Parliamentary Inquiry: Rural Health and Social Care

The APPG for Rural Health and Care Parliamentary Inquiry has been established to look at the key issues facing the country in terms of providing good quality and effective health and social care in rural settings. The Inquiry will explore how England has developed its systems post-Beveridge, testing whether we now have a one size fits all model focused more on the needs of urban areas than rural communities.

The Inquiry is focusing on current practice and what needs to change to meet the specific challenges facing rural populations . Over the next 2 years it will hold 8 evidence sessions. The Inquiry is co-chaired by Anne Morris Morris, M.P. for Newton Abbot, and The Right Reverend and Right Honourable Dame Sarah Mullally Bishop of London.

The secretariat for the Inquiry is being provided by the National Centre for Rural Health and Care, which was established early in 2018. This organisation is Chaired by Professor Richard Parish and the Secretariat will also comprise Ivan Annibal, Director of Operations, and Dr. Jessica Sellick, Senior Research Fellow. More information about the Inquiry can be found on their website: https://www.ncrhc.org/about

The first session of the Inquiry was held on 30 October 2018. The theme of the session concerned how to most effectively define what we mean by the term rural in relation to health and care.

Evidence was provided by the following individuals:

Stephen Hall – Head of Statistics, Rural Policy Team, Department for Environment, Food & Rural Affairs

Dr Rashmi Shukla – Regional Director Midlands & East, Public Health England

Dr Robert Lambourn- Royal College of GPs, Rural Forum

George Bramley – University of Birmingham, City-REDI (Regional Economic Development Institute)

Professor Clive Ballard – Pro-Vice Chancellor & Executive Dean, University of Exeter Medical School.

Martin Collett - Operations Director English Rural Housing Association – Chair of National Housing Federation Rural Housing Alliance.

Phil Confue, Lead for Strategy and Planning: Countywide Services – Chief Executive Officer, Cornwall Partnership NHS Foundation Trust – Cornwall and Isles of Scilly STP Programme Director.

William (Billy) Palmer Senior Fellow in Health Policy – Nuffield Trust.

Key Issues Arising From Session 1

1. *Definition: The importance of appropriate definitions* - there is no consensus about how best to apply rural definitions which provide a uniform and helpful means of defining the health challenges facing rural places - this reinforces the urban bias in the way current resources are allocated. Furthermore statistically significant data collection as currently practiced masks the challenges faced by very small deprived areas in larger pools of data. Not only do we need a consistent approach to definition, we also need it to be applied more insightfully.

2. *Expertise: The availability of the right level of expertise in rural health and care settings* - almost all the key professions are in shorter supply in rural settings - this is a major contributor to the underperformance of small, multi-site rural trusts and impacts more widely to rural health inequalities. There are fewer health professionals per head of population in rural communities than urban areas. This is in part due to the lack of training infrastructure in rural settings linked to the phenomenon that students tend to stay where they are trained in terms of career locations.

3. *Understanding: The value of more analysis into the rural underpinning determinants of health and care which are multi-factoral* - the NHS does not currently have the capacity to "think rural" and many strategies and plans within the service lack any significant spatial analysis.

4. *Integration: The need for a more holistic approach to improve rural health and care involving an integrated mix of solutions around the issues/opportunities connected to: housing, technology, a rurally focused workforce, a "what works" approach to shared solutions and networking* - there are only a small number of powerful examples of joined up approaches to tackling rural health inequalities focused on a whole system and whole community approach. They merit far greater encouragement and dissemination.

5. *Education: In terms of professional education the importance of emphasizing rurality early in the curriculum taught to students* - there is compelling evidence that building specific rural dimension into the training of those who deliver our health and social care enhances the impact of services. There are very powerful examples of how this works in other OECD countries. We need to recognise and apply these approaches in England. We also need to seek to address the lack of any critical mass in terms of the NHS/Adult Social Care training infrastructure in rural areas. There is also significant consensus that extra capacity could be provided in rural settings through the deployment of more specialist generalists such as physician associates.

6. *What Works: The importance of sharing expertise, solutions and tools* - a formal approach to the dissemination of good practice, together with

tools to aid practical delivery, could make a significant difference to the delivery of rural health and care. There is scope to provide specific rurally focused tools in this context and to look at the "reverse transfer" of innovation from developing countries to rural settings in terms of health and care.

7. *Communities: The value of volunteers, drawn from rural communities, who could also support medical staff and help with technical infrastructure in rural areas* - the NHS operates a "one size fits all approach" to service provision. This militates against informal, local and innovative solutions to the challenges of delivering health services in rural settings. Service delivery approaches which depart from national norms are often seen as too risk based to receive formal funding and this militates against bottom up innovation in rural communities, where community action can build greater capacity in terms of rural health and care.

8. *Infrastructure: The fact that an appropriate infrastructure is key to supporting dispersed communities, despite the reduced economies of scale and the fact that the current funding formulae need to reflect this better* - far too little regard to rural issues is given in the allocation of funding and this drives significant health inequalities and under performance in many small rural based health trusts. For any given level of deprivation, rural populations fare worse than urban areas. There appears to be an ever increasing drive towards larger scale, more centralised service delivery, which is not always the best solution for patients in any given locality. This is exacerbated by poor physical infrastructure (road, rail and broadband) in many rural settings.

Conclusion

Session 1 of the Parliamentary Inquiry has established a thorough and deep seated list of factors contributing to profound rural inequalities in Health and Care. Over the next two years we intend to address each of these issues in more detail and identify specific, measurable, appropriate, realistic and time focused actions to resolve them .