**Parliamentary Inquiry into Rural Health and Care – Session 2**

**Present:**

Anne Marie Morris MP (Chair)
Professor Richard Parish CBE (Lead Adviser)

**Witnesses**

Professor Tahir Masud – President, British Geriatrics Society
Debbie Freake – Director of Integration Northumbria Healthcare NHS Foundation Trust
Sue Bradley – Chief Officer, Age UK, North Craven
Dr Simone Yule – Chair, North Dorset GP Locality

**Invited Participants**

Jacob Lant – Head of Policy and Public Affairs, Healthwatch
Caroline Cooke – Policy Manager, British Geriatrics Society
Margaret Clark CBE – Chair Rural Coalition
Dr Carolyn Chew-Graham, Professor of GP Research – University of Keele
Simon How – Health and Well-Being Programme Leader, Public Health England
Nick Clarke – Public Health England
Dr Jane Hart – Rural Services Network/Rural England
Sophie Cahill – Strategy Adviser, Department of Health and Social Care
Charlotte Kume Holland – Senior Policy Adviser, Department of Health and Social Care

**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.

**Anne Marie Morris MP** – Introduced the Inquiry and the theme for this session. The key rationale is to make an evidence based submission on the way forward in relation to rural health and care to Government. The first session was about the context for health and care in relation to rural practice. The theme for today is good and less good practice in delivering rural health and care. Anne Marie Morris MP introduced the witnesses and identified which members of the invitee group might most usefully contribute to each of the themes.

**Professor Tahir Masud – President, British Geriatrics Society**

Professor Masud explained that he had sought the opinions of members who are health care professionals as part of his preparation of evidence. 3 main themes emerged:

**Long distances in terms of travel** – This issue affects patients when admitted to hospital and also impacts through loneliness on their recovery from treatment in hospital. Poor transport in rural areas exacerbates this. It also impacts on health care staff delivering services. Home visits take longer for example, this reduces the productivity of those working in rural settings, it also increases costs. There are also a disproportionate number of people in rural settings, which leads to a differentially higher level of demand. Community support has also reduced around current spending priorities and trends. Older people in rural settings often leave it late to seek support. Another issue is that these individuals are often distant from major hospitals with specialisms, making their treatment more remote and demanding.

**Workforce** – recruitment and retention are real challenges. Professionals often feel isolated working by themselves, which makes the job less attractive. The lack of multifaceted teams in rural settings makes it difficult to manage co-morbidities. This has a knock on in terms of wider burdens (inc admin) on this smaller cohort of people working in rural settings. Only 14% of small hospitals have a dedicated frailty service. A lack of capacity in this context is a real disadvantage. We should consider how we can provide incentives to address these challenges.

**Variation in management of co-morbidity**- People with co-morbidities ideally need person centred, local mutli-faceted treatment hubs. In rural areas some of the wider infrastructure which provides these types of support are closing – for example pharmacies. Prevention is less effective because of this issue in rural settings. Hospital discharges are more difficult and this knocks on in terms of wider aspects of hospital performance. The Long Term NHS plan should make a contribution to addressing some of these challenges.

**Areas of good practice** – there are pockets of excellence across England– The BGS and Royal College of GPs Integrated Care for People with Frailty initiative– is a useful source of this. Advanced clinical and nurse practitioners have a particularly valuable role to play particularly when they are embedded more deeply in the community. Medication reviews in care homes for example are helpful when well planned. Pharmacists could have a key role in this agenda if it was systematically extended. There is scope to learn from other countries with rural settings, a community themed approach in Ullapool (Scotland) was cited as an example. Other OECD countries provide important sources of reference. Technology needs more investment to aid application. Information sharing is still an issue – Caldicott represents a barriers in this: guidance would be helpful in this context. Telemedicine has a major contribution to make. Denmark is a good example of how this is done effectively where in Professor Masud's experience it enables specialists to engage at more local and remote settings.

**Professor Richard Parish** – This evidence reinforces an emerging coherent dialogue around the key issues; advanced practitioners and community pharmacy, along with international best practice all chime in with a wider skein of evidence collected so far across the full inquiry and provided to the National Centre more widely.

**Dr Carolyn Chew–Graham** – mental health is a key issue and it is sometimes hidden in rural areas, self harm and suicide should be added to this list of key issues. Professor Masud indicated that he fully agrees with this.

**Simon How** – the role of carers is very important as part of this agenda. Professor Masud referenced a scheme in Worcester around hospital discharge which is an example of very good practice in this context. It was collectively acknowledged that carer needs have not been fully appreciated by society up until now.

**Nick Clarke** – expressed a view that it is important to make sure that engagement of carers is effectively conducted.

**Jacob Lant** – Referenced the issue of inequality and access to intensive care beds which leads to vulnerable older people having to travel long distances to access this facility, can definitely have a negative impact on their physical and mental health and well-being.

**Anne Marie Morris MP**– picked up on the challenge of expertise across complex co-morbidities. This is delivered patchily – she asked the question: how do we look at generating more generalist specialists? There is now an element of rotational experience built into new GP training practice. The variable distribution of geriatricians is a problem in areas where they are thin on the ground. They are often "trapped" in hospital and acute settings and should perhaps be more embedded in communities.

**Jacob Lant** – identified that the impact of transport on windows of opportunity for health appointments is an important theme. It would be interesting to look at how this might be addressed in relation to good practice in other settings.

**Margaret Clark** – Identified that rural proofing and other policy agenda were beginning to emerge from this discussion and looked forward to making more comments as the discussion unfolded.

**Debbie Freake – Director of Integration Northumbria Healthcare NHS Foundation Trust**

Debbie Freake began by identifying that from her perspective the most important thing is the expectation that the delivery of care is at the same standard on a universal basis. What does differ is the settings in which clinical pathways are provided. Rurality is not uniform and it is important to think about it in all is diversity as part of the considerations germane to this evidence session. Some needs relate to access to

transport – part of the importance isn't about proximity to health facilities but more broadly to settlements in terms of their full functionality, she drew comparisons between Hexham (well served) and Whitehaven (less well served).

In terms of treatment Debbie Freake identified that rural populations often present lat. She also identified that ambulance response times are very challenging – reducing the need for ambulance call outs is important to ensure a good overall provision of services.

Rural hospitals deliver on a smaller scale and this sometimes leads to the need to deliver services on a hub and spoke basis. A rural hospital often has a less extensive range of specialist services. In some cases however this can also positively and surprisingly lead to smaller rural hospital practices developing centres of expertise which reflect local circumstances.

Access to services for time critical services is an important issue – rural DGHs need very good "treat and transfer" mechanisms to work effectively as pathways through to specialised centres.

Small teams in key services are hard to recruit, manage and deploy in rural settings. These roles are often domestically unattractive for the wider social connections of those involved in key roles. It is also difficult to support and supervise trainees in these settings. There is some evidence that the rigidity of standards is unhelpful in making it difficult for rural areas to innovate.

Ensuring there are enough people locally to support health and care is an issue of national significance justifying national action– growing your own is an important aspect of the agenda.

Things are not uniformly bad - there is some evidence of rural innovation flowing into urban areas around actions in relation to for example: combined rotas, dual trained medics, more use of advanced practitioners, composite workforce approaches which involve bringing a team response to replacing traditional functions. Expert generalist roles are also acknowledged as being very important.

Minor injuries units are an important part of urgent care services. Whilst these units are unable to deliver to urgent treatment standards a good service can be provided where there are links to ambulance care and frailty assessment, which should be delivered as locally as possible.

Mental health should be delivered in the context of easy access to tertiary centres.

The Northumberland A&E approach based on networks has made a real difference to workforce availability – with links to different centres. This has removed the specialists problem, in Cumbria this is still and issue.

Complex comorbidities are more challenging in rural settings – post a certain age people do move into rural towns and this makes their needs easier to service. Primary and community care lead on this area of treatment. Secondary care strategies in this context need to focus on supporting primary care. Community engagement is important in making these services as effective as possible.

Co-location of community facilities and GP surgeries is a powerful driver of integrated care – which can also look outwards towards housing. IT is not as fully and as effectively utilised as it might be. Telehealth and remote consultations are very important facilities which if used well can improve health outcomes in rural settings.

The provision of secondary and tertiary care differs in rural from urban areas in of necessity being delivered around hub and spoke arrangements – arising from the fact that services are not all in the same place. Ambulatory care and early assessment are key parts of the patient journey in the context of these systems.

Obligate networks in Scotland are an effective concept, where tertiary centres are required to support rural areas.

**Anne Marie Morris MP** - In terms of acute and urgent care the question is do we need to rethink how we structure the delivery of services. The LIVES first responder service in Lincolnshire is an excellent example of what can be achieved through the effective engagement of the community and voluntary sector. Sensible risk appetite seems also to be a key element underpinning the effective design of rural services.

**Debbie Freake** - The "see and treat" model of care is very important to reduce A&E admittance, particularly in rural areas. Community pharmacists also have a contribution to make to reducing A&E admissions in all areas.

**Anne Marie Morris MP**– flexible models of primary and tertiary organisation are valuable and important. Community hospitals are being closed notwithstanding their overall positive contribution to some aspects of rural health and care delivery.

**Debbie Freake** – filling a building is less important than having a focused approach to catering for rural health needs. A needs based approach should be the driver for what is provided. This enables us to move away from an emphasis on beds. STPs have a role in looking at how to maximise the relationship with community services – a model of greater cooperation and collaboration is important in this context – an "obligate" approach might be a useful stimulant in delivering this.

**Professor Richard Parish** – In terms of mental health the issue is not just the distance people have to travel for treatment, but also the limited number of practitioners available in rural areas. The early diagnosis point is important – it is important to consider how might some of this be improved in rural areas?

**Debbie Freake** – Not sure that the issue of early diagnosis has been specifically looked at in acute terms. Support for this at the level of primary care is important. We also need to put more emphasis on public health programmes.

Workforce planning is a key issue for the Sec of State to concentrate on in relation to rural health and care– particularly taking account of the fact that rural areas are always at the end of the service delivery chain.

**Margaret Clark** – rural challenges are often seen as a problem. It is important to think about them also as an opportunities. We need to think about the positives as well as the problematic in this context.

**Professor Richard Parish** – an urban model of health and care explains why it is easy to see rural challenges as problematic.

**Jacob Lant** – the use of technology is important in the context of addressing a number of the challenges raised in this discussion and there is a real appetite in terms of older people to engage with technology in this context.

**Dr Carolyn Chew Graham** – conversely in relation to the point above some people are suspicious of technology – a recent PHD student has uncovered evidence in this context. The consequence of providing specialist and multi-layered support for individuals needs to be addressed to reduce the number of interventions focused on individual patients.

**Debbie Freake** –primary and secondary care liaison is key in the best interest of reducing the treatment burden.

**Simon How** – It is important to consider how seasonality affects demand in rural (esp coastal) areas.

**Debbie Freake** – this is understood and planning to take account of it is enhanced – primary care has traditionally been better at dealing with this than secondary care.

**Simon How** – not sure on what the reach of preventive campaigns in rural areas is due to connectivity problems. Interested to learn more about this. This could also be a priority for PHE to review.

**Sophie Cahill** – the work currently being undertaken to look at rural issues in the context of health and care is focusing on access, workforce and performance standards  - all are key areas for the Sec of State in terms of rural.

**Sue Bradley – Chief Officer, Age UK, North Craven**

Age UK North Craven employs10 staff – only 3 full time – it supports 2000 or so clients per year. The area is best described as a deep rural setting. The experience of delivering services can be summarised around 6 points:

- Life on the edge
- Uncoordinated work
- Infrastructure
- Mental Health
- Who is picking up the pieces ?
- Investment to maximise resources rather than invest to save

There is limited choice for people in rural settings. Hospital sites are distant from the area.

It is important not to think about just hospitals and GPs in conceptualising rural health and care. There is limited provision in terms of other infrastructure locally such as dentistry. These limitations stretch also to volunteers for example.

Some rural areas fall between a number of different centres of health provision. People feel disenfranchised when they are at the edge of facilities. This is exacerbated by a lack of public transport availability. This puts pressure on volunteers caring for people. The Age UK "Painful Journeys" report is a good exposition of these issues.

Sparsity of population increases the risk linked to innovative and creative projects – so innovation often fails, particularly in relation to areas with a small critical mass.

The absence of a fresh policy for social care and the fact that we are still waiting for the Adult Social Care Green Paper is a challenge in terms of rural settings as key issues remain unaddressed. The affordability of social care is a real challenge in this context.

Mental Health Support – less intense support is available in rural settings, particularly out of hours. Specialist help is a key requirement in a number of eventualities which cant straightforwardly be accessed in rural settings. Loneliness is an important challenge driving depression as a disproportionate issue in rural settings. Stigma is often still associated with loneliness – it is important to train organisations and volunteers to spot loneliness outside of the health and care delivery mechanisms, with a person centred focus. It is important to look at people who are self-medicating as a response to depression in rural areas in some cases for example through alcohol and/or comfort eating (leading to obesity).

Understanding the connections between dementia and depression is important. A significant amount of examination is important in this context – to avoid stereotyping.

Health and care is not in crisis in rural areas – but the key issue is that things get done slower in rural settings and are not always well coordinated. In many cases it is often carers who bear the brunt of the challenge in this context.

All in all there are some great ideas driven by necessity in rural areas– dementia collaborative care , referral systems like "Compass in Craven", social prescribing the problem is a lack of a consolidated plan to support whole system change/ development.

Real change can only be achieved when a person centred approach is the driver around service design.

**Dr Jane Hart** – There is significant hidden need in rural communities. It is not always fair to assume families will fill the support gap – this doesn't reflect modes of modern living. Carers are a greatly under appreciated resource they have considerable scope to monitor patient need. Often carers are not allowed to perform very useful but simple tasks. The employment infrastructure for carers is poor quality and unreliable. In terms of dementia village communities are often supportive as they know the individuals with the condition.

**Dr Simone Yule – Chair, North Dorset GP Locality**

**The key issues can be summarised as: Transport, Travel, Workforce, IT, Communication/Integrated Care**

North Dorset has seen a reduced practice number to just 6 practices – merger is happening quite extensively. There will soon be 6 partners for 26,000 patients in Dr Yule's practice.

Silo working has often been the norm in health delivery which is unhelpful in rural settings.

Conversations between different elements of the care pathway are now reaching greater maturity. The ICS approach has brought greater resources to localities from more acute settings. Rural hospitals are best when they function as community hubs. Hubs are not just about health, prevention and well-being is important. Proactive approaches are really important in this context.

Good practice is dependent on multi-disciplinary teams and effective outreach strategies. Dr Yule's Secretary of State ask for improvement would be to recognise one size does not fit all and devolution is important.

In Dorset there is a successful model of multi-disciplinary frailty teams working alongside community trust staff. This includes voluntary sector engagement and a community asset based approach. Mapping the capacity and focus of the voluntary sector in localities is an important aspect of this approach.

Travel distances lead to a lack of productivity. This along with poor IT connectivity can limit innovation. IT systems which don't integrate between different health and care providers are an institutional issue which sits alongside poor broadband and connectivity.

Social Care is very challenging in North Dorset in terms of domiciliary care – esp in terms of facilities such as end of life care. One small pilot based around the repatriation of acute funds at the local level is the provision of urgent care on focused packages of short term ultimately preventive care.

Transport is a really large determinant of poor quality health provision. There is little evidence that this has not been effectively resolved in rural areas..

Complex comorbidities and frailty are the biggest challenges in terms of the more elderly population in North Dorset. Pro-active and self care promotion are key facets linked to addressing these challenges.

Community care historically has not been readily available in rural areas it is not just underfunded but also hard to recruit to.

Joint working and enhanced services are key parts of the solutions to these challenges.

Preventive sign-posting is important in the context of making the best interventions in rural settings.

Some services, which can be provided on an integrated local basis in rural settings are very expensive to provide in rural localities where sparsity militates against integration and economies of scale.

Access challenges – out of hours access is very difficult to provide in rural settings exacerbated in part by travel distances and made worse by difficulties around workforce recruitment.

Locally there is no training scheme for highly autonomous nurse practitioners. New medical students are not trained to manage and take risks (which is an important aspect of effective rural practice based on deep seated experience) this is still more of a challenge in rural settings when GPs are replaced by nurse practitioners and paramedics.

Young GPs want a varied portfolio of work and this is a disincentive for them to work in rural settings. Urban settings offer less challenge in terms of travel and provide a more "dynamic" working environment.

**Anne Marie Morris MP** – Would it be fair to summarise your evidence as Primary Care has to change when you're looking at a rural setting?

**Dr Simone Yule** – we have to move away from a reactive model of primary care – this is a rural specific issue.

**Margaret Clark** – this discussion resonates in relation to other key determinants of the quality of life in rural areas. It demonstrates the importance at a local and national level of rural proofing. Defra should lead on looking at this from a holistic perspective. Funding regimes don't take account of the extra costs of delivering services in rural areas. When aggregated up those suffering rural disadvantage are as numerous as the population of the City of Birmingham.

Focused and long term funding of the VCS sector is very important in the context of this agenda.

From a Plunkett Foundation (Margaret Clark is Chair) perspective community enterprise as an approach to social care is an area worth nurturing.

**Anne Marie Morris MP** – this illustrates the value of the development of enterprise as a driver of sustainable approaches to community service provision in rural areas.

**Professor Richard Parish** – rural community enterprise has virtuous wider community impacts. It is also important in relation to prevention to note that many future health determinants are worse in rural areas.

**Sue Bradley** – prevention should be a future issue in terms of the Inquiry.

**Sophie Cahill** – her DHSC brief is to look at the main problems and challenges, which are distinctive in rural settings. Often the data masks rural issues. She is looking at models of good practice and talking to Government colleagues about the broader supra-health context for rural interventions, which have health impacts. She is seeing to identify what actions DHSC could take directly and if there are practical interventions already in play that would be more effective if better supported and engaged with,

**Simon How** – prevention needs to have a primary right through to tertiary care focus.

**Professor Richard Parish** – the relatively more acute decline of the economy in rural areas, which is worthy of ongoing consideration. The House of Lords Select Committee on the rural economy has also been looking at these issues.

**Professor Tahir Masud** – making links with the APPG looking more widely at impacts of loneliness is important in the context of this inquiry.