend to be more attractive to people coming towards the end of their career. • We find it <u>difficult to compete as a workplace of first choice</u> given our rurality – we are very peripheral to the centre and we find people coming to work in Cornwall do so because for them it's a lifestyle choice. • <u>The importance of lifestyle / work-life balance:</u> One important factor is having enough clinicians within close reach to provide on-call service. In urban areas this is less of an issue as there is a larger pool of clinicians, allowing staff to have a better work-life balance. Do you choose to work in a cathedral city such as Hereford as it is nice place to live or urban centre where there are many more clinicians so you actually have time off to live? • Attracting young people is dependent on <u>amenities and whether there is a buzz.</u> University towns with medical schools tend to do better than coastal towns where people just go to retire. Some specialties are more difficult to recruit than others – in rural areas there is the added difficulty that for young doctors the greater attraction is to work in a large urban area. This is because of the complexity of the work they can do there, the better transport links to see family and friends, and environmental factors (e.g. bars, restaurants). • There is a big problem recruiting GPs in some urban places – e.g. Plymouth which is distant from other places and not buzzing; as well as in rural parts of Devon and Cornwall. In rural areas which are not too distant from an urban centre they really struggle and without the trainees HEE provides the whole system, the whole trust would collapse. • There is generally the view could do more to <u>sell the benefits of working in and living in the shires more</u>. • Posts can be more attractive where an NHS employer is seen to be cutting edge, or have a specialism, or known for doing something well. • The cost of accommodation/housing for the workforce in Cornwall is much higher than in other areas.
Major employer *Educating people about the benefits of working for the NHS*	• The NHS is often the largest employer (not just) in rural areas and can provide a greater range of employment opportunities and opportunities for career progression and job satisfaction and job security and a pension. • Could promote better all the different roles

Opportunity to market the NHS	• Target young children • Model a campaign on the Army campaign (born in, made in NHS)
Reliance on non-UK workers	• It is not clear whether the NHS and social care providers in rural areas are more reliant or less on non-UK workers, though there is reliance for some job roles and there are concerns about BREXIT which is affecting auxiliary staff as much as clinical. • Relaxation of immigration cap would help with recruitment. Interviewees referred to doing a lot of international recruitment in nurses and consultants. • There was a call for honesty around the fact that NHS would always need to recruit a percentage of its workforce from aboard even with all the initiatives to support home grown talent. • The Government has announced it will no longer cap the number of non-EU doctors and nurses coming to the UK. We've found with Brexit doctors are more reassured than nurses (particularly those working in care homes) about their future residency.
The seasonality of the workforce	• In some rural areas there is a seasonal workforce and this can place specific demands on health service provision.
Access to and take up of training opportunities	• Travel time is seen as particular barrier to attending training events by staff based on rural areas. One solution has been the use of webinars. There is the need to free up time for staff to attend training and education often this not is even possible for mandatory training. New staff start they quickly get impression from colleagues there no time and little opportunity for further training and education • There is the view that providers may rely too much on HEE to organise and provide training – especially GPs – when part of the tariff includes an element for training. CCQ should look at training as part of their inspection. If training has been identified for the operational needs and safety then should be undertaken
Opportunities for progression	• Views varied from rural areas being similar to other areas to it may be greater harder with larger organisations covering greater geographical areas making it difficult for people to be recognised and promoted. Career planning is more difficult due to change in the system. A nurse might spot their dream job and start preparing for it and may not be there in 2-3 years' time. There has been planning blight due to recruitment freezes. Generally opportunities for progression are seen as good but there is often an issue in backfilling posts.
Career pathways	• There have been negative effects from consolidation. Investment in larger specialist centres reduces exposure to new developments in rural areas making less attractive to staff. Interviewees could not easily identify examples of good practice in providing career pathways. Technology will affect future career pathways • Have to be seen as being particular good at something to attract staff
Disruptive change leading to waste of resources	• There has been disruption due to change leading to a loss of continuity and, expertise in the system. Reorganisations have resulted in expensive redundancy payments for some staff who have been re-employed elsewhere in the system and this was considered to be a waste of resources.
The role of the third sector	• Volunteers are seen as a community asset. However, there are perverse incentives / barriers to working with third sector which include issues around information governance issue when working in partnerships. The creation of umbrella organisations has helped in this regard. The third sector can play an important role in new models of delivery being piloted
Widening participation	• One interviewee noted they 'Do not have a large ethnic population' whereas another mentioned disabled people were not given sufficient consideration and that the NHS should be able to make adaptations for disabled to have careers in the NHS. Another group within rural areas that is over looked is those that underachieved at school – NHS provides an ideal second chance to a meaningful career and there is the need to consider other entry routes. • Under-employment • Second chance of people who did less well at school • Under performing schools affecting supply • Schools that have never sent students to medical school • Selective schools may be having an effect on supply
Bursaries	• The removal of bursaries for nursing students was seen as disincentive for potential

	recruits.
Local university	• Provides nurse training • Chance of new medical school
Use of Technology	• There is a much greater scope for delivering services through technology including learning from the provision of telecare in Australia and North America. • Considerable effort being made on linked patient records but this hugely complex and there is no single solution. • Greater use of AI - Diagnostics, treatment and prevention, likely to reduce numbers in clinical roles • Genomics medicine offers the possibility of more personalised care • Digitalisation - Likely to reduce the number of workers needed • There has been a lack of capital investment in technology • There is scope to involve companies more in development and use of health technologies. • Only large urban hospitals, for example, University Hospital Birmingham have been able to implement electronic prescribing systems which district could benefit from if they had the resources to pay for its introduction, to train staff and update their systems. There are capability and cultural issues around the use of digital technology to support access and clinical routine tasks. A greater role for technology could reduce travel for staff and patients e.g. point of care testing in investigations, routine follow up appointments post-surgery where technology supports using non-consultant level staff to do the follow up but district hospitals do not have the appropriate ICT.
Innovation	• Getting people to adopt innovations is challenging. Must meet the needs of the population • Staff can become insular and culturally they don't look outside of Cornwall for innovation and ideas. • Membership of Innovation Councils to help take things forward • AHSN work with secondary care
Examples of good practice	• <u>Patient Safety Collaborative in Care Homes</u> in Wolverhampton – enhanced monitoring of residents leading to fewer hospital admissions and enhanced job satisfaction for care staff • FloTeleheathCare in Stoke • HEE STAR https://hee.nhs.uk/our-work/hee-star a vehicle to provide solutions or options for trusts to bolster their workforce. We've developed this because the supply is no longer as it was (need is going up, ageing population, funding etc.) so the same solutions or approaches we've always taken are not working. We need to be more imaginative. We need to start thinking outside the box, not looking for the same people with the same skills as we're all competing with each other and we can't afford them as the wage bill for trusts can't now replace like for like. • <u>Cultural change programmes:</u> Worcester has an 'intentional culture change' programme
Flexibility	• 12 hour shifts don't suit younger or older nurses
Apprenticeships	• Useful route • Issue of levy taking money out of the system without routes in place to distribute it • Waiting for trailblazer • Centre should have though pathways out – not rely on 13 regions to do so, duplicating efforts
Over-reliant on agency and locum staff	• There are a lot, suggesting desire for flexibility • The cost of locum provision is higher in rural areas.
Young people	• Want more experiential career path and are more interested in helping others (volunteering, ethical ethos) – scope for marketing campaign • Have more choices • Careers service
Patients and communities	• Access to services – the furthest from acute services they are, the less and poorer the outcomes. • Communities are the building block - how can we build community resilience and support people to self-support?

	• It's about to be announced that we are to become one of the national pilots for social prescribing. We'll have care navigators that sit with primary care. • This is so important because we know just one thing, like loneliness can lead to 5 conditions that takes up 75% of spend. We need to shift to prevention services. • How can we make every contact count and intervene in the right way? • We've got issues with delayed discharge as staff are risk averse e.g. they think a patient should be able to walk upstairs before they are discharged when they live in a bungalow. We're developing shared personalisation plans and this will list what they can do and achieve on a good day so when they are looking to be discharged from hospital we have a realistic idea about what they can already do or not do.
Devolution	• We want to think about market forces where some areas get higher or less funding to reflect local circumstances rather than a one size fits all standard approach
Rurality weighting in financial planning	• Need to take account of additional costs • Because people stay they eventually reach the top of their pay band so there's an added cost here from having a stable workforce • There are national pay scales and London weighting and we need to look again at these pay scales. • The cost of housing facing the workforce.
Supporting Carers and volunteers	• We need to look at the whole circle of health – rural communities find ways to help themselves (e.g. providing lift to GP practice) and we need to think about how we support people to stay well and supported and prevent people from getting sick. In rural areas this requires more investment in primary care. • What health and care services should people living in rural areas expect? We cannot provide equivalent health outcomes in some areas for people in rural areas compared to if they were living in a city, so we have to make the services as accessible to them as possible. • People want services close to them but we don't have the money and it doesn't become clinically safe in a more rural area as the infrastructure, the workforce isn't there and it's expensive. For example, in x there are not enough natural births to make the community midwifery unit proficient so it needs to move to a place where the midwives see more cases, are part of a larger specialist team and where they can practice safely. • We need more data, more information about community and voluntary support.

Group discussions

What USPs might rural areas have for attracting and retaining staff?

1. **Factors relating to rural areas themselves**: lifestyle; cheaper property (but more so in some areas than others); peace and quiet; a healthy lifestyle (but this was contested – people might walk more in London); nice area for children to grow up, good schools (Grammar schools in parts of Lincolnshire); belonging (more connected to the community – a lot of emphasis placed by participants on the importance of social relationships); strong social capital. These factors 'tick a lot of boxes'. But is this a bit like "England's green and pleasant land"? There was also agreement that the *reality does not necessarily accord with this picture* – there are issues of in-work poverty, affordability of housing, etc., and these may be set to get worse as/when interest rates increase. Also these positive factors may appeal more to some age groups than to others; and it was noted that the desires of young people are changing. (There was a range of views about whether a negative feature in rural areas was diminished access to 'culture' – some felt that there was less access to theatre, music, etc. but that others pointed out it is possible to reach major urban centres, London quite by train relatively easily, etc.)

2. **Factors relating to jobs health and care in rural areas***:* may be more opportunities for 'empowerment' – in a smaller team workers may be empowered to take greater responsibility and fulfil a broader range of tasks.

3. **Attracting people to rural areas:** a possible role for 'golden hellos'; issue of whether training courses should have a compulsory 'rural module' (probably something quite 'holistic') – so that trainees gain exposure to a rural environment/ rural issues.

What would constitute a more nuanced understanding of the issues around workforce development in rural areas?

4. **The rural environment is not homogenous***:* there are different populations in different rural areas and people in rural areas need not have a deep attachment to the land. Contention that 'ruralness' and 'remoteness' are two different things. It is important to get beyond the 'stereotypes' (and 'stigma') associated with rural areas.

5. **Is/ should healthcare be a 'national' service?** Question was raised about whether people should expect the same things/services from the health service in rural areas compared with urban areas. If they get less, should they pay less? (A strong view was expressed that the service is 'national', while others thought there was a postcode lottery.)

6. **Is the NHS model fit for purpose?** A point was raised that the NHS was designed on a pre-World War II model (to deal with mass casualties) which may not be relevant way to organise now. Also a view that 'the care system is broken'. What a health and care service needs to focus on is: (1) keep people well, (2) make people get better, (3) help people cope – with services organised around these principles.

7. **Importance of social capital and the voluntary sector:** Issue raised that "social capital helps people survive" in rural (and urban) areas. Workforce development needs to take this into account and emphasise the importance of the voluntary sector; making links between different policy domains and looking at policy domains other than health for improving health and developing the workforce in rural areas. This highlights the importance of *'softer skills'* which are of particular value – and the importance of *'resilience'* for staff and patients. (The view was expressed that patients and staff may be more resilient in rural areas than in urban areas.)

8. **Role of technology:** Can/will have an enormous impact on delivery of health and care. There is an increase in what can be done on smartphones – e.g. ultrasound/ taking x-rays. (Yet there are philosophical and social issues associated with this.) With an increase in technology solutions there will be a need for *more technicians*. There is also a question of what technology means for training – will a 7-year full-time degree be required? What about shorter- and part-time training? Perhaps the 'top 1-2%' will no longer go into medicine, but will be attracted more by AI – so in the future medicine may have a different cohort to draw from to train to become doctors.

Other issues/ questions

9. **What lessons can we learn from Brexit to 'sell rural health'?** It was contended that stereotypes were very important in understanding how people voted in the EU referendum and in understanding the 'Leave' vote. This underlines the importance of unpicking/ challenging stereotypes in 'selling' careers in health and care in rural areas. The EU referendum also

highlighted that deference to 'professionals'/'experts' has diminished. This needs to be taken into account in promoting careers in rural health and care.

10. **Importance of communications/ social media:** In promoting careers in health and care the role of social media is extremely important. This suggests a need for investment in communication and the importance of hospitals/ care organisations having a good comms team.

Sandpit sessions on Workforce Issues

There were three sessions each with approximately 20 individuals who broke into groups of four to five. The sessions only lasted 30 minutes which limited the number of questions that could be asked. We focused on:

- Challenges and Opportunities in the supply of workers
- Challenges and opportunities for career pathways

These were assigned to different groups who were asked to report back. In the first session groups were asked to work through the worksheet for each area However, the next two sessions we asked groups to focus more on opportunities and best practice questions first before working on the questions around challenges, as it was felt this would complement the interview data better, which is already provided fairly detailed information on challenges. The tables below include written comments from the record sheets completed by groups supplemented with notes of the conversations.

Challenges and Opportunities in the supply of workers

How big a challenge?	• The biggest challenge is securing workers especially in (remoter areas like) Boston and Spalding. In Lincoln City it's okay. • Not all employers offer agenda for change. Terms and conditions changed • Migrant workers not prepared for reality in Lincolnshire – it's not necessary leafy and pretty	• Dependant on the type of worker but they are interlinked • Workers depend on other workers also being there • Challenge is attracting people into particular roles • Further challenges is attracting young people to rural areas	• Big problem • Making rural more attractive • Distances workers have to challenge • Cost of housing • Aging population, workforce • Spouse occupation
What aspects are important and for whom?			• Isolation • Remoteness • Small size • Housing supply • Quality of training • Breadth of skills/attitudes to cope with
How could you address them?	• Some employers have different terms and conditions (e.g. Hospices) • No agenda for change – would be good to do as a county • Great to have joined up recruitment and retention strategy	• Vocational training programs • Target rural youth and encourage them to stay on their original communities • Technology to replace/substitute services provided by workers. But this dependent on good broadband infrastructure • Need to improve public transport	• Generic health workers • Social determinants of health • Right here/ right place in Shropshire • Extended GPs • Schools
What are the opportunities?	• Lincolnshire • Good schools, green space, low cost of living,	• Widening participation – foundation year • Pharmacy is recruiting locally	

	low cost of housing low crime rate – great for family life • Sense of neighbourhood and community • 2 Universities, new med school and a school of nursing • Repurposed midwifes • Providers support pre and post reg student • Opportunities to expose students to lots of variety • Broadband improving – innovative delivery models • In employment in Lincolnshire lifestyle is good • Cultural offer good	• Look at city centre • Create attractive place to live • Linking professional to local institutions • Multidisciplinary / professional training – clarity on role • Innovative approaches in training • Create a community • Challenge entry qualifications	
Can you name any good practice?	• Statutory providers working with the voluntary sector • New roles in county – apprenticeship nursing, nurse practitioners • Good links to (local) University • Good student attention at local universities	• Salaried GPs vs being partners • Northern Ontario THENet[71] • Cuba[72]	-
Anything else?	• Seasonal migration • 3000 mobile homes – elderly residents on the course, cold vs overheating • COPD – under resourced, need better delivery models • GP caseloads, seasonal growth • Coast line – very high deprivation • Road travel can be slow in the county		

Challenges and opportunities for career pathways

How big a challenge?	• Retention • Elderly workforce • District nurses – silo mentality • Training of new practitioners	• Skills deficit • Social care fragmented • Community don't think about health • Too narrow	• Large: 40,000 nursing vacancies in England	• Scale of roles • Generalist vs specialist • Tribal drinking • Sparse opportunities

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[71] See protocol for evaluation published in BMJ Open: https://bmjopen.bmj.com/content/5/7/e008246 [accessed 16.08.2018]

[72] See for example: Keck, C.W. The Curious Case of Cuba. Am J Public Health. 2012;102:e13–e22. doi: 10.2105/AJPH.2012.300822

			Different system		
What aspects are important and for whom?	• Job satisfaction	• Short termism	• Access to affordable housing • Access to continuing education • Centres of excellence are usually in urban areas	• More career opportunities • Flexible rules • Vacancy factor
How could you address them?	• Introducing refugee doctors to rural areas • Combined services • Different types of service • Investment • Innovative programmes	• Young professional encouragement • Affordable housing • Technology • Greater integrated work	• Encourage local authorities to build affordable housing • Recognise the cost of living / working in rural areas – e.g. rural weighting allowance	• HEE –new roles • Developing working hours to meet society need • Challenge culture
What's working well, what is not?	• Local pharmacy • Physician associates	•	• Little working well • STP is forcing centralisation in urban areas. • Loss of bursaries is reducing recruitment	• Neighbourhood team – MDT • Clinical pharmacy
Can you name any good practice?	• Refugee doctors • Interaction between volunteers and practitioners. •	•	• Greater use of telehealth can enable practitioners to demonstrate their expertise without having to move to an urban centre	• NTi – as above • Local mental health trust • Lincs Partnership Trust – set up own back system for psychiatrists – saved money

Report back of five key points at plenary

1. There are layers upon layers of challenges facing workforce planning and development in rural areas. This reflects "supply issues across the board". However, a rural perspective is helpful because the complexion of precise needs varies between urban and rural areas, and between different rural areas

2. Not enough is known about how people transition between roles. It was questioned whether some people think of 'careers' (although some obviously do so). Going forward there is a need to think about 'segmentation', including a focus on 'how to keep millennials' happy given differences in aspirations and values from previous generations.

3. In rural areas in particular there is a need for greater emphasis on combined services. This needs to include the voluntary sector, which plays an important role.

4. People/ potential employees are attracted to success (albeit there is an issue of what 'success' means and how this varies for different people). Being known as a rural 'centre of excellence' will likely attract people to rural areas.

5. When looking at/ borrowing good practice it is important to appreciate similarities and differences across rural and urban areas.

Appendix H: All Party Parliamentary Group on Rural Services 4 July 2018: Research in relation to forthcoming Adult Services Green Paper – Survey Results

Introduction

The Rural Services Network (RSN) in partnership with the new National Centre for Rural Health and Care commissioned a survey of rural upper tier authorities in RSN membership to ascertain their views and experiences of the issues trailed in the build up to the Green Paper on Adult Social Care. The survey (details of which are attached at the end of this report) also asked a number of additional contextual questions. The results are set out below.

Respondents

12 responses were received from RSN members. They were:

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

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

Table H1: Percentage of funded clients over 65 and cost of supporting those clients as a percentage of the whole council budget alongside increase in this percentage over the last 5 years

Local Authority	Percentage of all people over 65 years in the local authority area who are in receipt of council funded support	Percentage of the net overall council budget spent on supporting these people	Percentage increase in expenditure on supporting council funded clients over 65 in the past 5 years
Cornwall	3	29.5	16
Hampshire	4	68	3
Herefordshire			2
Lincolnshire	7	42	13
North Yorkshire	5	43	5
Nottinghamshire	4	40	1.5
Rutland	3.6	25	1
Shropshire	4.5	45	45
Somerset			5
West Sussex	2.4	26.5	11

The scale of adult social care funding as a percentage of all expenditure is interestingly juxtaposed with the proportion of the over 65 funding it represents, in relation to the 8 authorities who answered this question. This demonstrates, with some modest variations meriting further analysis (West Sussex, Rutland and Cornwall) that a very significant amount of overall council funds are being spent on a relatively small proportion of the over 65 population of the authorities concerned.

Authorities reported the following increase in spending over the last five years: Cornwall (16%), Hampshire (3%), Herefordshire (2%), Lincolnshire (13%), North Yorkshire (5%), Nottinghamshire (1.5%), Rutland (1%), Shropshire (45%), Somerset (5%) and West Sussex (11%).

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

Seven Principles

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

1. Quality and Safety Embedded in Service Provision

A lack of transport options and the distance between individuals needing care in rural settings were highlighted as the main challenges in this context. Other major order risk factors were cited as: a lack of workforce choices and limited funds to underpin the cost of an increasingly expensive service. There was a recognition in a number of authorities that they needed to meet a rural premium cost in terms of attracting a quality workforce. Supporting sustainability and choice were referenced as key challenges exacerbated by rurality. The challenge of facilitating good quality provision for self-funders was acknowledged as a general principle first and then as an issue exacerbated by rurality. Contractual approaches to setting quality and safety standards and quality assurance approaches were cited as factors underpinning quality and safety.

2. Whole Person Integrated Care with the NHS and Social Care Systems Operating as One

There were some examples of progress but broad unanimity that this was not in place in any of the areas we received feedback from. The complexity of the organizational framework for supporting people was cited as being exacerbated by the physical sparsity of counties such as North Yorkshire and Lincolnshire. Poor broadband was referenced as a rural challenge in using IT 'connectivities' to their maximum in addressing the challenge of greater integration. Integration in a rural area was identified as being hardest for those with the most complex needs due to the dispersion of specialist providers of services. The difference in terms of funding constraints on each sector was referenced with a view from some areas that the lack of a need for a balanced budget within the NHS side of the equation led to an unbalanced set of expectations amongst providers in terms of the affordability of care.

3. The Highest Possible Control Given to Those Receiving Support

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

4. A Valued Workforce

The environment within which the workforce operate was cited as a common challenge, particularly in respect of the housing options available to low paid workers in rural settings. The role of good quality and well adapted housing for older people were cited as factors which ameliorated the pressure on care workers in relation to the intensity of personal support required by clients. The need to provide wage enhancements particularly in relation to retaining a stable workforce was referenced as a key challenge in rural settings. Working on a third party basis with the intermediary organisations providing carers was identified as a challenge. Setting minimum expectations, particularly in terms of workforce training and development was referenced as a key challenge. An ongoing lack of recognition of the value of adult social care as a profession was identified as a problem.

5. Better Practical Support for Families and Carers

All respondents recognized the very important role this had to play. A number of respondents cited examples of facilitated and manage networks for families and carers. In a number of cases IT approaches were being used to seek to overcome the challenges of sparsity. The development of flourishing communities in rural settings through indirect investment (i.e. in activities which were not directly care related) was cited as an activity likely to underpin a better environment for families and carers to operate in. The provision of respite care in rural settings was referenced as a key challenge for families and carers in rural settings. The importance of providing good quality information services to promote resilience amongst rural carers was identified as an area of good practice. Profiling potential developments amongst those with the greatest likelihood of need to support preventive strategies and tailor the support available to individuals were cited as examples of good practice. This was referenced by one respondent as being about "pre-eligibility" awareness.

6. A Sustainable Funding Model for Social Care Supported by a Diverse, Vibrant and Stable Market

All respondents identified this as an aspiration rather than a reality. The use of preventive funding strategies to reduce the scale and growth of the level of adult care need was referenced as a general point applying in both urban and rural settings. A lack of providers, a lack of suitable housing, exacerbated by a complex operational framework, with significant distances between agencies and poor IT connectivity were all cited as severe challenges in rural settings. Identifying local and "place" specific contracting approaches to the challenge of providing services in rural settings were identified as key factors in seeking to address the problems arising from rurality.

7. Greater Security for All

Managing expectations about what is practical in terms of budgets, particularly in view of the additional costs of providing services in rural settings was cited as a key element of addressing this principle. The burgeoning costs of supporting people with disabilities was identified as a challenge which was as severe and as exacerbated by rurality as adult social care. The patchy operation of the direct payment system was identified as an area requiring further attention. The development of a two-tier system in terms of the quality and range of residential care choices was identified as being more starkly split between local authority and self-funded clients in some rural areas. This was put down to the limited range of residential care options in some rural settings. The development of micro-providers of care (based on examples of the work of organisations such as "Community Catalysts" in Somerset) was referenced as a key innovation making care more local and more affordable in some rural areas. The challenge of predicting and therefore planning for the likely demands of older residents was identified as a general point, which is exacerbated by sparsity. The factors which made this more of a challenge in rural areas were cited as: limited choice of providers, greater distances between clients, poor IT provision in some rural areas and in many cases a lack of co-terminosity in terms of geography amongst the agencies concerned. Overall there was a strong degree of pessimism about being able to deliver this aspiration under current funding conditions.

Key Rural Challenges

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

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

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

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

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

Relative Challenges

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

	SEVERE	SIGNIFICANT	MODERATE	INSIGNIFICANT	TOTAL
The range, availability and affordability of housing stock	0 (0.0%)	6 (75.0%)	2 (25.0%)	0 (0.0%)	8
Distance/travel times to care	3 (37.5%)	5 (62.5%)	0 (0.0%)	0 (0.0%)	8
Technology, e-medicine and access to broadband	0.00% 0	75.00% 6	25.00% 2	0.00% 0	8
The rural premium in terms of the additional cost of living in rural areas	12.50% 1	62.50% 5	25.00% 2	0.00% 0	8
Workforce issues in terms of the availability of care staff	5 (62.5%)	2 (25.0%)	1 (12.5%)	0 (0.0%)	8

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

Innovation and Good Practice

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

- Lincolnshire – investment in mobile working for social care assessment staff. Investment in remote access to GP/Medical support for care homes.
- West Sussex - tele support for carers. Risk stratification tool (Docobo) which reduces the need for customers and their carers having to travel for support.

- Rutland – GP video consultations. Self care toolkit – helping people to manage their own care more effectively.
- Nottinghamshire – Florence Telehealth – which enables people to monitor their own conditions and liaise with clinicians.
- Flexible and Multi-Disciplinary Approaches – the following examples were identified:
- West Sussex – development of a multi-agency approach to supporting hospital bed discharge called "home first".
- North Yorkshire – an extra care facility in Bainbridge, which provides services to the local community in addition to residents.
- Lincolnshire – multi-disciplinary neighbourhood teams – facilitating a person centred approach to prevention and enabling more effective hospital discharges.
- Cornwall – the use of health and social care data to enable a predictive analysis of the likelihood of frailty.
- Somerset – Village Agents (older person befriending and support) – provide care support and navigations for vulnerable older people.

Other Examples of Innovation – the following examples were identified:

- Rutland – preventive model of support for "pre-eligible" adults.
- Hampshire – Connect to Support – directory of support and assistance for clients online.
- Shropshire – Modular housing pilot to address the challenges of living in inappropriate housing for vulnerable older people. Use of "off the shelf" technology – e.g. "Alexa" to support people living in their homes for longer.
- Lincolnshire – HomeFirst – an initiative to develop shared objectives across council and NHS providers to prioritizing home based care.
- West Sussex – Shared Lives provides an opportunity for individuals to receive care in a more local setting rather than relocating to a residential care placement if they live within a more isolated rural area.

Costs

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

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

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

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

Summary/Overview

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

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

Dispersed population patterns lead to higher service provision costs in terms travel to care distances and reduce the contact time that can be allocated to clients. This can be exacerbated by seasonal weather fluctuations.

In many rural areas there are very few providers of social care to choose from due to the relatively high cost of providing services and the small number of clients.

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

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

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

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

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

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

Notwithstanding the practical challenges facing rural areas in terms of connectivity there is a strong consensus that technological solutions provide real, but largely unfilled potential to improve outcomes for adult social care clients.

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

Direct payments have the potential to help stimulate very local enterprises providing care, but are not effectively rolled out; the people eligible for them are often not well supported in their use. In

cases where vouchers are used rather than direct financial payments innovation and choice is further limited due to the limitations placed on the use of the vouchers.

The housing stock in rural areas often fails to match the needs of the vulnerable older population. There is an acknowledgement of the need for but a lack of adequate provision of extra care housing in many rural settings. The lack of a suitable housing stock puts pressure on smaller rural care homes and leads to the danger of a two-tier system in terms of care choices between local authority and self-funded clients.

The declining number of rural GPs has a knock on effective in terms of support for vulnerable older people in rural settings and where they have a key role in preventive strategies limits their potential impact.

Whilst preventive strategies based on mutli-agency working and early intervention offer the potential to reduce rising costs they are more difficult to deliver in rural areas. This is because of the wide distribution of clients and the greater distances, which agencies seeking to work collectively have to overcome in pursuit of integrated care approaches.

There is a strong feeling amongst respondents that the challenge of supporting people is getting worse. Very few have a long-term plan for overcoming the scale of challenge they face under the current system of providing adult social care. There is a wide acknowledgement that not only does the funding regime for providing adult social care need to change but so do attitudes about what is expected.

Respite care is more difficult to provide in rural settings due to sparsity in terms of the number of eligible clients within manageable geographical bounds.

There is a very acute cost linked to providing support for younger and disabled local authority clients, which is equally as severe as the pressures put on local authority finances by adult social care. Taken together adult social care and these costs are rapidly eroding the financial viability of many local authorities.

Survey Questions

Please describe your "adult social care geography" in relation to the questions below:

1   How rural are you (over 80% of your population, over 50%, less than 50%?)

2   How many neighbourhoods (LSOAs) in your area are in the bottom 20% of the English Indices of Deprivation in terms of the health score? If you don't have this data give an explanation of how you judge the relative health of your population?

3   How severe are the challenges of securing an adequate workforce to meet the adult social care needs of your population in terms of residential care?

4   How severe are the challenges of securing an adequate workforce to meet the adult social care needs of your population in terms of domiciliary/home care?

5   What proportion of your over 65 population receive care funded by the local authority?

6   What proportion of your over 85 population receive care funded by the local authority?

7   In relation to the rural-urban classification what proportion of those over 65s supported live in rural areas?

8   In relation to the rural-urban classification what proportion of those over 85s supported live in rural areas?

9   Green Paper will follow 7 principles – in a sentence indicate, in respect of the services you fund/provide, for each how deliverable they are in your experience and in a separate sentence what the challenges to delivery are:

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

10   How do each of the factors set out below impact on the delivery of services for older people in your area?

  o   The range, availability and affordability of housing stock
  o   Distance/travel times to care
  o   Technology, e-medicine and access to broadband
  o   The rural premium in terms of the additional cost of living in rural areas (please explain how you quantify this as part of your answer - for example do you take account of travel times in your procurement of adult social care?)
  o   Workforce issues in terms of the availability of care staff

11   How would you rate the impact of each of the factors identified above?

- Severe Significant
- Moderate
- Insignificant

12 Please give a brief description of examples of innovation and good practice in terms of:

The reduction of rural health inequalities through technology
Flexible and multi-disciplinary approaches to the provision of support
Other innovations enabling people to remain independent and in their own home

Costs

13 What proportion of net council funding do you spend on adult social care?
14 Over the last 5 years by what proportion has this increased?
15 How do you anticipate the cost of adult social care developing over the next five years?
16 Do you have the resources to meet these costs?
17 Compared to adult social care how challenging is the cost of children's services?

18 Do you have any other final comments, which will be helpful to the APPG in undertaking this review?

Appendix 1: Non-UK EEA and non-EEA workers in the health and social care sectors

This Appendix outlines UK immigration policy and implications for non-UK workers in the health and social care sectors. While immigration rules are the same across the UK, the impact of changes in such rules and the dependence of different local areas (including urban and rural areas) on migrant workers may vary.

Immigration policy

Current UK immigration policy can be traced back to 2008 with the introduction of a points based system. The Home Office has responsibility for UK immigration policy. The independent Migration Advisory Committee (MAC) provides economics-based advice to government on migration issues and has been involved in virtually every significant labour market migration policy decision since 2008.

In current migration policy there is an important distinction between European Economic Area (EEA) and non-EEA labour. The key features of current UK labour immigration policy are:

- EEA citizens coming to work in the UK are eligible to take up employment in any job - as a member of the EU the UK is not able to use any kind of visa system to control migration from other EU member states
- Citizens of countries outside the EEA are subject to immigration control (they do not have the right to enter the UK to live, work or study unless they are granted a visa). Since 2008 there has been a points-based work permit system (PBS) for non-EU citizens.

Hence there is an important *distinction between EEA and non-EEA labour*. There is an *underlying assumption* in current immigration policy (pre Brexit) that *migrant workers from the EEA can help in addressing skill shortages in the UK* and for low-skilled jobs can play a role in addressing *labour shortages/ providing flexible labour* where there is an inadequate supply of UK labour. These assumptions are being challenged in ongoing debates about the shape of UK immigration policy in the after-Brexit period.

The Points Based System for non-EEA labour

Since 2008 the UK has seen phased implementation of a Points Based System (PBS) designed to meet UK skills needs – with an emphasis on highly skilled individuals to contribute to UK growth and prosperity and skilled workers (with a job offer) to fill specific gaps in the UK workforce.

The PBS has five tiers. Tier 2 (General) is of foremost significance here. To qualify, a migrant worker needs to have a job offer and a certificate of sponsorship (CoS) from an organisation (i.e. an employer) that is a licensed sponsor in the UK. The migrant worker must also surpass a skills threshold, which incorporates an English language requirement and a maintenance threshold; and a salary threshold. It is the employer's responsibility to show that the job exceeds a skills threshold and cannot be filled by a worker who is settled in the UK (this is the resident labour market test [RLMT]). Where a job is included on the MAC's Shortage Occupation List (SOL) (see below) usually there is no obligation for this resident labour market test or to pass a skills threshold. The MAC specifically advises on which occupations should be included in the SOL for Tier 2 migrants. Over

time the general trend in immigration policy has been one of *increasing selectivity*. The SOL in force as in 2018[73] only included a few health-related occupations, specifically: 2211: Medical practitioners (selected job roles); 2217: Medical radiographers (selected job roles); 2219: Health professional not elsewhere classified (selected job roles); 2231: nurses; 3213: paramedics.

As part of the UK Government's approach to controlling net migration, an annual cap of 20,700 was put on Tier 2 migrants in April 2011. From late 2017 this cap came under increasing pressure. With the NHS accounting for around 40 per cent of all Tier 2 places, it was announced in June 2018 that doctors and nurses would be excluded from the cap.[74] This relaxation of immigration rules makes recruitment of non-EEA labour easier in all sectors.

The case of nurses

With regard to *nurses*, in 2016 the MAC[75] considered that the shortage of nurses is mostly down to factors which could, and should, have been anticipated by the health, care and independent sectors, while noting that issues of an ageing population, problems with staff training, pay and recruitment had been compounded by the squeeze on NHS budgets. The MAC's report noted problems in recruiting nurses in remoter rural areas, but noted difficulties in urban areas and local areas with a high cost of living also.

In 2016 *research* by the Institute of Employment Studies sought *to explain the variation in the recruitment on non- EEA) nurses at trust level in England*.[76] It found that the shortage of nurses had broadened out from local skill shortages to become a national issue. At regional level quantitative analysis showed that trusts in London and the South East were more likely to recruit from outside the EEA. Trusts located in areas with higher proportions of people living in rural areas had lower usage of non-EEA nurses, while trusts located in areas of lower unemployment had higher usage of non-EEA nurses. Accompanying qualitative evidence showed varied and differential recruitment of non-EEA nurses amongst trusts. This was attributed to a trust's own approach to workforce planning and whether they had recruited outside the EEA previously, local demographics, the 'attractiveness' of a trust, and differences in skills needs. Large, acute teaching and foundational trusts were able to offer new recruits and trainee nurses more experience across different specialisms, which made them more attractive to new recruits than those that did not. Trusts in big urban centres reported the advantages of good transport links, settled diverse communities and a busy location in being able to 'pull' nurses in. This could leave neighbouring trusts struggling to attract adequate numbers of nurses. Interestingly, retention was reported to be better amongst non-EEA than EEA recruits – sometimes because they had family members back home dependent on their income, and partly because of greater restrictions associated with their entry to the UK. Five policy interventions to address nursing shortages were identified: (1) improve retention of the current nursing workforce; (2) 'grow your own' by increasing numbers in pre-registration nursing education; (3) attract 'returners' back to the workforce, who are qualified but not practising; (4) recruit internationally; and (5) improve productivity/ change skill mix and/or different working patterns.

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[73] https://www.gov.uk/guidance/immigration-rules/immigration-rules-appendix-k-shortage-occupation-list
[74] https://www.gov.uk/government/news/doctors-and-nurses-to-be-taken-out-of-tier-2-visa-cap
[75] https://www.gov.uk/government/publications/migration-advisory-committee-mac-partial-review-shortage-occupation-list-and-nursing
[76] https://www.employment-studies.co.uk/system/files/resources/files/mac0716.pdf

EEA labour and the impact of Brexit

In late July 2017 the Home Secretary commissioned *advice from the MAC on the impacts on the UK labour market of the UK's exit from the EU*. The MAC was asked to consult widely and to prepare a report by September 2018. A Call for Evidence issued in August 2017 asked for information and statistics on EEA migration trends, recruitment practices, training and skills, and the economic, social and fiscal impacts of migration was accompanied by a briefing note setting out the role of EEA workers in the UK labour market. The consultation period closed in 2017. In March 2018 the MAC published an interim update on EEA-workers in the UK labour market, summarising evidence on what employers said about why they employ EEA migrants and what might happen if a more restrictive migration policy was introduced,[77] together with Annexes containing consultation responses by sector.[78] This supplementary material presents key statistics on the health and residential & social care sector[79] and provides an overview of responses relating specifically to the health sector and the residential & social care sector. (Key points are presented to provide context for the workforce situation in rural areas – even though there is only one mention of 'rural areas' in the evidence reported for these two sectors.)

With regard to a more restrictive migration policy, taking all sectors together key points emerging are:

- employers were concerned about the prospect of restrictions on the ability to recruit EEA migrants;
- employers were fearful about what the future migration system would be: many of those using the Tier 2 system to recruit higher-skilled workers felt that it was time consuming, costly and overly complex;
- many submissions to the MAC saw no alternatives to EEA migrant labour;
- training of UK-born workers may be a strategy to fill skill shortage in the longer-term.

The health sector

Evidence from the health sector focused on high-skilled roles – notably medical professionals such as consultants, GPs, nurses and dentists. It highlighted the time taken to train qualified staff and potential difficulties arising in recruiting replacements for EEA and non-EEA workers should this be necessary.

The health sector has high-quality sources of data on migrant workers (and this data was referred to in the Call for Evidence): in England NHS digital publishes data on *Hospital and community health services staff by nationality and age band of workers*.[80] These data are available online at England level.[81] The use of nationality rather than country of birth under-estimates the dependence on non-EEA migrants many of whom have become British citizens. And the most commonly quoted figures

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[77] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/694494/eea-workers-uk-labour-market-interim-update.pdf

[78] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/695111/MAC_ANNEXES_-_FINAL_-_Interim_Update_v4.pdf

[79] These statistics encompass changes in employment, the migrant share of employment, median hourly real wages (in aggregate and by migrant group), output per hour and the largest occupations in the sector by employment in aggregate and occupational skill level by migrant share.

[80] https://digital.nhs.uk/data-and-information/find-data-and-publications/supplementary-information/2018-supplementary-information-files/hospital-and-community-health-services-staff-by-nationality-and-age-band-january-to-september-2017

[81] In these data the use of nationality rather than country of birth underestimates the dependence on non-EEA migrants many of whom have become British citizens. The most commonly quoted figures on EEA citizens working in NHS England include Irish citizens who would not be affected by future restrictions on migration post Brexit if the Common Travel Area continues.

on EEA citizens working in NHS England include Irish citizens who would not be affected by future restrictions on migration if the Common Travel Area continues.

In terms of changes in the employment of EEA healthcare staff since the referendum on Brexit, there has been a marked fall in the number of Spanish and Portuguese nurses and midwives; numbers of other EU nurses and midwives are higher though not enough to compensate. For doctors there is no evidence of any fall since the referendum. The year to September 2017 saw the number of EU nurses joining fall by half compared to the previous year, below the number of leavers for the first time since 2012/13. There is also a problem with more UK nurses leaving than joining since 2013/14. Specific organisations reported more recent changes, including a 94 per cent decrease in the number of EU midwives registering to work as a midwife in the UK in the 12 months to June 2017, while the British Dental Association noted that applications from EU dentists to work in the UK had decreased by 90-95 per cent. Interestingly, in the only reference to 'rural areas' in the evidence on the health sector it is noted that "in some parts of England and Wales, such as coastal towns and rural areas, dentists from EU countries were delivering in the region of 30 per cent of NHS dentistry".

The majority of respondents submitting evidence to the MAC from within the health sector said that access to migrant workers was essential to the continued provision of health services in the UK. The British Medical Association said that the ability of UK health services to retain and recruit qualified doctors from overseas was essential, particularly in the short-medium term until domestic supply was increased. The Department of Health noted that if the NHS were no longer able to recruit EEA doctors, nurses and other health professionals it was estimated that, after five years, there would be around 6,000 fewer EEA doctors and 12,000 fewer EEA nurses in the UK. While extra training places and reduced attrition rates could help reduce this shortfall, but they would be insufficient to fully bridge the gap.

Residential & social care

The evidence published by the MAC indicates that the residential and social care sector employed 1.8 million workers in the UK in 2016, 1.5 million of whom were UK-born (Figure 19.1). The remaining 300,000 workers are predominantly made up of non-EEA workers – who made up 11.3 per cent of sector employment in 2016, compared with the combined EEA sector share of 5 per cent. By contrast with the health sector the care sector is characterised by low skills, with 51.1 per cent of UK-born workers and 60.4 per cent of migrant workers in low-skill occupations.

The evidence highlights varying dependence on non-UK labour at regional level, with London and the South East most dependent on immigrant labour. Evidence from the Care Association Alliance indicated that in London, 42 per cent of care assistants were non-British nationals (13 per cent from the EU), 40 per cent of senior care assistants were non-British nationals (8 per cent EU) and 45 per cent of nurses were non-British nationals (21 per cent EU). No mention is made of 'rural areas' in the evidence reported by the MAC for residential & social care.

In relation to recruitment and skills Care England outlined a number of ways they attempted to attract individuals to work and stay within the sector including pilots testing out new ways of integrated working, offering new incentives such as reviewing pay structures, introducing 'golden hellos', offering staff benefits such as vouchers, discounts at major stores, discounted health club membership, travel discounts, Childcare vouchers and paid Nursing and Midwifery Council membership. Other measures included developing local schemes to "grow their own" nurses by

linking with local colleges and universities to create new career pathways for recruiting and developing nurses within nursing care homes, offering access to clinical specialist training and post-graduate qualifications, as well as creating opportunities for leadership development or stepping onto specialist roles.

The Care Association Alliance reported that one main advantage of EEA employees was that they work longer hours; therefore, to fill four full-time equivalent posts may only require three EEA employees. Anecdotally, care providers told the Alliance that non-UK staff (either from the EU or outside of the EEA) were much more flexible when working unsociable hours. This suggests that more UK staff may be needed to replace non-UK staff.

Announcements on immigration policy in Autumn 2018

In September 2018 the MAC published its final report on EEA migration in the UK[82]. It recommended that there should be a less restrictive regime for higher-skilled workers than for lower-skilled workers in a system where there is no preference for EEA over non-EEA migrants. It also recommended the abolition of the cap on the numbers entering the UK under the Tier 2 (General) scheme is abolished and that the Tier 2 (General) scheme be extended to medium-skilled workers, with the existing salary threshold of £30,000 retained and an extension of the Immigration Skills Charge to cover EEA citizens. The MAC saw no need for a work-related scheme for low-skilled workers (with the possible exception of a seasonal agricultural workers scheme). While expressing serious concerns about social care, the MAC concluded that the sector needs a policy wider than just migration.

The UK Government has subsequently announced its backing for a skills-based immigration system with no preference for EEA citizens, as set out by the MAC.

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[82] https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/741926/Final_EEA_report.PDF