Summary of Responses to Session 1 of the Parliamentary Inquiry into Rural Health and Care

Introduction

This summary sets out a brief synopsis of the responses to the call for written evidence in relation to the first session of the Parliamentary Inquiry into Rural Health and Care. This session will explore:

What are the needs of rural communities and how are they different from their urban counterparts?

Written responses were received from:

- NHS Kernow Clinical Commissioning Group
- Dispensing Doctors' Association
- Plunkett Foundation
- Professor Alison Marshall, University of Cumbria
- GP committee of British Medical Association
- Arthur Rank Centre
- Health Education England
- Farm Safety Foundation
- NFU Mutual
- Professor John Shepherd, Birkbeck College
- Rural England/Rural Services Network

Some organisations submitted responses by more than one individual

Responses to each question are summarised below with direct quotations in italics.

Questions and Responses

There are different types of rural settings: Cumbria, Surrey and Devon are for example very different. How important is the spatial context of a place as a starting point for planning key services?

Rural is about isolation – it is best defined as: *"time to access support or for support to get to you"*

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Rurality does not simply relate to geography, but also the ability, or not, to access, regular and reliable and affordable public transport, especially if one does not have access to personal transport opportunities.

The ONS rural_urban classification can be used – but it is important to acknowledge that rural areas are heterogeneous.

There are a number of definitions, including the United Nations, Office of National Statistics, DEFRA and Scottish Office. Most of these definitions relate to population density or size of settlements. For instance, the ONS definition is that any settlement below 10,000 is classed as rural. This is a reasonable starting point, but there is a lack of granularity, as it means that Kendal and Manchester are in the same category – when clearly they are very different in character. There are definitions in development that also categorise 'market towns or hubs' as 10,000-30,000 inhabitants, which is an improvement. However, there is no easy definition that also takes into account access to services, which is an important factor.

It is the issue of a patient's ability to readily access health and social care by virtue of geography, distance and isolation outside the conurbations and large towns. Distance/ travel patterns/public transport routes are crucial factors in this.

"Compare us with say the USA and Canada we have hardly begun to look into these issues in any depth at all."

What do we mean by deprivation in a rural setting? How do we currently take account of these issues in our planning and strategy development and do we do it effectively?

It is useful to think of deprivation in terms of the cost of living or availability of services compared to local peers – in Cornwall higher living costs due to travel and a low wage economy define deprivation. We need to take account of: population, geography, travel time and the availability of public services in coming to planning decisions in rural settings.

"Re-thinking the English of Multiple Deprivation" report by Ian Smith, commissioned by Power to Change demonstrates the need to interrogate the information available on a community by community, region by region basis.

The allocation of appropriate resources is inadequate partly due to poor data in the deprivation experienced in these areas as well as an urban bias.

Measures of deprivation are predominantly urban based. For example car ownership is seen as a sign of wealth. In a town it is a luxury, in remote and rural areas it is an essential lifeline without which it is exceedingly difficult to live.

Distance and sparsity have an additional impact, usually of raising the price of transport and infrastructure connectivity and thus raising the cost both of delivering and accessing services beyond that which might be the case in suburban and urban settings.

Do we need improved identification of the "hidden" nature of isolated pockets of rural deprivation, which are masked by the relative affluence of surrounding areas?

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This is a major data challenge – it requires access to (anonymised) household/individual information.

"A resounding yes - So as an example in our Annual Report for Public health 2017 we describe how deprivation and healthy life expectancy varies by > 10 years along 5 miles of one bus route. We should look at identified communities and assess their need."

"Yes we most certainly do. One size or definition does not fit all and what passes for being rural near Guildford is so very different to an equivalent part of South West Cornwall. There appears to be no difference in the eyes of those who decide what rurality is when working out the funding formula. It is also easy to aggregate the wealth of a county (i.e The Duchy) in order to conveniently ignore or reject the reality and depths of depravation in places like Camborne and Redruth."

There is a preponderance of over 65 year olds in rural areas - what are the impacts on health and care needs – and medical training?

"Generally I would question the 65 years base - probably better focus on the more elderly (75+?). The main issues are access to services and rural provision of domiciliary care."

"Workforce, workforce, workforce and then everything else". A skewed population demographic - itself magnified in a low wage economy like Cornwall has not enough people to step into a caring role, as part of a long peninsula we are less resilient as we cannot draw from our borders, nor can variation in demand be absorbed by neighbouring providers. For medical training it is harder to attract people to come and train or start their career as a senior clinician, when the peer support network is not there. Our main providers work in a form of isolation and this is unhealthy when they are not able to share ideas, expertise and solutions on a regular basis. It is much more important for network ways of working when isolated and rural.

This phenomenon leads to greater care needs and costs per individual, invariably increased loneliness and isolation, depression, lack of mobility and co-morbidity issues.

These individuals place a heavy cost burden on the NHS because of the intensity of their need and their distance from services. They probably have the highest unit cost of any category of person to support.

"There can also be greater pressure on hospices, leading to 'hospice at home' arrangements due to shortage of beds. There could be an opportunity here to look at the issue more positively, through the 'compassionate communities' movement (see, for example, the work of Prof Allan Kellehear at University of Bradford). The thinking is that death and preparation for death affects more than just the individual, but also carers, friends and communities, and services need to be designed in a way that recognises this issue."

This section of the population have greater health needs though with a lesser medical workforce due to difficulty in attracting and retaining talent in rural areas, which makes these settings less attractive to work in.

"We can't recruit carers because they act afford to live in the area and they can't afford the long drives in for a daily commute. The impacts of travelling time reduce "productivity" in all spheres. The

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over 65s from all backgrounds are surviving longer and their needs/demands and expectations are the same as those in the cities."

Medically speaking there needs to be an emphasis on early intervention and prevention. Training should involve placements, which allow medical professional to experience rural areas for themselves. Arthur Rank Centre is well accustomed to providing rural placements for clergy in training, and would be very happy to work with partners to share expertise to enable such a possibility for the medical professions.

Rural areas suffer problems with recruitment across the spectrum of health and adult social care– how do these manifest themselves?

"Competition for people of working age, higher wage costs, we have set living wage as benchmark for the lowest paid carers yet competition from supermarkets, tourist industry etc provide many alternative work options, being a long way from training establishments does not help. Our young people leave to seek higher education and evidence suggests they do not return until their 50's."

This situation creates a finite pool of employees who rotate around H&SC providers/commissioners within their rural area/setting. Whilst consistency and local experience and knowledge can be a positive, it can also be a negative in the sense that employees know it is a closed market and there is little external competition forthcoming for places.

"The attraction of seasonal work, better paid jobs with national employers such as Tesco, Asda et al, mean that workers can get a less stressful way of life with better remuneration."

There is a particular problem with the recruitment of rural GPs at the current time and this has a knock on effect in terms of other health and care support due to the key role GPs have in treatment and diagnosis.

"There are problems of recruitment to rural professional positions, as they are perceived to offer lower opportunities for progression and achievement. Individuals are often also reluctant to relocate as schools are often of a lower quality than elsewhere and there may be limited jobs available for spouses or partners. An approach in Cumbria is to develop a dedicated cross-sectoral platform for recruitment, Choose Cumbria, that promotes Cumbria as a place to live and work - https://www.choosecumbria.co.uk/"

"In terms of GPs: getting partners is difficult, getting locums nigh impossible except at a MASSIVE cost. We are ageing workforce."

Widening participation is a significant challenge to support into professional career pathways. It is difficult to recruit local populations into professional careers through this pathway. We also face the drain of talented youth to the "Bright Lights" for further education who then fail to return. There is also a lack of peer/professional support to support practice across challenged areas.

What are the threats arising from these recruitment issues and how do we address them? Does this cover some occupations and services more than others and if so how?

"There is a challenge to the viability of services because of the disproportionate costs in providing an equivalent level of care for a rural population. I believe it covers the whole range, so it is difficult to recruit consultants to a small, isolated provider (lack of peer network, career opportunities, research,

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credibility) there is a defined pool of qualified staff which impacts on competition, we are seeing this across all grades and it requires a mature approach and workforce strategy that aligns the available skillset to the health and care need."

"I do not support the premise that well paid GPs are the priority. Good quality nursing and social care is the bedrock upon which we can redress this situation. Drop the need to have to obtain a degree, as the negatives surrounding this requirement (3 years, huge costs, reduced bursaries/grants and high educational requirements) are not helping. We need those who are innate carers first and scholars second."

"We could face the closure of some rural practices, or mergers, which would mean one practice covering an even greater geographical area than current practices do. It is not uncommon for some rural practices covering in excess of 100 square miles."

Once recruited, there are limited opportunities for professional development in health and care. Rural departments, units or practices tend to be smaller and the staff need to travel further to do their work (both commuting and if they need to go out to visit patients/clients). This means that staff are more stretched.

There needs to be a more joined up approach with the network of voluntary services and professional services including and agreed triage support matrix to ensure all professionals/volunteers/specialists can identify the severity of the issue and the necessity or otherwise for escalation and who to escalate to.

Could technology play a central role in rural health and care? What are the features of rural health challenges it could overcome? What are the practical issues to be addressed in using it? Where are there sustainable examples of good practice?

"The VA in the States use remote technology with patient and clinical decision maker many miles apart, observations can be made at a distance. This helps clinicians operate at the top of their licence and avoids the need to spend time (not making decisions) travelling between remote sites. This could work well in urgent care, with remote patient monitoring supporting a network of dispersed urgent care centres."

"The housing stock plays an immense role in the overall H&WB of local residents. Poor accommodation standards are detrimental to all ages. Adverse living conditions can and do create health and social care problems from birth right through until end of life care. Creating suitable and affordable housing stock is key to the future well-being of everyone – not just those living in rural areas. If such properties cannot be bought and owned by many, then suitable social housing stock must be provided. This is a case of spend to save…"

Broadband and mobile connectivity are real impediments to the use of technology in health provision.

"From 2014-2016, the Cumbria Rural Health Forum, explored this issue and developed the Cumbria Strategy for Digital Technologies in Health and Social Care (see the Journal Article Ditchburn J, Marshall A. The Cumbria Rural Health Forum: initiating change and moving forward with technology. Rural and Remote Health 2016; 16: 3738. Available: www.rrh.org.au/journal/article/3738). There are certainly drivers for using technology that are less acute than in urban contexts, particularly the difficulty in travelling (note, it is not always the

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distance that is an issue, but the travel time required. It can take over an hour to travel 20 miles if there is no bus service and only a single carriageway, windy road), as well as the challenges of access to professionals."

"Patient education is key to the success of this modality. Smart technology to support healthcare is underutilised in favour of traditional face to face methods."

What is the impact of housing on the key features of rural health and care? Is there enough of the right type of housing to enable people to stay at home into their old age in rural communities?

"Affordability, suitability, accessibility. Having suitable housing of the right quality and composition is useless if there are no complimentary services such as transport access, wifi (treatments, communication...) wrapped around them. Such a service must be viewed as an entire capability provision and not simply the sum total of different strands of work.....the threads must be woven together astutely and carefully and in the correct sequence."

Shortage of housing supply and of the right range of housing in rural areas are real challenges.

The Rural Housing 5* Plan which challenges the sector to increase delivery of rural housing and continue to contribute to a living and working countryside is important. In respect of housing relating to health and social care, the specific challenges are presented by an ageing population, access to services and availability of affordable housing should considered in relation to any proposed housing development.

"We have a whole village that is second homes bought with mortgages backed by the impossibly inflated values of their primary residence. They have priced the local youngsters out of the market so we don't have a sustainable population spectrum. Even for the GP housing is expensive with little choice and there i little choice of schooling so recruitment is an issue. Turning to patients there is a shortage of downsizing homes and anyway there is a reluctance to leave a family home. If people have to go into care then sometimes they have to leave the district altogether."

Affordable housing and supported living both need more attention to encourage a cradle to grave ethos in terms of housing availability in rural areas. Success here will rely on local authority and integration of health and social care services.

Rural housing is less energy efficient with implications for the health of the elderly in particular.

What are the challenges to housing supply in the context of vulnerable old people and people with disabilities in rural settings? Are there examples of rural innovation?

"An example of innovation is from Loreburn Housing Association with Strathclyde University, looking at providing non-standard services to their clients. Todman, Andy; Taylor, Simon 2017. From Africa to Dumfries and Galloway: Connectivity in a Rural Community. Journal of Corporate Citizenship, Volume 2017, Number 68, December 2017, pp. 109-117(9)
https://doi.org/10.9774/TandF.4700.2017.de.00010"

Expensive land prices are a key challenge. The impact of local authority cost cutting which reduces the availability of small warden aided facilities.

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The challenges of housing supply include - location close enough for family to provide general support, social housing scarcity, lack of adaptability of buildings, clashing systems (and criteria) to request and secure social housing in adjacent areas.

What are the cost drivers in rural settings? How do these apply to people's lives generally? How do they manifest themselves in relation to the health and care agenda?

"Cost of travel, cost of food, low wages, rural populations are reliant on private cars for transport – In Cornwall the evidence is that we have cars on average 6 years older than average, an illustration that is a necessity and a significant drain on personal finances."

"Cost of new homes, infrastructure access and public service provision, mains services and access to suitable sites (green grey or brown). The young generally want to live in town, the older genartion(s) want more space. Urban arteas are more costly places to live and there are fewer housing opportunities for the young to afford to do so. Lack of work, drug abuse, social exclusion, and lack of meaningful work add to problem of trying to live well."

The funding in the GP contract formula has a rurality factor, but most rural surgeries that dispense use the income from dispensing to cross subsidise the GP service. If they lose the dispensing, or see a fall in dispensing income, the whole practice could be under threat.

Lower income is commonly associated with high costs of doing business discourages GPS from moving to these areas.

Access to support services, wages and availability of employment, young people and access to education, low skilled workers and low earning potential. Leading to increased levels of poor mental health, stress, anxiety and depression.

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