

Parliamentary Inquiry into Rural Health and Care Session 3 – 1 April 2019

Present:

Anne Marie Morris MP Morris M.P. (Co- Chair)

The Rt Reverend and Rt Honourable Dame Sarah Mullally, DBE, Bishop of London (Co-Chair)

Witnesses

Dr John Wynn-Jones Wonca (Working Party on Rural Practice and Keele Medical School)

Jonathon Holmes – Senior Policy Analyst Healthwatch England

Professor Stuart Maitland-Knibb – Director National Centre for Remote and Rural Medicine (UCLAN)

Councillor Lee Chapman –Portfolio Holder for Adult Services, Health and Housing, Shropshire Council

Invited Participants

Rev Jason Roach - Minister, The Bridge Battersea, London City Mission / Bishop's Advisor, London Diocese

Jeremy Legget – Policy Adviser Action for Communities in Rural England (ACRE)

Professor (Emeritus) John Shepherd – Birkbeck College

Maria Ball Chief Executive – Quantum Care

Tish Hanifan – Society of Late Life Advisers

Simon How - Health and Wellbeing Programme Leader, PHE East of England

Gemma Hopkins – Senior Public Affairs Officer, BMA

Matthew Isom – Chief Executive – Dispensing Doctors Association

Lizzie Swain – Office of Ruth George 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 – Office of Anne Marie Morris M.P.

Introduction

Anne Marie Morris MP – welcomed all the participants and explained the background to the inquiry in terms of progress to date. She also introduced the Bishop of London, Dame Sarah Mullally, the inquiry Co-Chair.

The Bishop of London - introduced herself. Her background is in health (she was formerly Chief Nursing Officer for England) and most recently she served as a Bishop

in the South West in Devon. She has observed the impact of isolation and from a Government perspective has seen some of the challenges particularly in relation to access to Centres of Excellence in terms of health care for people in remote rural settings. The Bishop also has insights into the difference between rural and urban places and understands the challenges facing rural communities more widely.

Dr John Wynn Jones

Dr John Wynn Jones – introduced himself and WONCA – which is the World Organisation for Family Doctors representing 500,000 family doctors and GPs globally. Dr Wynn Jones Chairs the rural part of this very large organization. He also set up the Institute for Rural Health in 1997 along with the European Rural and Isolated Practitioners Association (EURIPA). In 2001 he set up the Welsh Rural Postgraduate Unit. He has helped to establish rural campuses in Mid-Wales and Shropshire. Dr Wynn-Jones was a rural GP in Wales for 37 years. He is currently Senior Lecturer in Rural and Global health at the Keele Medical School.

His current roles are:

- Senior Lecturer in Rural and Global Health at Keele Medical School
- Chair Wonca Working Party on Rural Practice (Wonca World Organisation of Family Doctors/GPs Represents 500,000 doctors in over 130 countries)
RuralWonca

His interests lie in workforce development, creating and growing a multidisciplinary rural workforce that is not only socially accountable but “Fit for Purpose” to meet the challenges that individual contexts pose.

Some of Rural WONCA's activities include:

- Large global rural network of doctors, other health professionals, students, academics and policy makers
- Producing policy documents and statements on rural health
- Annual World Rural Health Conferences (Last was in India where we had over 1K delegates, joined by India's Vice President and we hosted India's National Consultation on Rural Primary Care)(Next is in New Mexico)
- Student and Young Doctor/Health Professional Network called Rural Seeds
- Rural Medical Education Guidebook produced as a request from WHO (Over 70 chapters written by international experts from around the world)
- Close working with NGOs and particularly with WHO

Recent work for World Health Organisation (WHO) has been the development of a “Checklist for Implementation of Pathways to Train and Support Rural Health Workers in LMICs” Prior to this they were also involved in a programme called “Increasing Access to Health Workers in Remote and Rural Areas Through Improved Retention” Many of the issues identified are also relevant for rich countries such as

ours. The project includes an extensive literature review and a check to aid countries develop an effective rural health workforce.

Generalism

There has been an ever-increasing move to specialisation in the health workforce. We no longer produce generalists and the only true generalists in medicine are GPs and Care of the elderly specialists. This is even more stark in places such as the USA where family medicine does not necessarily generate the income to repay the huge costs of medical training. It is also a major problem in countries such as India where they produce enough doctors, but few want to be generalists and work in rural areas.

The specialist boom has led to staffing shortages in our smaller hospitals which are more reliant on generalist consultants.

This has had a major impact in Australia and coupled with the urban centric accreditation rules imposed by the various colleges has led to major shortages across its rural health infrastructure.

The “Rural Generalist Movement” started in Queensland and has had an extraordinary impact in a few years. Prospective rural generalists/GPs receive 3 years of GP/Family Medicine Training. They then receive a further years training in a speciality of their choice. These include Obstetrics & Gynaecology, Anaesthetics, Mental Health, Aboriginal Health, Public Health, Surgery, Academic Practice, General Medicine, Emergency Medicine and Paediatrics.

This has transformed health care in Queensland, eliminated vacancies and Rural Generalism has become a first career choice amongst medical students. Its has become so successful that Australia has appointed a Rural Health Commissioner and one of his remits has been the roll out of rural generalism across the whole country. A similar process is happening in Canada. New Zealand has established a rural hospital generalist programme where doctors are trained to provide health care in its smaller district rural hospitals.

RuralWonca is working with senior rural nurses around the world to promote a generalist approach to rural nursing. Such a scheme in the UK may sound quite alien to start with but it would have a major impact on staffing across the rural areas with the regeneration of our community hospitals and care being provided closer to where people live.

Education and Training

There is an urgent need to address the crisis in rural recruitment and retention here in the UK and create a national rural health workforce that is “fit for purpose” to meet the challenges that the rural context provides.

From the evidence that 3 factors impact globally on rural recruitment and retention.

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

2. Ensure that students have significant and substantial rural experience as early as possible in their undergraduate training.
3. Provide rural Family Medicine/GP training schemes

These 3 areas have driven rural training programmes around the world over the last 20 years and he is delighted to say that green shoots are beginning to appear here in the UK.

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

Medical Schools in England, Scotland and Wales are beginning to adopt Integrated Longitudinal Clerkships. This idea started in South Australia at Flinders University as a way to embed and train medical students in rural practice. It has become extremely successful and has spread around the world. Instead of the traditional model, where students learn in hospitals, they spend a year in rural practice, viewing the patient journey from a different perspective, working and learning within a health team and following the patients into hospital when necessary. Evidence suggests that these students do as well and probably better than their peers in examinations and it improves rural recruitment.

He wished to bring the attention of the inquiry to 2 innovative medical courses which are being established in Scotland and plan to start in 2019 & 2020 respectively.

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

HCP-MBChB Edinburgh is even more innovative and is aimed at established rural health professionals wanting to convert to medicine (Nurses, pharmacists etc.) They undertake 3 years part time distance learning in their work setting before going to Edinburgh for a final 2 years. Both schemes are subject to final GMC approval but we need have more innovative rural schemes such as this. There are other similar innovations globally that we can learn from.

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

Rural Proofing for Health

This was something that was developed at the Institute of rural Health in collaboration with the Countryside Agency and later the Commission for Rural Communities. And they emphasised the importance of introducing the principle of Rural Proofing (often referred elsewhere as the Rural Lens) to health and care. The IRH developed 2 toolkits over a period of time. It was flattering to us that elements were copied in New Zealand, South Africa and parts of the USA.

Too often policy can have an adverse impact on rural communities and rural practice unless it is rural proofed at an early stage before implementation. Both the new GP contracts in England and Scotland were not rural proofed and concerns persist that they will have an adverse impact on rural practice. The institute secured funding to rural proof the 2004 GP contract but not until it was implemented. Sadly, this was too late to stop the closure of many of the country's branch surgeries, which closed as a result of the contract.

The concept of Rural Proofing for Health seems to have slipped from the radar. The demise of the Institute coincided with DeFRA taking the tool off their website. Unfortunately the toolkit is lost and many people have been trying to retrieve the information from DeFRA but to no avail. A pronouncement that all health policy should be rural proofed before implementation would be greatly welcomed and I am sure would have a beneficial impact on rural health care.

Workforce Configuration

Dr Wynn-Jones has seen a huge change in the quality, diversity and configuration of rural health workforce over the years. The New English GP contract provides funding support for Social Prescribers, Pharmacists, Physicians Assistants and Paramedics.

The provision of care to the rural aging population will have complex needs and will need complex solutions. The management of Non-Communicable Diseases (NCD/ Chronic diseases has taken centre stage in primary care. The majority of people over 65 have one chronic condition with many having more than one. These complex co-morbidities will need skilled GP interventions with GPs increasingly becoming complex problem solvers with the actual care being provided by others in the team.

He has travelled to many countries in recent years and having witnessed the benefits and contributions provided by community health workers in LMICs, he feels that a network of community health workers recruited from local communities might help address this growing rural health burden.

When it comes to creating a rural workforce, the UK always been resourceful (RCGP was largely established by rural GPs) and he wondered whether we should be looking to establishing a national resource for the rural health workforce as part of the National Centre for Rural Health and Care.

Resources and funding formulas

He does not see himself as an authority on rural health economics, especially regarding the effectiveness of the national funding formulae. Worldwide formulae are also problematic when they exist. He asked for examples of rural premiums from around the world. No one seems to be happy with their experiences.

The recent Nuffield Trust work for the National Centre suggests that the rural premium is not high enough and that the development of fair rural formulae is complicated by a disproportional aging rural population, distance, low numbers, historical localised funding practices and a clear lack of evidence to base any formula on.

In conclusion

From the perspective of workforce there is evidence that we in the UK are gradually but be it very hesitantly moving in the right direction.

We need to be bold and look at new models rather than tinkering at the edges
He would ask you to look at the 2018 Delhi Declaration which we published at our world Conference in Delhi this year. It identifies 6 crucial areas for the development of rural health care.

RuralWonca was also able to influence the final declaration of the 4th WHO Global Summit on Human resources for Health in Dublin in 2017 which stipulates the need for an effective rural health workforce and together with the Delhi Declaration provides a blueprint to work with.

The world bank also asks us to look at the health workforce from a different perspective. Rather than see an expanding workforce as a financial drain, we should see it as an investment in the rural economy. He concluded by saying that he suspected that in most of the UK's rural communities, the health and care sectors is fast becoming one of the major sources of employment.

Ann Marie Morris MP – Are there any examples of secondary or tertiary care to add to this excellent presentation?

Dr Wynn-Jones The rural generalist programme has embraced issues such as emergency medicine. It could be argued that all GPs should have training in emergency life support as part of a wider generalist competence. GPs have become deskilled with regard to practical skills. The New Zealand hospital model and some examples of approaches in the US in terms of secondary and tertiary care exist and are worthy of more attention. The National Rural Health Association in the US is doing some really interesting work and a similar cross sectoral, multidisciplinary organization in the UK would be valuable.

Gemma Hopkins (BMA) – concurred with Dr Wynn-Jones presentation and explained that the BMA are keen to start spreading good practice where it is identified from this

inquiry. The approaches around recruiting into rural areas and generating people fresh from University as rural practitioners were themes which had particularly resonated.

The Bishop of London – asked Dr Wynn-Jones (in relation to the proposed new medical course in Edinburgh where health professionals are given the opportunity to retrain as doctors) about the impact of moving experienced and skilled people currently working in rural practice. She was interested in how you encourage people from rural backgrounds to go back into rural work settings. She identified that it would be interesting to look at the drivers, which cause people to move back to rural settings. She identified that rural schools and driving up expectations about services and skills in rural settings was important

Dr Wynn-Jones – identified that his view was that we need a compelling brand for rural in terms of health and care. This needs to be bound up with a re-invention of the generalists ideal –this could also lead to the re-birth of rural generalist practice and a renaissance for small DGHs and local community hospitals. Technology has a role to play here in supporting people working in the field to become sophisticated generalists.

Jonathon Holmes

Jonathon Holmes – explained the background to Healthwatch as an organization. The role of Healthwatch England as the national organization is to aggregate up to themes from local practice at a national level. Loneliness and isolation are key themes in terms of the characteristics of rural places. The social care agenda is also very important in terms of the patient experience. Healthwatch Devon is an area where there is evidence of isolation facing younger people – this is not just an issue for older people. Social media can be a positive joining up force for young people in terms of engaging isolated individuals. The tech agenda is very important in primary care and its wider applications to social care and public health in tackling some of the problems patients face arising from rurality. The infrastructure in some rural settings is a challenge – online and mobile deficits are challenges in this context. The role of the voluntary sector is often challenged in rural areas in addressing problems such as isolation due to the large distances over which it has to operate.

In terms of health system integration – there are no easy answers. The NHS Long Term plan in terms of the transition to Integrated Care Systems provides an opportunity within this agenda. As we move towards a more integrated planning approach there will be scope to think about things in a more holistic way, which is not just limited to the commissioning of services and internally NHS focused. Local authorities and the voluntary and community sector are key aspects of this agenda.

How we measure and think about the success of a service is an interesting question – particularly in terms of the application of generic metrics to the functioning of rural health services. Using somewhat “abstract” indicators of performance is not

particularly conducive to the needs of the patient. We need more of a patient and less of a systems focus in how we measure issues.

In terms of social care the Green Paper is still awaited. Many issues from a healthwatch perspective will be about how we resource and support the cost of social care. Healthwatch focus groups have indicated that patients find the social care situation difficult to understand and when they do they are not pleased about the approach as it currently operates. The Care Act requires information and advice to be free to all from local authorities in relation to the costs of care. Evidence suggests that this does not work very effectively and this is a key gap which needs to be addressed.

Anne Marie Morris MP – a focus on the importance of the challenges facing the young as part of this agenda is helpful. Does healthwatch have any rural specific data?

Jonathon Holmes – there was no rural urban component when the healthwatch movement was established. More work needs to be done to enable the data which is available to be interrogated effectively. The range of data isn't a problem having the resources to analyse it is the key challenge.

Maria Ball (Quantum Care)– indicated that she was confused as to where the social care agenda comes into healthwatch? She indicated that she thought many people would be interested to understand this better.

Jonathan Holmes – Healthwatch run “enter and view” visits to care homes which look at the user experience and then feedback to the CQC. More broadly their role is to look at the experience of the end user more generally.

Maria Ball – how visible is the outcomes of these Healthwatch engagements?

Jonathon Holmes – The information collected is stored and can be thematically interrogated. Often this information is collected and then fed into third parties such as commissioners.

Anne Marie Morris MP– should the remit of Healthwatch be broadened taking account of the integration of health and social care as integration proceeds?

Councillor Lee Chapman – in Shropshire – insight reports received from Healthwatch Shropshire are welcome and are used to inform the commissioning approach. The extension of Healthwatch and the decision about how to fund social care are linked – Dilnot 2 would have brought this to a stronger focus, under circumstances as they currently exist Healthwatch provide a useful alternative view.

Bishop of London – expressed enthusiasm in favour of joining up data and insights. She raised the key challenge of how can we engage people to see health more broadly than just thinking of hospitals?

Jonathon Homes - In terms of engaging the user it is important to think about going to the end user as a means of engaging people rather than expecting them to come to institutions. This is much more difficult in rural settings due to sparsity. Embedding the message in third party centres such as Post Offices etc is a good additional means of addressing this.

Professor Stuart Maitland-Kinbb

Stuart Maitland-Kinbb – introduced himself. He is a GP by background and has experience in emergency medicine. Prior to that he was a nurse. He trained in the military as a generalist. He is keen to take General Practice back to when the majority of care was delivered by the GP. He previously set up a remote urgent centre offering primary care, which was successful. He then moved into the University of Central Lancashire (UCLAN) to look at training and development in remote settings.

GPs now operate within a chronic disease model – where GPs transfer people to third parties for treatment.

The National Centre for Remote and Rural Medicine has a Post Graduate programme focusing on remote and rural practice.

In the UK transfer times are not quite big enough to be a driver of the sort of bespoke innovation that operates in “bigger” countries such as Australia and Canada. Generating a sense of excitement and engagement with third parties is important in getting people to want to work in rural settings. Engaging those without the expected qualifications and growing your own are both important facets of responding to the rural health challenges around recruitment and retention. The military approach is an interesting example of a route into medicine – it follows a non-traditional role to recruitment and its operating environment has much to link it with rural settings.

Funding streams do not cover remote and rural practice in the way they are considered. By putting an emphasis on excellent primary care with allied health care professionals we can nudge the agenda away from challenged secondary care in small rural hospitals as the core rural offer for people in terms of health and care.

Currently the STP focus is on secondary care and there is scope for diversification and innovation if we are prepared to take a different attitude towards the management and scale of risk.

Anne Marie Morris MP–is the STP approach too much of a one size fits all methodology? How can rural be made more of a valued component within the STP environment?

Dr Maitland-Kinbb – we need to think completely differently about the dynamics of life in rural settings. An appetite for difference and risk is very important in the context of the planning of services in rural places.

Anne Marie Morris MP– How do we achieve this as a process of culture change? Should acute and urgent care sit more in primary structures? – what structure and training would you introduce and how should we get funders to recognize the need for this if that was recognized as desirable?

Dr Maitland-Knibb – We need to push GPs outside of their comfort zone in relation to practice. We need to think about how GPs are better supported in more extensive primary settings. Collegiate models, some using technology can be used to address these challenges.

Anne Marie Morris MP– Agreed with the premise that distance is not as strong a dynamic for system development as in deep rural settings in Australia for example. Rural settings do provide distinctive challenges in the UK for the delivery of health and care however. Responding to them is in part about personal expectations, which apply urban service assumptions to rural areas where such models are sometimes not sustainable or achievable.

Dr Wynn-Jones – Rural Generalism is country, health system and context specific. Despite the smaller distances in Europe compared with Australia, Canada and the USA there must be a European perspective on Rural Generalism. Skills such as Advanced Obstetrics, Surgery and Anesthesia may not be relevant but other skills such as Mental Health, Emergency Medicine, General Medicine, Public Health, Dermatology etc could make a huge contribution to current shortages and bring care closer to where people live.

Dr Maitland-Knibb – The key is enhanced primary care, which is deliverable at a high standard and quality in rural settings in the UK. Not everyone wants to work in rural practice but a dedicated rural practice programme can attract people if well planned.

Professor Shepherd –explained his background. He has a generic non-health perspective. The UK is not big enough to have a rural character that can inform a discrete policy approach in the way this happens in places like Canada. In England we have a rural/urban system. In this environment we are not in a position where one size fits all. Overlain on this complex settlement pattern is the complexity of demographic change. There is evidence that younger families are moving into in some senses deep rural areas. Urban fringe is often an area where demographic change is outstripping public service provision. If you look at the data on rural and urban places in terms of sectors of economy and age groups a nuanced understanding is required to grasp their different needs. The one area of straightforward and generalizable difference between rural an urban settings is to do with business productivity – this is interesting in terms of the relationship between health and business success in rural areas. Health and productivity is an important theme, which merits further discussion. Managing rural data is a sophisticated process if we want to interpret information for example from Healthwatch the effective development and use of a robust evidence base is important.

Anne Marie Morris MP – how might we be better at using rural_urban classification to interrogate data?

Professor Shepherd – the use of data at a national level is too generalist. We either need central provision by a purpose built unit to enable the interpretation of rural data at meaningful geographical levels or to develop the capability to understand rural data at the local level. This issue speaks to place based policy as a wider theme in Government.

Dr Wynn-Jones – the links between this evidence agenda and rural proofing are really important.

Professor Shepherd – The link between data interpretation and policy development is often rather weak in the way it is used by many agencies.

Jason Roach –Adviser to the Bishop of London– Getting the buy-in from the public on a new form of delivery is key to the achievement of better outcomes in rural settings. Learning environments, which operate by bringing practitioners and planners together would be valuable in this context. In terms of the growing your own strategy are we limiting ourselves by saying this has to involve just doctors? The key driver should be the quality of care provided not just way it is labeled.

Dr Maitland-Knibb – Agreed that people providing these services don't have to be doctors. Nurse led approaches can be very powerful. We do need to be able to link programmes of support to a medical training model. People need to be trained to interact remotely through wider approaches to health and social care training. This should also link into mental and adult social care models. The focus should be on being in communities. This is very dependent on public agendas.

Tish Hannafan – Advocate for the elderly – anecdotally she has heard that moves towards centres of excellence have the propensity to isolate those in rural areas even more significantly. In terms of social care – people's lack of knowledge bearing in mind the length that the funding arrangements for care have been in place is very disappointing and suggests things are not working well.

Dilnott 2 would make a big difference if these aspects of the review were implemented. Section 4 of the Care Act (Information and Advice) is implemented in a very uneven way. Oversight of this has been neglected. Websites are not the best way of providing this advice especially in rural areas due to challenges of connectivity. For Social Care two key points are important – one of the things that changed in the Care Act was the assessment of need this works less well in rural areas (unmet needs are not so easily covered by the Voluntary and Community sector and family due to isolation). Additionally in the countryside due to a long tradition of needing to be more self sufficient due to remoteness from services, people often get used to not asking for help.

Jonathon Holmes – agreed that this dislocation in terms of asking for help often only at a very late stage in rural areas is a problem.

Tish Hanifan– in terms of rural vulnerability the role of faith groups is important – a decline in these support structures around social trends in terms of organized religion is removing some of the important “informal” support for people in rural areas, which existed previously.

Councillor Lee Chapman

Cllr Chapman introduced himself. At Shropshire he has been the Cabinet Member for Adult Social Care for 6 years now and latterly has also become responsible for housing and the Council’s role in terms of public health.

Medical models are probably too predominant in the way we think and operate. We are creating expectations that all the solutions are medical. People are often described as service users rather than people and this is unfortunate as this approach is predicated on the idea of a council paying for a service. Councillor Chapman prefers to use terms “people” or “residents”.

In Shropshire the population is old and getting older. 33% of those who live in his ward are over 65. Supporting this population has a very significant impact on Council budgets.

Cllr Chapman would argue that adult social care in operation in Shropshire is one of the most efficient examples of service provision in this context in the country. 85% of people needing help are dealt with by telephone. Only 15% of the remaining 15% get a paid service from the Council. Shropshire follow up clients to check their response to advice and this is rare across local government as a whole.

Good service management has enabled the Council to achieve a 35% reduction in Adult Social Care costs. The Council is head of class in terms of hospital discharge where an integrated team of nurse practitioners, occupational therapist and social workers operate together. Another example of innovation is the “two carers in a car” model. The Council know that their approach to managing care is effective.

The Council has harnessed an electrical process system for care referrals – this is sophisticated and GIS mapped in terms of domiciliary care needs assessment and demand profiling. Notwithstanding this, costs in terms of adult social care in Shropshire are rising at £8million p.a – a 1% in council tax brings in £2million. The Council currently has a £35 million deficit in relation to adult social care.

Radical solutions are the only way forward. These approaches need to consider the economics of the care market. Care is the largest economic sector in Shropshire.

A more nuanced view of risk in a clinical environment is crucial to managing pressures. We need a “grown up” conversation about how we manage risk in terms of issues for example such as end of life care. Looking realistically at what technology can provide will make a difference when effectively applied.

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

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

Additional comments: understanding data – local authorities have traditionally been responsible for producing a Joint Strategic Needs Assessment – PHE has recently looked at global health data which is also useful.

What we need to add - the new Director of Public Health in Shropshire is looking to work on a “place plan” basis for strategic working across the council. This will involve bringing together housing, health and employment at the neighbourhood level based on a “whole person approach”. 3 pieces of data have recently been used to profile demand: all houses below energy efficiency, over 65s and people living alone (supported by data gathered through Fire Service Safe and Well visits) – this enables the use of predictive analysis to consider vulnerability. The commercial world has been doing this sort of profiling for years and it is something which is very important as part of future planning in terms of local authorities and health and social care.

Anne Marie Morris MP – the issue of risk is very interestingly something, which arises from this presentation and resonates with the messages from other witnesses. We need a very practical and realistic approach to this. The over medicalised approach is also a very strong theme arising from the presentation.

Jeremy Leggett – The NHS Long Term Plan focus on higher health inequalities – is based on an approach focused on concentration not dispersed areas. This will drive resources away from rural areas. The plan has not been rural proofed. This should be challenged.

Professor Shepherd - agreed with this perspective.

Jeremy Leggett - From a resources point of view we are seeing this concentration of resources taking effect as of today around the 10 year plan. We have heard some good examples of what we can do better in terms of primary and secondary care, learning how best to use these ideas needs us to drill down into the policy process and tackle the issue of risk. There are other factors behind the challenges we face– one is due to the way the internal market and the cost of procedures are thought out. The internal market does not work as effectively in a rural dispersed area and this needs to be fully understood and taken account of. STPs transition is an opportunity to begin addressing this issue.

Simon How – Primary Care Networks may be a solution to overcoming the challenge of rural areas being neither too large nor too small to merit special attention and understanding.

Dr Maitland-Knibb- Remoteness means that this approach isn't financially attractive to providers in many areas.

Cllr Lee Chapman – it is often hard to convince GPs to combine on a territorial basis that makes sense.

Dr Wynn-Jones – Proposed new GP networks with mixed urban and rural components are a real challenge – perhaps more than just rural places.

Simon How – Community network engagement – building on a Canadian model with people having several roles in a community are very powerful.

Maria Ball – Qunatum Care have previously been part of the enhanced health vanguard programme. It helped them work through positive examples of care skills development. It also left them with a strong conviction about the importance of generalist approaches to service provision in rural areas.

Anne Marie Morris MP – closed the session and thanked all participants.