

**APPG on Rural Health and Social Care**

**Parliamentary Inquiry: Session 6**

**Structural challenges of fitting current delivery models into a rural setting with different needs and challenges**

 **Friday 28th February 2020 – 12:00-14:00
The Wilson Room, Portcullis House, House of Commons**

**Present:**

**Anne Marie Morris MP**, Chair

**Witnesses**

* **Richard Murray –** CEO, The Kings Fund
* **Dr Ian Hume –** BMA GP Committee
* **Professor Martin Green** – Chief Executive, Care England
* **Tim Goodson** – Chief Officer, Dorset CCG
* **Dr Alex Degan** – Medical Director for Primary Care, Devon STP
* **Dr Richard West** – Chair, Dispensing Doctors’ Association

**Invited Observers**

* **Nadine Trout** – Rural Services Network
* **Andrew Dickenson** – Health Education England
* **Ade Tams –** Health Education England
* **John Wynn-Jones** – National Centre for Rural Health and Care
* **Louisa Collyer-Hamlin** – Care England
* **Simon How** – Public Health England
* **Gemma Hopkins** – BMA
* **Dr Ankit Kant** – Dispensing Doctors Association
* **Dr Matthew Isom** – Dispensing Doctors Association
* **Sabina Hafesji** – NHS Confederation
* **Jessica Ferguson** – Pharmaceutical Services Negotiation Committee
* **Justin Newman** – The Centre for Ageing Better
* **Ross Jago** – NHS Devon CCG
* **Kate Woolland** – IESO Digital Health
* **Rhys Davies** – Community Catalysts

**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
* **Graham Biggs –** Rural Services Network

Anne Marie Morris MP welcomed the guest speakers and audience

She explained that she would welcome comments on secondary care although the focus of evidence today was likely to be focused on primary care as a consequence of the nature of the background of the witnesses. She also indicated that she was particularly interested in the approach taken in terms of supporting people with co-morbidities in rural settings.

**Richard Murray – Kings Fund**

Mr Murray explained that the Kings Fund have been working with STPs/ICSs since their inception. He went on to mention that the Kings Fund also has a track record developing around work with PCNs.

Mr Murray identified that the frame of reference in the context of systems in the NHS should be the concept of “place”: He identified two dimensions to the systems discussion in relation to place - trying to make the NHS work better and secondly working with local government and other partners around local infrastructure in terms of housing, transport, access to services all of which impact on effective local delivery.

Mr Murray went on to explain that by looking at localities you can undertake smart design, which best matches resources to local circumstances. Mr Murray is optimistic that the new GP contract will drive more diversity of delivery around local care systems and that this will have a positive effect in rural areas.

A key challenge is that this place based approach can become clouded by the generic notion of what an ICS/STP should look like. “System by default” could be a danger. Some ICS areas are very large and will face challenges around locality planning such as the North East and Cumbria ICS. The key question to consider is what is beneath these big geographies? where are the most important decisions being taken?

A second issue is that much of the NHS planning model is based on an urban mentality. It is important that local decision making is preserved in the transition to ICS so that rural areas can ameliorate this urban tendency. Those ICS concentrating on local decision-making structures are the best examples of approaches which are likely to be sympathetic to rural.

Another interesting dynamic in the context of health and care in rural settings is the move away from competition. The Long Term Plan is putting more resource into primary care, community care and mental health. Notwithstanding this there is still overall a high acute financial footprint which drives the way funding is allocated in other settings often because better data is available on the acute sector. As you move further away from the acute model the structural approaches become less relevant. As more people’s treatment moves into primary and communtiy care the market forces factor will be challenged which has an acute bias. One specific area of failure is that the market forces factor does not recognize rural workforce recruitment challenges. The current process of stepping away from Payment By Results should be a good thing for rural areas, as long as a flexible approach is possible going forward.

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

In terms of NHS England and NHS Improvement and their role in the facilitation of good practice in the move to a new ICS approach– this needs to be properly resourced to enable things to operate effectively in rural areas. We may need an intermediate structure that sits below an ICS agenda in very big geographies recognizing place and locality as important dynamics. The NHS has a tendency to revert back to its own view of the world. ICS geographies don’t map onto other administrative boundaries and whilst they have their own logical justification this makes joined up planning across sectors really difficult.

At the heart of many challenges in rural (and urban) settings is a desperate shortage of staff – recruitment as opposed to retention is a massive challenge in rural settings, underpinning some of the real structural challenges raised above. This problem exists in many cases in rural settings in spite of systems. Where there are no teaching hospitals it is harder to recruit staff and this naturally disadvantages rural places. Overall the latest agenda in the NHS are still based largely on the notion that big is beautiful and this may not help rural areas.

In response to the specific issue of comorbidities in rural areas raised by Anne Marie Morris MP, Mr Murray outlined his view that these are very challenging and are significantly exacerbated around poor access to services and poor transport systems in rural areas.

Anne Marie Morris MP asked – are there barriers to achieving full system integration including the voluntary and community sectors (VCS) and other sectors in rural settings?

Mr Murray explained that a lack of devolved power within structures often gets in the way of engagement with the VCS, procurement on a competitive basis often doesn’t work in rural areas where the market is broken and the choices don’t exist for it to structure competition around. He also pointed to the ongoing split between the NHS and local government as an impediment to joined up approaches to health and care at the local level.

Anne Marie Morris MP asked: is the provider/commissioner distinction unhelpful? Could something different be created to deliver horizontal integration?

Mr Murray said his view was that an adversarial approach to procurement should go but seeking to join everything up through merging provider/commissioner roles would also have significant risks of failure because it would blur accountabilities. A more strategic approach to focusing on the needs of the population should be the key driver of re-design. Currently the mood music is still too heavily focused on urban models of secondary care.

Anne Marie Morris MP asked Mr Murray’s opinion in relation to the question: is there a role for a new intermediary care setting for people with acute needs in rural settings where traditional care homes aren’t the best solution?

Mr Murray identified that some people would argue community hospitals could make a come back in this context. The case for centralization in urban areas is also somewhat exaggerated and this militates against more decentralized local care models. If other national models can run smaller units of care rather than massive hospitals then it is perfectly reasonable to ask why not here? Technology provides the opportunity to offer specialized care at distance. Canterbury in New Zealand is a good example of remote care in this context.

**Dr Ian Hume – BMA**

Dr Hume introduced himself as having a number of roles, these include: being a member of the GP Committee of BMA (GPC), the GPC representative for Norfolk and Suffolk, the Deputy GPC premises and finance lead, a Board Member of the Dispensing Doctors Association, a rural GP for 30 years and deputy of the BMA regional council. He also cited significant applied experience of work with secondary care colleagues.

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

In a rural community it is important to have GPs with flexible skills. Community engagement is important and this should lead us to be sensitive about the implementation of change. Urban models aren’t always transferable to rural settings. Isolated GPs face increased workload and higher levels of vulnerable older patients than their urban counterparts. In terms of appropriate planning geographies Dr Hume’s experience is that his area - Norfolk and Waveney is a natural community which runs also into Suffolk and works as a logical area. The pattern of acute care is also determined by the geography of the area with the fixed need for 3 acute centres based on the distribution of the population.

Recruitment is the biggest challenge in rural practice. New changes are beginning to bed into rural places. In terms of examples of good practice – finance is always a challenging determinant. Dr Hume agrees that scaling up of acute hospitals has been the key mood music The NHS funding formula more generally disadvantages smaller units of delivery and rural areas. Dispensing is being increasingly squeezed as a strand in the functioning of rural GP practices.

In terms of Dr Hume’s experience of structures, local delivery groups are currently organized at the level of the CCGs (areas with a population of 250,000 or so). PCNs add a new layer at the 30-50,000 population scale. PCN structures require time to get established and generate engagement. The full engagement of GPs in the local roll out of local structures is patchy. Procurement rules often militate against joint working and effective delivery mechanisms.

It is important not to neglect a consideration of premises issues in the assessment of systems. There is scope to develop a premises strategy in localities. There is scope to look down stream from bigger health hubs to “hublets” which could reach out to the community more widely. Broadband and technology challenges can frustrate effective system development.

Turning to the end user, one key element of known good practice is that fast track systems for frailty management (there are more frail old people in rural areas) and enhanced referral systems for these individuals in terms of care pathways are important. Overcoming challenges such as poor broadband and remote services, which militate against the delivery of this approach needs careful attention in rural systems development.

**Anne Marie Morris MP** reflected on Dr Hume’s evidence that the message back to Government is that the policy approach doesn’t quite fit the applied experience of rural GPs. It would be helpful for the BMA to provide some evidence to feed back to Government about what doesn’t fit through specific examples.

**Professor Martin Green – Care England**

Professor Green indicated that he was keen to reframe the systems discussion. His view is that structural discussions can divert us from concentrating on people and their needs. In understanding what is required the changing population demographic is really important. Co-morbidities are increasing making providing suitable care more complicated. At the heart of the design challenge we should recognize that people want to live a life rather than be fitted into service models.

Integration is the key to facilitating a good experience for end users of services. Professor Green agreed that workforce issues are a huge challenge and that the increasing focus on specialisms is unhelpful in the development of a flexible workforce.

The key challenge those developing systems face is to think about what is going to make the difference to people’s life and to consider how we achieve this. In considering the challenges in this context it is important to reflect that some of the needs faced by people don’t have a locus in health. Other service providers even in the retail sector can make changes which have a wider impact on the health and well-being of residents and at the local level those planning health services need to recognize this.

Professor Green went on to say that thinking more innovatively about the use of health related facilities for wider community benefit, for example developing care homes as wider community hubs is an example of a highly desirable innovation.

Technology provides a very good opportunity to re-engage communities in a broader community and health agenda. Innovations around transport policy will definitely have a knock-on effect in terms of health outcomes for example. Professor Green is also interested in domiciliary care and widening its remit and activities as a way of building hyper-local responses to the systems challenge around health and care. Can electrical cars for example provide a lateral solution to people accessing domiciliary care?

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

**Anne Marie Morris MP** summarised the comments from Professor Green as the challenge is how we make all this work through culture change. She reflected that there is an international global shortage of workers. The challenge, in part, in terms of addressing this is to consider how we do things differently and focus more on generalist rather than specialist approaches. One key question is how do GPs feel about the need to be more generalist as they are at the interface between primary and acute care? She also reflected on the fact that perhaps PCNs might provide a new impetus to innovation in this context.

**Tim Goodson – Chief Officer Dorset CCG**

Tim Goodson explained that Dorset was one of the first wave ICS. He feels the principle underpinning ICS geographies is that an ICS should be big enough to be strategic but small enough to implement change. Mr Goodson identified an example of the challenge of integrated delivery in the form of the use of care records across delivery geographies in the care journey of individuals. This agenda is important in joining up the integration between service providers. It is hard to see how very large ICS can achieve the ICS agenda in this and a number of other contexts.

Almost irrespective of rural/urban issues is the bigger discussion about the pattern of investment between the acute sector and the primary sector. PCNs have made a useful systems start to driving a step change in this context. There is likely to be a time lag before these benefits are fully realized.

Dorset CCG has tried to structure its approach around a natural community approach based on the two local authority areas in Dorset. Experience of working in this way is that workforce is probably the number one challenge in the rural settings in Dorset.

One area of innovation that Dorset ICS are exploring is the idea of a virtual medical school as a means of addressing some of the skills challenges faced in the locality.

The lack of good broadband is a key determinant in the rolling out of a new service approach.

In terms of structures Mr Goodson has a plea around moving things forward namely, a recognition that “one size doesn’t fit all”. Mr Goodson feels that GP engagement can lead to the identification of local service delivery solutions if GPs are empowered to be flexible in their activities. A too deterministic approach to systems implementation will create a challenge and disincentive to making new structures work on the ground.

Dorset ICS have worked with the Kings Fund to consider the transfer of good practice from Alaska and New Zealand and this work has been really useful in thinking about stretching the envelope of what can be achieved and creating a framework for community involvement. This work has helped the ICS to consider how to move away from a community hospital model to the development of a community hub model.

In summary Mr Goodson reflected that investment in very local community referenced services is important and it takes time and not a concentration on moving bigger structures around.

**Anne Marie Morris MP** – reflected that we are learning through the dialogue in this session that small is beautiful. She identified that she was very attracted to the idea that community actually means community in how people are engaged in service planning. She asked Mr Goodson how has local authority engagement worked? Are budgets shared to a degree and where is mental health in the mix?

Mr Goodson identified that the Dorset ICS has only just begun to pool budgets. Planning has been aligned quite well over a longer time period between those involved in the delivery of services. He believes Health and Well-Being boards provide scope for greater engagement. PCNs could be the cohesive drivers of relevance going forward. In Dorset reaching out to Police and Fire is also seen as a key approach. Concentrating on how do we spend the Dorset £ and how is it being spent in the right areas is an important consideration. He identified that alignment around key challenges on a very big joined up strategic basis, which then focuses health resources at the very local level is the best way forward.

In terms of mental health and well-being Mr Goodson reflected that in Dorset co-design has been a powerful aspect of the development of services. There are some joint NHS/Local Authority job roles in this context, which are the focus of innovation in Dorset.

**Dr Alex Degan** – Medical Director for Primary Care, NHS Devon CCS

Dr Degan began by saying there are many common themes linking into the evidence given by the other speakers in the material he has prepared for submission.

Dr Degan is a GP in mid-Devon. He has a background in commissioning and is currently Primary Care Medical Director for Devon STP a county with a population of 1.1 million people. There are 31 PCNs in Devon. The standard NHSE contract involves a 30-50,000 population range for PCNs. In Devon the threshold has been lowered to 20,000 recognising the small scale of many localities.

Working in rural areas enables a small practice to know its patients well and to provide enhanced levels of insightful care. The Partnership Trust localities team is based in Dr Degan’s local surgery and this leads to very good joint working between district nurses and the GP surgery.

One of the key challenges is distance from services for rural patients. PCNs are providing a useful systems development for enthusing people at the local levels. They are re-balancing a feeling of strategic disempowerment.

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

A virtual pharmacy school is being considered in Devon to address some of the challenges, which are faced. PCNs are bringing GP practices into a more collaborative framework around workforce issues.

There has been a change in the GP workforce. GPs historically worked on the basis of a vocation sometimes for 90 or so hours per week. The new generation of GPs is seeking more of a work/life balance. This is a challenge for primary care in rural areas where demand often outstrips supply. Many GPs also want portfolio careers – there are few opportunities for GPs to achieve this in rural settings.

IT quality is a challenge in Devon, which impinges on good service delivery in the field where it involves using e-enabled approaches.

The New Zealand Canterbury model referenced by the Kings Fund and the Buurtzorg (a Dutch patient centred approach) model have both been inspiration for innovation in Devon.

In Moretonhampstead the NEDcare CIC approach is an innovative approach to the provision of care, which demonstrates the potency of community engagement.

Another model of good practice is the Netherlands co-generational living in care settings approach.

Keeping the wider determinants of health in view is also really important in any consideration of systems innovation. Social isolation, transport challenges and fuel poverty are all important dynamics, which need to be considered.

As a seminal driver to more effective joint working, the “holy grail” would be a single IT system. Having scope to double run approaches would help with transition in this context.

**Anne Marie Morris MP** asked Dr Degan for his view on how, from the perspective of the patient, could we make things work better in a rural milieu?

Dr Degan – commented that this is variable on the ground in his experience. There are examples of good joining up of services in some areas but in others this is less well delivered – his applied experience of the working with district nurses in his own practice is a good example of how things can work well.

**Dr Richard West – Chair Dispensing Doctors Association**

Dr West’s first reflection was that the practice he first worked in was a universal hub. Local rural general practice was a powerful common denominator. This is no longer the case and integration is the poorer for the loss of this.

A lack of population density means we need to think about a different model, which moves away from seeking to concentrate things in one area. This puts a focus in part at least on the importance of rural transport systems. Motor insurance is a challenge for people working as community transport volunteers and Government could intervene to tidy this up.

The Pharmacy contract has changed. This brings with it some positives around wider pharmacy practice however in rural areas a lack of pharmacy is the driver for the Dispensing Doctor approach.

Dr West posed the question: is there scope to reverse some of the proposed changes to the role of pharmacists into GP practices? He identified the prescriptive approach to the training of pharmacists as being unhelpful. The opportunity to train staff in GP practices could be a real positive.

A local recruitment strategy could make a real difference to a joined up solution to care for non-clinical jobs.

PCNs are constrained in sharing opportunities where people have to travel for very long distances and therefore staff are “time poor”.

VAT and other systems create problems around joint employment of staff and innovation amongst a range of other organisations. Can Government address some of these challenges?

ICS are dominated by organisations with management capacity. The number of meetings militates against GP and other small scale components in the system. This leads to a big organization agenda in the mentality of these structures.

In terms of IT and patient contact there is a distinction between transactional and deeper conservations and in terms of the latter we need to recognize the limits of IT, which is by its nature impersonal.

The specific resource costs of developing innovative services are often missed in the drive to join things up.

In terms of co-morbidities – increased specialism has impacted negatively on managing complex conditions.

In planning change it is important to look at patient needs rather than treatment journeys driven by systems planning. New approaches are predicated on a lack of trust to devolve solution to localities and are therefore over prescriptive.

**Anne Marie Morris MP** indicated that the evidence given had revealeda number of emerging strands. She had derived the view that the whole issue of primary/secondary integration, particularly in rural areas is not sufficiently on the agenda and it needs to be. In policy terms we have perhaps decanted some urban approaches/solutions into a rural milieu without thinking about how they fit. She went on to say that the new CMO is very interested in rural issues. She then invited comments and reflections from the audience.

**Rhys Davies** – Community Catalysts – explained that they have developed a small community enterprises model – similar to the NED model in Devon for the delivery of care. Over 300 people have been supported to become self employed through this approach which also involves ensuring the carers meet the regulators requirements.

**Anne Marie Morris MP** asked what are the barriers to making this approach work?

Mr Davies indicated that in Somerset encouraging participation on the part of people through more personalised budget allocations has been important. This has empowered people to be more focused on choosing their own care. Over regulation in terms of care is a key challenge, recognizing that a balance has to be stuck between patient safety and flexible systems.

**Kate Woolland** from Ieso digital health responded to the overall debate with reference to mental health –she referenced the IAP Digital Mental Health Care programme – this is an agile system which can help people with quick and accessible support, through booking a time for a therapy session which works for them. This is particularly important for people in rural places. It works well where mental health is a component of comorbidities.

**John Wynn Jones** from the National Centre for Rural Health and Care offered a reflection on the generalism/specialism debate – his view is that the focus should be on the training of the next generation of GPs. He referenced the Australian model of rural generalist doctors. In Queensland this approach has led to the reduction of vacancies. In the UK we are fixated on generic training. We need the concept of a rural medical school and dedicated rural training. The University of St Andrew’s is developing an interesting approach in this context. 3 approaches are key to increasing the pipeline of rural GPs: choose rural students, give rural experience and provide rural training examples.

**Anne Marie Morris MP** invited **Ivan Annibal** to offer some concluding thoughts. He thanked everyone for their participation. He reflected on the message that small is beautiful. He also reflected on the fact that taking as wide as possible a view about the determinants of health was important. He identified how innovation is often stifled by other agencies, which have an indirect relationship with those managing the need to change such as HM Treasury. He summed up his thoughts by explaining how overall the concept of place is a really important component of future systems development.

No further comments were raised and **Anne Marie Morris MP** thanked everyone for their contribution and closed the meeting at 1.55 pm.