APPG on Rural Health and Social Care

23 June 2020

Parliamentary Inquiry Session 8a

Coastal Issues

Present:

Anne Marie Morris MP - Chair

Witnesses

Vaughan Thomas – Chair, Isle of Wight NHS Trust
Maggie Oldham – Chief Executive, Isle of Wight NHS Trust
Darren Cattell – Director of Finance, Isle of Wight NHS Trust
Katherine Nissen – Chief Executive, Cornwall Rural Community Charity
George Coxon – Care Home Owner, Devon
Dr Mark Spencer - GP and Lead – Healthier Fleetwood

Invited Observers

Robert Seeley MP
Ade Tams – Health Education England
Kate Pym – Pyms Consultancy
Father Jonathan Sibley – Social Issues in South Lincolnshire Group
Michelle Howard – Assistant Director People, East Lindsey District Council
Professor Mark Gussy – Global Professor in Rural Health and Social Care, University of Lincoln
Anna Prytech - Rural Health and Care Wales Project Manager
Beth Davies – Office of Virginia Crosbie MP

Secretariat Team

Ivan Annibal - Director of Operations, National Centre for Rural Health and Care **Dr Jessica Sellick –** Senior Research Fellow, National Centre for Rural Health and Care
Jonny Haseldine – Parliamentary Assistant, Office of Anne Marie Morris MP

Apologies

The Right Reverend and Right Honourable Dame Sarah Mullally DBE – Bishop of London
Professor Richard Parish CBE – Chair National Centre for Rural Health and Care

Anne Marie Morris – welcomed delegates and explained that this session would look at coastal issues in terms of rural health and care. It is the eight in a series of sessions building up to an overall report in early 2021. She introduced the speakers and invited the team from the Isle of Wight NHS Trust to begin with their evidence.

Vaughan Thomas, Chair of Isle of Wight NHS Trust - began with a socio-economic cameo of the island. It has a population of 140,000, high levels of deprivation and a significantly skewed geography towards older people. Tourism and agriculture are the predominant economic sectors. The island has some specific issues. The key challenge is of scale, which is based on the relatively small size of the island (in population terms compared to the English mainland), which nonetheless still has the largest number of people of any island in the UK. This makes it difficult to provide services as it effectively falls between two stools being neither so small as to just incorporate into a wider system with a locus outside the island but being too small to drive out economies of scale. In addition being an island makes it really difficult to access services and support from the mainland and this has an impact on the logistical functioning of the trust.

Maggie Oldham, Chief Executive Isle of Wight NHS Trust - introduced the structure of the Isle of Wight which is an integrated trust covering mental health, community and ambulance services– this integrated trust state makes the organisation distinctive in England terms. In terms of scale its resources are very small compared to UK norms – for example it can only deploy 4-6 ambulances at any one time, some of which are sent to the mainland to transfer patients to partner hospitals for treatment or to return tourist patients to their local NHS. This means that for a minimum of half a day the island is without those ambulances. By comparison the next smallest ambulance service in the UK has 150 ambulances in each shift. The Trust has no resources to deal with major incidents. One recent example of the trust challenges has been the need to establish the special care baby unit, which has been downgraded from a neo-natal intensive care unit. Due to the small scale of demand on the island there are some days and even weeks with no babies in this facility. In some cases this leads to the strange and distinctive challenge (in a traditionally hard pressed national picture of the NHS) of how do you motivate a workforce which might not even have a patient at certain times? Another example was the older people secure mental health ward, which currently had capacity for just 4 patients. Dealing with mentally unwell elderly people is at all times a challenging and specialised role. In order to staff this unit the island trust was entirely dependent on agency staff. Many services on the island are dependent on agency staff who face regular challenges in accessing it. A key theme, in view of these challenges, of the strategy for a sustainable future, is how to work more effectively with mainland providers. The "joining up" benefits of the current state of integration are attractive and there is a desire to retain them but this is very hard to maintain this when everything has to function at a very small scale.

In broader socio-economic terms education is a really important issue in the island. Nearly all schools required improvement historically. Notwithstanding recent

improvements this is still an issue as the workforce have been through a system which does not offer the strongest start and the recruitment pool on the island is challenged. The trust find many people leave the island and don't return until late career or retirement age, they experience very few home-grown applicants for key posts. Deprivation is a significant challenge in terms of public health, with a high incidence of a number of lifestyle issues (smoking, alcohol and obesity) prevalent in this context. Travel and access options constrained by living on an island can exacerbate people's conditions in this context.

Darren Catell, Director of Finance, Isle of Wight NHS Trust – introduced the financial challenges facing the trust. Scale is a big issue, this is exacerbated by geography, demographic, economic and deprivation challenges. The operation of the trust in an island setting makes these challenges more acute. 27.3% of the population is over 65 years of age, and an increase by 20% in the over 80s is projected for the next decade. The island population swells (doubles with over 2.5m visitors each year) as a consequence of seasonality with an impact on A&E. Geography as already mentioned has a major impact on recruitment issues and drives up the use of agency staff and overall costs. In terms of finance, the national funding formula especially in terms of emergency services means the trust can't cover its operational costs. The long term strategy is to work with mainland partners to ensure clinical and financial viability. At a national level financial allocation strategies require further refinement to recognise these cost drivers for atypical trusts like the Isle of Wight.

The distance between people and providers is a real issue in relation to costs. Moving clinicians between sites is really challenging and expensive. A&E consultant availability (where there is a national shortage) is a real problem. Maternity services can't harness economies of scale. Geographical dispersion means district nurses spend an inordinate amount of time on inefficient travel. Transport options sometimes need the trust to deploy a specialist transport supplement. There is no recognition of this within national tariff funding. The coastal context is a driver of skewed demography but the volume of patients with conditions linked to older age in places such as the Isle of Wight is not covered by the funding formula. The seasonal economy causes major fluctuation in terms of workforce demand. Travel times exacerbate cost and increase risk. Hidden pockets of deprivation also exist which are masked by the broader data and drive up cost. Some of these issues have been set out in detail in research by both the Institute for Fiscal Studies and Portsmouth University which can be shared.

Anne Marie Morris – invited Bob Seely MP to offer a view.

Bob Seeley MP - indicated that the evidence given had set out a clear and distinctive Isle of Wight perspective. The Isle of Wight is the only unconnected island with a sizable population in the UK. He explained that there are around 20 MPs who have populations serviced by unavoidably small hospitals and that work to harness their common interest and influence is important. This will help the trusts affected by these issues to make the case around exceptional funding support. He also went on to offer

the view that we need significant public health support in coastal settings, which have a high incidence of the health lifestyle challenges set out in the evidence.

Anne Marie Morris – expressed an enthusiasm for connecting with the MPs representing the unavoidably small hospitals constituencies as a means of linking them into the work of the Inquiry. **Bob Seeley** indicated he would connect the Inquiry up to these individuals through a "whatsapp" group, which has been set up for these MPs.

Anne Marie Morris– Reflected that the coastal challenge as described goes above and beyond the funding formula and also covers structures within the NHS and more widely in social care. She asked if over and above funding there are other ways of addressing these challenges?

Vaughan Thomas highlighted integration as a strength – the organisation has the "whole train set" in its purview and notwithstanding some of the scale issues it is able to work more effectively in terms of the relationships between acute and primary care. He explained that the challenges described are not well understood by the regulatory bodies, which work in a national pattern of delivery where these issues are atypical. He went on to identify that partnering with others is important. He drew attention to the renal service on the island, which is provided remotely from Portsmouth and works very effectively. He reflected that overall the client is not worried about who "owns" the service as long as they get receive it so, this approach works well. More widely still there is evidence from third parties about how the financial model disadvantages the Isle of Wight – the key challenge is to move forward with action planning which is supported by a wider appreciation by third parties of the issues facing the area.

Maggie Oldham identified that the difference between structures and relationships is important. She drew attention to strong relationships across the health and social care divide but pointed to how structurally it is very difficult to make everything work. Returning to the renal service, she reflected how the inspection regime, as the service is run remotely from Portsmouth (and deemed by the regulator to be a Portsmouth service) is difficult to interact with in terms of the Isle of Wight experience. More widely a number of procurement exercises in relation to the tendering of services can leech capacity from out of the Island where off shore providers win the contracts and don't have the insights and local presence required to build the strength of the health infrastructure locally.

Anne Marie Morris thanked the representative from the Isle of Wight NHS Trust for their contributions. She moved on to invite Katherine Nissen from Cornwall Rural Community Charity to provide her evidence.

Katherine Nissen – Cornwall Rural Community Charity – Katherine introduced her organization as part of a wider network of 38 members across England. Katherine identified that Cornwall is often seen as a holiday destination and there is a real

affluent/poor divide in the county. Cornwall has an ageing demography it only has one hospital and significant travel times challenges for those accessing acute services. In the summer months the capacity of roads to take emergency or NHS service related transport is very challenged. The seasonal nature of work is also a common factor in many towns. She has some local intelligence that the tourism sector in some settings has been very badly affected for the longer term by the current pandemic. There is a feeling in Cornwall that national policy makers don't understand the challenging mix of remoteness, deprivation and ill health, which characterizes a number of communities in Cornwall.

Housing is a challenge in the county, in some inland places there is significant poverty manifested around poor housing. Some significant parcels of land are owned by large estates, which provides a generational challenge for some families, who have a long term experience of variable investment and support by landlords. Cornwall also has distinctive fishing communities where debt is one of the key issues people face. This experience of debt then ripples out to the health and social care agenda.

Katherine drew attention to the new community groups springing up in relation to Covid-19 pandemic. This has led to a new found neighbourliness, one aspect has been the process of looking at how longer term visitors can be built into transient communities rather than just seen as second home owners. In the short term some local food chain innovation has cropped up through the use of farm outlets and very local supply arrangements and it would be a shame to lose this as we exit the pandemic.

In terms of hidden deprivation in the last economic downturn (2008) resources were available from the EU to address this challenge. There is some concern that these pooled resources will not be available on this occasion to ameliorate the economic impacts of the pandemic.

Managing the response to the challenges around health is in some cases a cradle to grave journey in Cornwall where parts of the indigenous community live very locally focused lives. The needs and challenges facing these individuals are sometimes masked by the way deprivation is measured. Farmers and fishermen, both of whom represent distinctive economic sectors in Cornwall have particular needs which require more than just a standard approach. In fishing communities Cornwall Rural Community Charity has facilitated mobile doctor and dentist services working with the fishermen's mission. CRCC is also working with primary schools around the development of positive community messaging and lifestyles.

The cost of travel is a big issue in the provision of health and care in Cornwall. Digital connectivity is also a problem, Cornwall Rural Community Charity have worked directly with Cornish Care homes to address links between families and individuals in care homes using IT.

Managing the balance between people returning as holiday makers to restart the economy and the threat Covid-19 might bring to rural places in Cornwall is the next challenge facing the area

Social determinants of population health in terms of disabilities and lifestyle choices are more common in coastal communities in many places in the UK. Cornwall Rural Community Charity has experience of the pressures this puts on unpaid informal care workers through the insights developed through its management of the Kernow Carers service which recognises the crucial importance of this group of individuals. Social isolation is also a major challenge in a number of coastal settings and in some cases leads to higher than normal levels of suicide.

Anne Marie Morris – Thanked Katherine Nissen for her evidence. She reflected that the challenge of resilience is a key issue arising from this witness testimony. She identified the points about needing to look more closely at the role of volunteers and the integration of second home owners as particularly useful contributions in terms of the Katherine Nissen's evidence. Anne Marie Morris moved on to invite Dr Mark Spencer to present his evidence from the perspective of Healthier Fleetwood.

Dr Mark Spencer – began his presentation by identifying that he recognized many issues raised by Katherine Nissen in terms of coastal poverty and isolation. He went on to explain that Fleetwood is a peninsula with poor traffic links, which feels isolated though only 10 miles north of Blackpool. Over 50 years economic structural change has robbed the town of its raison d'etre. 53% of residents live in the worst quintile of poverty in all neighbourhoods in England and this impacts on healthy living patterns. The area also has a lack of aspiration and significant levels of multi-occupied housing. Until recently it had only 50% of its quota of GPs due to problems with recruitment. Fleetwood is 17 miles from nearest A&E department. Notwithstanding significant investment the health of town was still decreasing until recently.

The Healthier Fleetwood, turnaround strategy was inspired by Professor Michael Marmot and his view that you should listen to residents as part of planning an approach. On the ground residents were fed up with short term consultation. A longitudinal approach to active listening has been the way forward. Listening events have been running for 4 years. The area has been characterised by a sense of hopelessness. Dr Spencer cited the example of one patient with heavy alcohol dependency who reported " –Its not the fear of dying that stresses me out it's the fear of living." By deploying long term listening strategies the initiative has begun to build a new sense of community.

The second part of the strategy is about building confidence. Enhanced self care amongst local people is the desired outcome. This is based on the analysis that confidence is built by "doing". Healthier Fleetwood has provided support for people to do things for themselves, whereas the traditional NHS model takes control away from people by treating rather than enabling them. This approach has evolved into the notion more widely of social prescribing in national policy terms. Dr Spencer

provided examples of resident supported social projects including a Men's Shed initiative set up by a local resident which is now self sustaining and supports 40–50 people. Harmony and Health is a singing group which, has delivered a range of outcomes including help with some of the participants tackling obesity. A number of initiatives have focused on veterans.

Dr Spencer identified that hope drives the reduction of self destructive approaches around poor health outcomes and this is a core theme arising from the work of Healthier Fleetwood. The effect of the initiative should be seen in terms of the family and connections around those benefitting not just as a series of individual outcomes. The success of the initiative has spread widely and there is now a waiting list of clinicians wanting to work in the area.

As a consequence of the initiative prescribing of medicines and use of A&E has declined, utilisation of GPs has also declined. This initiative chimes with the NHS Long Term Plan focus on primary care it is consistent with the development of Primary Care Networks. The core message from the Healthier Fleetwood model is about paying attention to well-ness as a key determinant of wider outcomes.

Anne Marie Morris– reflected leadership is important in getting an initiative like this off the ground and asked how did GPs become the natural leaders of this initiative? How was the wider community of health professionals engaged and where did the resources come from?

Dr Mark Spencer – replied that GPs had been drawn into the development because low levels of trust in public servants needed to be addressed. Leadership based on listening has been the key driver of success. When the initiative was started it began without resources. The faith community has given free use of facilities, which was helpful in establishing the initiative. In practice it has not been expensive to do a lot of practical things related to the initiative. Since its inception Healthier Fleetwood has had significant offers of money from third parties over the years based on a track record of success. NHS funding of £30,000 helped set up Healthier Fleetwood as "an entity" which has helped with its sustainability.

Anne Marie Morris – asked how relationships with more traditional bodies working in this space are managed.

Dr Spencer - explained Healthier Fleetwood works as a connector focusing on things that really matter, like for example another example of success, access to healthy food- which has led to the development of a coordinated food alliance. Overall he reflected that the process of enabling the community to develop its ownership of the challenges it faces lies at the heart of the success of the approach.

Ann Marie Morris – thanked Dr Spencer for his evidence and invited the last witness George Coxon to provide his evidence.

George Coxon - began his evidence by acknowledging, that as the last speaker his evidence would reinforce the key points raised by the other speakers. His own background s ais a mental health nurse. 15 years ago he set up a care home in Teignmouth and now has two care homes. A key theme of his evidence is based on the importance of managing the transition between health and care settings, which is very important in his experience.

In terms of providing effective social care the first challenge is about connecting people. "Nothing about us without us" is an important mantra in terms of care home management from his perspective. Decisions affecting service provision are often taken by policy makers who are too remote from local contexts. Mr Coxon identified that service provision in his area had been enhanced by the development of the Devon Care kitemark a key aspect of which is about sharing learning. Devon has a mixed economy in terms of care providers driven by its rural/coastal context. There are 513 care homes in Devon. 20% of which have had a Covid-19 outbreak.

Deprivation leads to great discrepancies in life expectancy in a number of rural settings in Devon (which those with only a superficial knowledge of its character assume is an affluent area) and has a major impact on welfare. Travel times and organisational structural complexity are challenges in the provision of healthcare in the county.

Many smaller care homes have been adversely affected by the pandemic and are in a state of significant financial vulnerability.

We now need to think about what life will look like post Covid-19. We want to maintain and sustain some of the good habits, which people have picked up during the lockdown.

Any short term loss of care homes will exacerbate a lack of choice and opportunity in the rural/coastal parts of the county.

Tourism is an important sector economically which has been adversely affected by the pandemic with broader knock on effects to indigenous communities more widely. Local populations are concerned about welcoming back visitors for fear of a second peak in relation to the coronavirus.

The wider determinants of challenge in terms of rural health and care in rural/coastal Devon stem from population expansion, and a skewed demographic profile towards older people. Accessing the hard to reach is a key challenge in the area because of its scale as a geography.

Devon has a profile of care homes based on small providers in small clusters. Many are threatened and have challenges with their capacity. Many care homes are feeling overloaded. People in homes are feeling fatigued by the rigours of dealing with the virus.

Reflecting and working with the nature of the place is important not just following set rules and approaches in terms of social care. End of life care is a challenge for some people who would prefer (with dementia for example) to die at home. Care home capacity is mixed – media headlines have been exceedingly negative. Changing the narrative is important away from homes being seen as characterized by isolation and illness.

Mr Coxon offered his final thoughts in terms of the challenge of recruiting and retaining staff, which he feels will be exacerbated by Brexit. He also reflected on the difficulty of getting health and care providers to work cohesively together, particularly in relation to the cultural differences between the way each sector is both perceived and operates.

Anne Marie Morris – thanked Mr Coxon for his evidence. She reflected that the distribution of rural care homes impacts on secondary and tertiary care in rural settings. In rural areas distinctive and small clusters of homes represent the nature of rural communities, but bring challenges in terms of both sustainability and capacity to support the transition in and out of acute care.

George Coxon – acknowledged the insights in this analysis. He identified the big provider, profit maximization approach as an issue, which can militate against the most effective provision of care.

Anne Marie Morris – thanked all the speakers for their evidence and invited Ivan Annibal to offer some concluding comments.

Ivan Annibal – thanked the speakers. He reflected that the session had identified some of the distinctive challenges facing the provision of health and care in coastal settings. It had helped reinforce that like "rural" the term "coastal" is not a single entity. The evidence from the Isle of Wight has helped highlight the difference between coastal and island settings. The failure of funding strategies to acknowledge the combination of remoteness and seasonal flows into coastal places is a big challenge. Acute distance from services, skewed demography, patterns of extreme deprivation and a lack of skills and workforce options are all key features, which have been identified through the session. Taking a whole population, enabling, primary care focused approach, as witnessed by the achievements of Healthier Fleetwood demonstrates in part the potency of supporting people through strategies, which increase self-care.