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NATIONAL CENTRE FOR RURAL HEALTH AND CARE

Rural Proofing for Health Toolkit

How to address the needs of a rural population

Published December 2020

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INTRODUCTION TO THE TOOLKIT

Toolkit Aim

This Toolkit seeks to help those in the health and care sectors to address the needs of their rural populations when they develop strategies, initiatives and service delivery plans.

For ease of use the Toolkit is based around six main themes:

- Main hospital services
- Primary and community health services
- Mental health services
- Public health and preventative services
- Social care services
- Workforce

What is Rural Proofing?

The term 'rural proofing' is used to define a systematic approach which identifies any notable rural differentials likely to impact on service effectiveness and outcomes. It assists service providers by enabling thinking about appropriate solutions, mitigations and opportunities. The objective is to ensure equitable outcomes for service users who live in rural areas.

Rural Proofing can help to:

- Optimise the outcomes achieved by strategies and plans
- Demonstrate a commitment to act equitably and benefit all communities
- Support locality-based approaches to working and service
- Design out any unintended gaps in service provision
- Identify opportunities to innovate or make better use of available resources
- Embed good practice within strategy and plan making

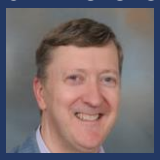
Rural proofing recognises that rural areas have distinct geographies, often characterised by a dispersed population and small settlements. This can present challenges both for providers who deliver services and residents who use them. There may be lost economies of scale, if smaller service hubs are needed, and extra downtime or travel costs for those visiting service users at home. Gaps in infrastructure (such as public transport and digital connectivity) may also be an important rural consideration.

TOOLKIT ENDORSEMENTS

"Those of us who represent rural constituencies know only too well the severe impact that mental health problems can have on our, often isolated, communities. I very much support the need to address this issue in rural communities and welcome the toolkit as a critical step in tackling this."

Anne Marie Morris, MP
Chair of the All-Party Parliamentary Group on Rural Health and Care

"I welcome this toolkit and, in particular, its potential to contribute towards addressing the current and future workforce needs of the health care sector in rural areas."



Andrew Dickenson
Health Education England

"This toolkit makes a positive contribution to that rural conundrum of trying to deliver high quality services, which are accessible for their users and in areas where it is typically hard to achieve economies of scale. The National Centre is pleased to offer its support."

Professor Richard Parish, CBE
Chair of the National Centre for Rural Health and Care

"It is essential that emerging strategies and policies are considered through a rural lens, so equitable outcomes can be sought. I commend this toolkit as a means to seek improvements in the access that rural residents have to quality health and social care services."

Graham Biggs, MBE
Chief Executive of the Rural Services Network

"Rural and remote services face unique pressures when planning and delivering services for their patients. These challenges must not be overlooked if rural services are to be delivered effectively and provide good health outcomes for rural patients. This toolkit is a very welcome resource for commissioners and providers to identify and overcome these challenges."

Nigel Edwards
Chief Executive, Nuffield Trust

Rural proofing was originally introduced as a central Government policy in 2000 to improve policy making. It remains a Government commitment. See the national context page for further details.

USING THE TOOLKIT

The Rural Proofing for Health Toolkit has been written mainly for those who are responsible for planning and designing health and care strategies, plans and service delivery. They may be from health and care commissioners, providers or other partnership bodies.

The Toolkit has been developed primarily with England's health and care systems in mind, but its principles should be applicable elsewhere (not least around the UK).

Users of the Toolkit are likely to be working at the local or sub-regional level. This could include Sustainability & Transformation Partnerships, Integrated Care System partnerships, Clinical Commissioning Groups, Primary Care Networks, Adult Social Care Directorates, Children & Young People's Social Care Directorates, Public Health Directorates and Child & Adolescent Mental Health Service teams. This list is not meant to be exhaustive.

The Toolkit may also prove useful to organisations representing the needs of health and care service users, including organisations from the voluntary and community sector. Their interest could involve championing use of rural proofing and the Toolkit.

It is intended for application across different types of rural geographies, from remoter or sparsely populated areas through to mixed areas, where a rural hinterland adjoins larger urban settlements.

There is no fixed way to use the Toolkit. Its application needs to align with local priorities and with local strategy or plan making processes. However, based on evidence of rural proofing to-date, the following are suggested:

- The six theme pages in the Toolkit can be used selectively to match the focus of strategy or plan making tasks. However, it is recommended that all the theme pages are reviewed to see if they contain points of relevance. This is likely to be especially true of the workforce theme, since that issue cuts-across the other themes;

- Rural proofing should start early in the strategy or plan making process, so it can inform thinking from the outset. It is less effective if it is applied later as a bolt-on;

- Rural proofing should, for maximum effectiveness, be embedded within and used throughout the strategy or plan making process. This might cover stages such as those illustrated in the graphic below;

- Rural proofing should aim to be evidence based. Valuable rural (and locality) evidence could be generated both by gathering consultation responses such that those from rural areas are tagged and by disaggregating available data geographically, as far as possible;

- Rural proofing should be careful not to assume (inadvertently) that rural areas are homogenous. Needs can vary according to location and settlement size. For example, what works for villages near to a city or large town may not work for villages in remoter settings;

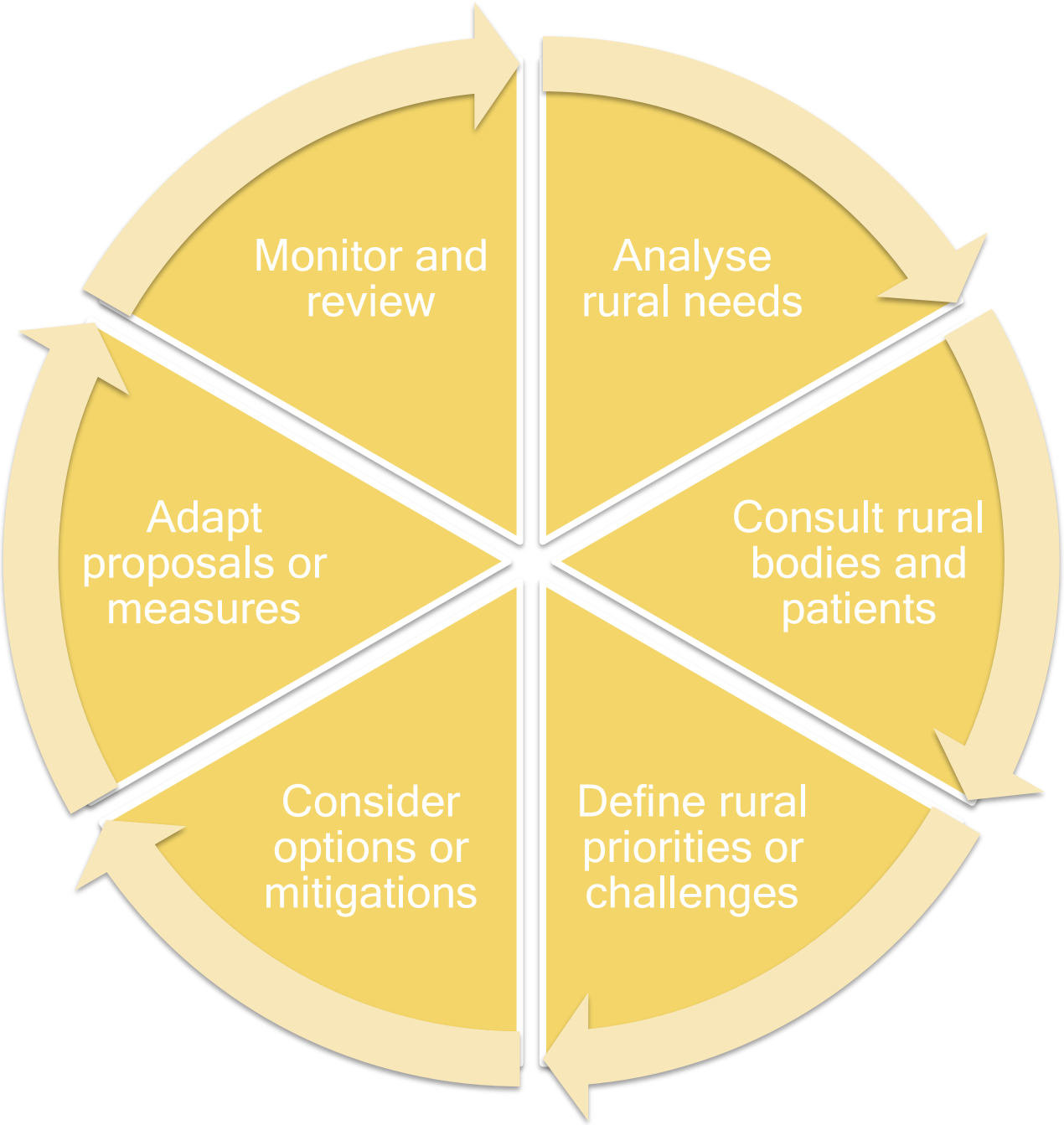
- Where rural proofing indicates that proposals will create negative rural impacts, other options should be considered. In broad terms they could include revising proposals, adding local flexibility to proposals, introducing rural-specific measures and taking mitigating action;

- Subsequent monitoring or evaluation of strategies and plans can produce important lessons about service effectiveness and outcomes in rural areas, which can inform future change. This can include lessons about what worked well and what didn't in rural settings;

- Designating an individual to champion rural proofing can help, with a role to ask rural questions. Ideally, this is someone at an oversight level e.g. on a partnership board. One option is to involve a local organisation which represents rural interests;

- Rural proofing should be easier to undertake and deliver the best return where it is built into and carried out as an integral part of strategy or plan making processes.

RURAL PROOFING IN A TYPICAL STRATEGY OR PLAN MAKING CYCLE:



RURAL PROOFING HEADLINES

In essence 'rural proofing' seeks to ensure that strategies, plans and services can be delivered effectively in rural areas, so the intended benefits reach all service users. It aims to inform and improve service planning and design processes. Although it is likely to identify some challenges, it should also help to identify solutions and, in some cases, opportunities.

When developing health and care strategies, plans and services, the Toolkit should help to address considerations such as the following:

1. That services which must be located at a main hospital, nonetheless, need to be sufficiently accessible to rural patients and their families (including those without a car or unable to drive), which could include putting mitigation measures in place.

2. That more non-acute services could be made accessible locally, closer to where rural residents live, at health centres, care hubs or community hospitals.

3. That services which deliver care to people in their own homes need to be designed so they work for people in outlying or harder-to-reach locations (whilst retaining the care time made available).

4. That rural delivery benefits could be realised from collaboration across health and care sectors and the creation of multi-disciplinary teams, including enhanced partnership working with voluntary and community organisations.

5. That preventative initiatives which encourage healthier lifestyles and wellbeing should be promoted in rural settlements and available to different rural groups, taking pressure off statutory health and care services.

6. That developments or innovations in health service provision, including in digital adoption, should be utilised wherever possible to seek rural solutions.

7. That workforce planning needs to be alive to issues arising in rural locations, including at smaller hospitals, such as recruitment or retention issues and access to professional training.

8. That both statistical analyses and service user feedback on health needs or inequalities should be disaggregated to reveal local and rural evidence, thereby informing service planning.

The theme pages in this Toolkit provide more detailed rural proofing material about six topics. They are intended to help those who carry out a rural proofing review or assessment.

RURAL FACTS AND FIGURES SUMMARY

Rural settlements in England are usually defined for statistical purposes as those with a population of less than 10,000. This includes small towns, villages, hamlets and isolated farms or dwellings. However, it is recognised that somewhat larger towns often play an important role as service and employment centres for their rural hinterland.

Some statistics are only available at higher geographies, such as local authority areas. For these statistics there is a list of local authority areas which have been classified as 'predominantly rural', where at least half of their population lives in rural settlements.

More information about these classifications, including maps, can be found in a leaflet published by the Department for Environment, Food & Rural Affairs. Click here to view.

The figures cited below are for all rural areas across England. It should be stressed that, in practice, no two rural places are alike and their needs will vary. Whilst some are remote, others are close to large urban centres. Analysis undertaken at the local level can usefully explore this variation.

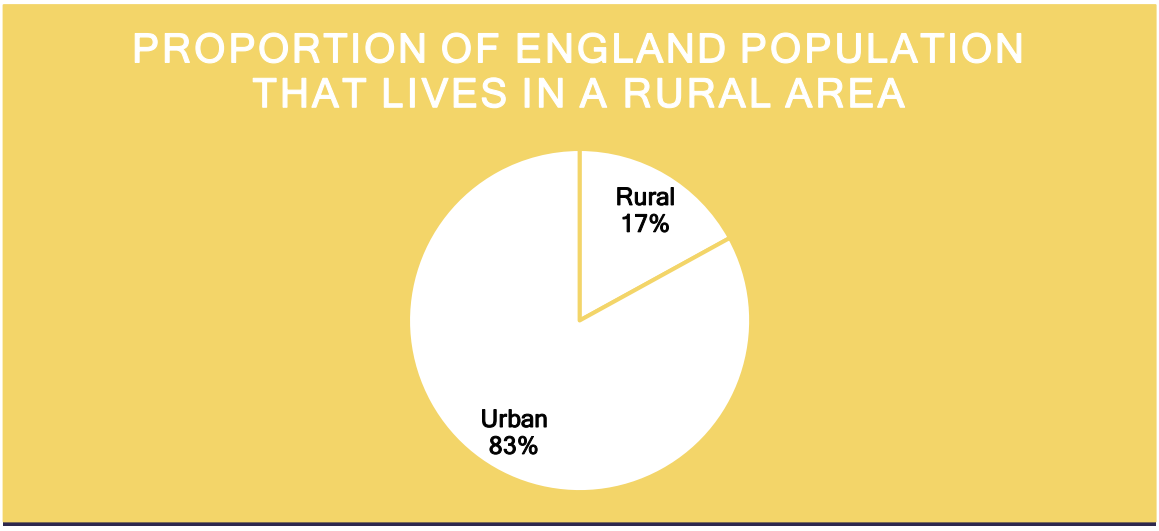
Headline facts and figures

- 9.5 million people live in England's rural settlements, which is 17% of the population (2018 figure).
- Older people comprise a larger share of the population in rural than in urban areas: 25% are aged 65 or over and 3% are aged 85 or over (2018).
- Average life expectancy at birth is higher in rural than it is in urban areas (2015-17).
- Travel times from home to health facilities are longer in rural than in urban areas, especially for those relying on public transport (2016).
- Shire areas score relatively well on some public health indicators e.g. sexual and reproductive health, and poorly on other indicators e.g. NHS health checks (2016 or earlier).
- Mental health problems are generally less common in rural than in urban areas, though are more common in the most sparsely populated areas (2004).
- Rural residents are more likely than urban residents to provide unpaid care to someone else (2011).
- Very few journeys by rural residents are made by a local bus service, reflecting their limited availability (2015/16).
- Some rural residents have only slow broadband connections and the mobile signal can be weak (2019).

RURAL FACTS AND FIGURES IN DETAIL

Rural population

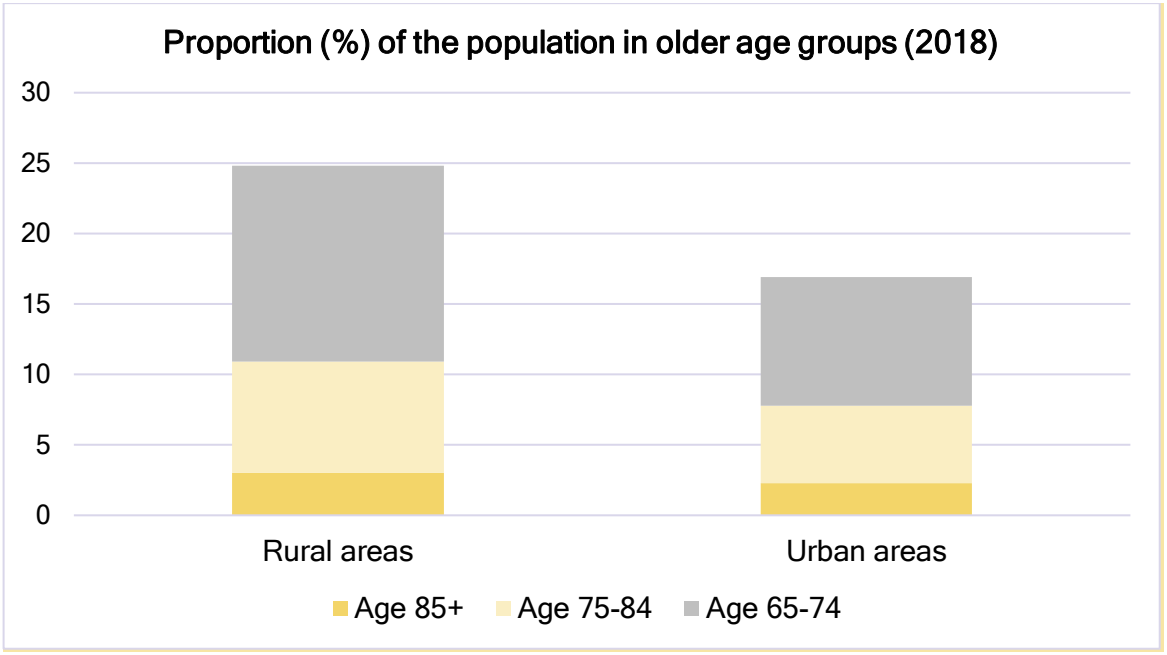
9.5 million people live in rural settlements in England (2018). They comprise 17% of the country's overall population.



Source: Defra, based on Office for National Statistics data

Age profile

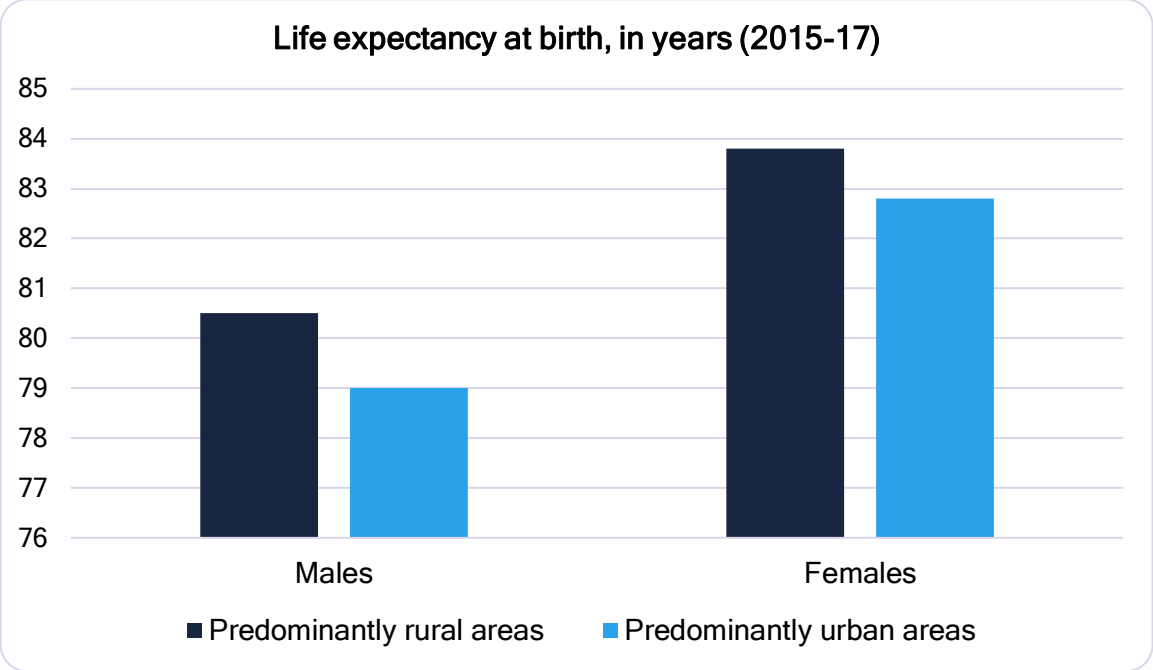
Older people form a larger proportion within the population in rural areas than in urban areas. Those aged 65 or over comprise 25% of the rural population and those aged 85 or over comprise 3%.



Source: Defra, based on Office for National Statistics data

Life expectancy

Average Life expectancy in predominantly rural (local authority) areas is 80.5 years for men and 83.8 years for women. These figures are at least one year more than the equivalents for predominantly urban areas.



Source: Defra, based on Office for National Statistics data

Travel to health services

Journey times to reach services are on average longer for rural residents than for their urban counterparts. This is most marked for those using public transport, which may also be infrequent.

Average minimum travel time by public transport and by car to reach nearest facilities (2016)

To reach the nearest:	By public transport or walking		By car	
	Rural areas	Urban areas	Rural areas	Urban areas
GP surgery	23 minutes	11 minutes	11 minutes	8 minutes
Hospital	61 minutes	34 minutes	26 minutes	18 minutes

Source: Department for Transport accessibility statistics

Delayed transfer of care from hospitals

Analysis identifies that rates of delayed transfer of care from hospital are on average higher in predominantly rural areas than in their urban equivalents by some margin.

Rates of delayed transfer of care from hospitals in 2016/17

Predominantly rural areas:	Predominantly urban areas:
Rate = **19.2** cases per 100,000 adult population	Rate = **13.0** cases per 100,000 adult population

Source: Analysis of National Health Service data

Public health indicators

Public health summary indicators provide information at the upper tier local authority level (namely unitary and county councils). These indicators show that most, though not all, shire areas:

- Score better than the England average on childhood obesity, tobacco control, the best start in life and sexual/reproductive health; but
- Score worse than the England average on NHS health checks, alcohol treatment and drug treatment.

Similarly, indicators about young people show that those living in predominantly rural areas:

- Score better than the England average on school exclusion levels and mental health needs; but
- Score worse than the England average on risky behaviours, being bullied, smoking and alcohol consumption.

Source: Analysis of PHE Public Health Outcomes Framework 2016-19

Mental health

Rural research on this topic is quite dated. Four points from a summary of the rural evidence base (Rural England CIC, 2017) are that:

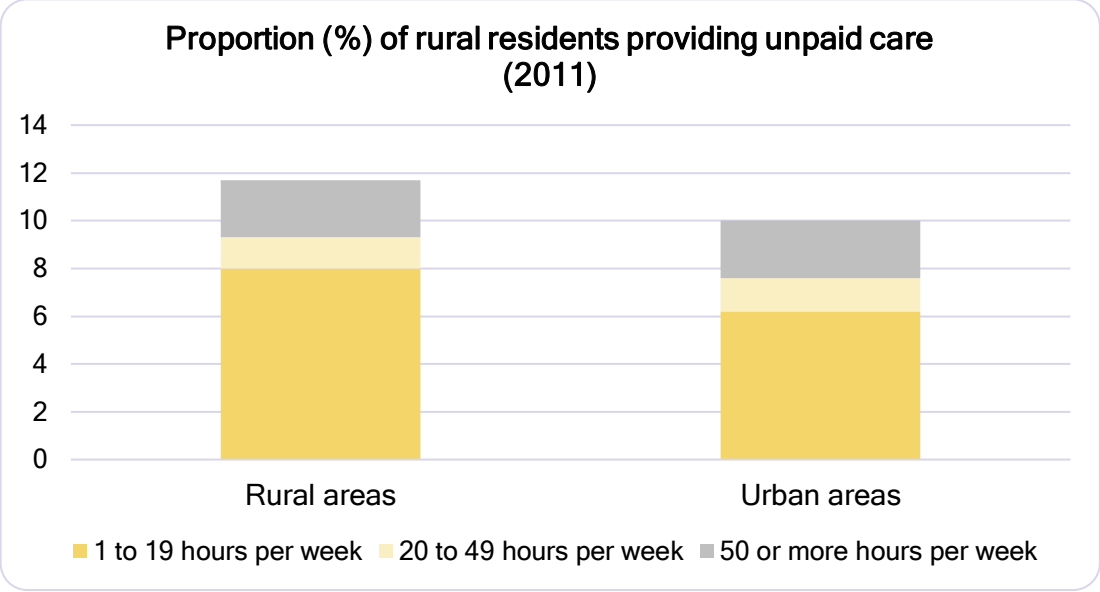
- Rates of mental ill-health are lower in rural areas, overall, than in urban areas. That said, rates are also higher in the most sparsely populated areas;
- Age standardised suicide rates are comparatively high in rural areas (being 19 and 6 per 100,000 people for rural men and women respectively);

- Stigma about mental health and patient confidentiality can be particular issues within small or close knit rural communities; and
- There are fewer mental health professionals, on a per head of population basis, working in predominantly rural areas than in predominantly urban areas.

Sources: Commission for Rural Communities, Scottish Association for Mental Health, J Fitzpatrick and A Mayers

Informal care

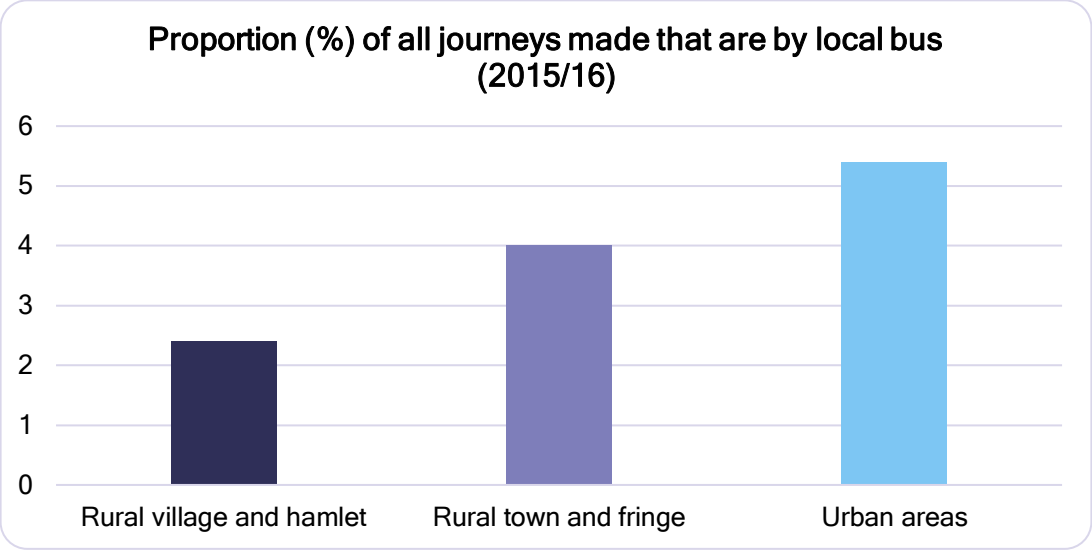
Almost 12% of rural residents regularly provide informal or unpaid care. This is a slightly higher percentage than for urban areas. That difference is accounted for by the proportion of rural residents providing up to 19 care hours per week.



Source: Office for National Statistics Census of Population

Public and voluntary transport

Few journeys are made by a local bus for those living in smaller (rural) settlements, just 2.4% from villages and hamlets, and 4.0% from rural towns or fringe areas. This reflects the availability and frequency of bus services.

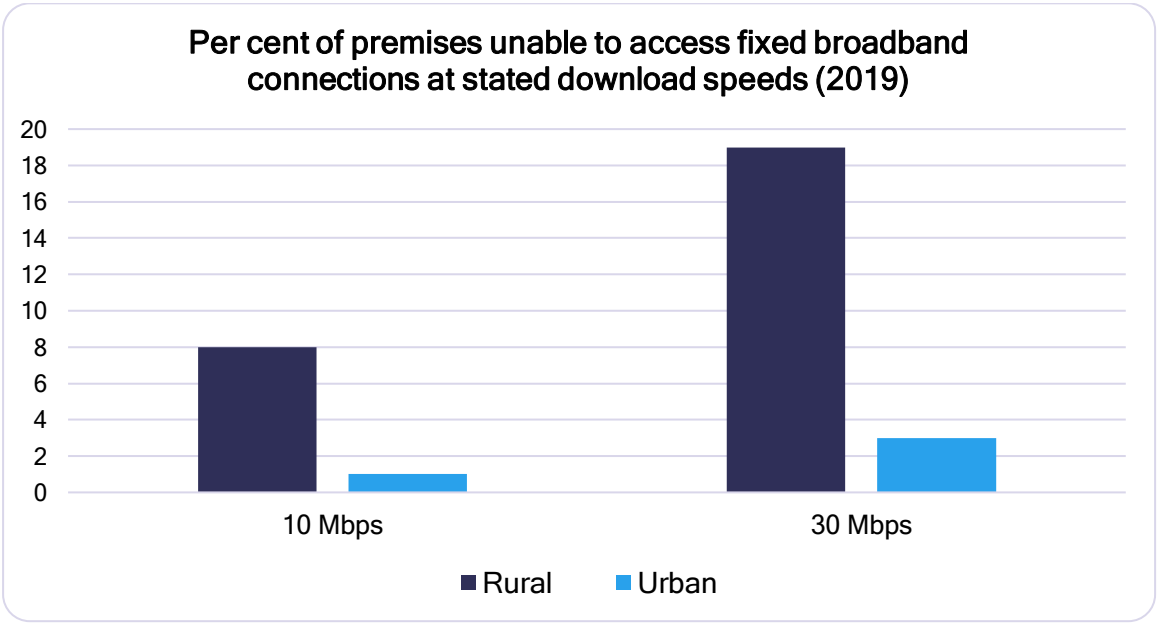


Source: Department for Transport National Travel Survey

Two thirds of community transport schemes in England, using minibuses or cars, either wholly or partially serve rural areas. However, rural schemes are typically smaller in scale than urban schemes.

Digital connectivity

For some rural households, especially in the smallest settlements or at remoter locations, broadband connection speeds are slow. Almost a fifth of rural households cannot access a superfast broadband connection (30 megabits per second download speed). There are similarly gaps in mobile network connectivity in rural areas, albeit these are reducing in number.



Source: Ofcom

ABOUT THE TOOLKIT PROJECT

This Toolkit was researched and written by a team that consisted of Brian Wilson and Jane Hart from Rural England CIC, Billy Palmer from the Nuffield Trust and rural researcher Sonja Rewhorn.

It was commissioned and funded by the National Centre for Rural Health & Care and by Rural England CIC. The National Centre receives its funding from partner organisations and Rural England CIC receives its funding from its supporters (as listed on its website).

The project was fortunate to be advised by an expert Reference Group whose members were:

- Professor Richard Parish CBE (Chair at the National Centre for Rural Health & Care)
- Dr John Wynn-Jones (Rural Health & Care Alliance and Rural Forum at the Royal College of GPs)
- Dr Rob Lambourn (immediate past Chair of the Rural Forum at the Royal College of GPs)
- Jane Randall-Smith (Rural Forum at the Royal College of GPs)
- Stephen Chandler (Corporate Director Adult Services at Oxfordshire County Council)
- Jonathan Owen (Chief Executive at the National Association of Local Councils)

Many other organisations and individuals assisted the project, including those who responded to a survey about rural health challenges and opportunities and those who supplied information for the case studies. Glen Garrod, Executive Director of Adult Care and Community Wellbeing at Lincolnshire County Council, deserves special mention for commenting on the Toolkit, when in draft, from a social services perspective.

Last, but not least, an acknowledgement is due to the former Institute of Rural Health which started the ball rolling by producing earlier versions of the Toolkit in 2005 and 2012.

NATIONAL CONTEXT

Rural proofing was initially introduced in England in 2000 by the Rural White Paper. As a Government policy it is now overseen by the Department for Environment, Food & Rural Affairs (Defra).

Defra produces rural proofing guidance for use by Whitehall Departments and their agencies. This therefore includes the Department of Health & Social Care, plus NHS England and Public Health England. That national guidance can be found on the Defra website, click here to view.

When making or revising national policies, Departments and their agencies are expected to:

- Identify any direct or indirect impacts of the policy on rural areas;
- Make an assessment of the likely scale of those impacts;
- Consider actions to tailor the policy so it works well in rural areas; and
- Post implementation, monitor the policy effect in rural areas, adapting it if necessary.

Three particular issues which are highlighted in the Defra guidance are:

- Demographics – citing the high proportion of older people living in rural areas;
- Access to services – citing distance, transport links and low population density; and
- Service infrastructure – citing challenges with broadband and mobile connectivity.

Many commentators on rural policy note another linked issue; that there are often higher costs associated with service delivery in more sparsely populated areas.

The rural service delivery challenge has sometimes been represented as striking a balance between three goals, namely that services should be: of high quality; have reasonable costs; and be easily accessible. Whilst achieving (let alone maximising) all three of these is not easy, it is rarely a simple trade off and approaches can usually be found which fit rural circumstances.

SIX TOOLKIT THEMES

MAIN HOSPITAL SERVICES

The NHS Long Term Plan for England cites a number of clinical priorities where service improvement should make the greatest impact on health outcomes. They are cancer, cardiovascular disease, stroke, respiratory disease, diabetes, maternity and neonatal, and young people's care. Naturally, main hospital services must play a crucial part in addressing these priorities. That said, there is a clear expectation that, in future, more services will be available outside a main hospital setting and that fewer patients will need to attend them for treatment.

Main hospital estates and their emergency and elective services are being reconfigured and, in some cases, centralised into specialist units. Irrespective of the merits, one challenge this brings is how to ensure that main hospitals remain accessible to those from outlying rural areas who may have long or complex or costly journeys, be they patients, visitors, carers or staff.

The following questions are intended to help improve rural service planning and design:

1. If assessing options for reconfigured or new acute and elective services (including A&E and out of hours services), what can analysis show about **travel times** and transport options to main hospital sites from settlements across the area served? What is considered a reasonable travel time?

2. What **transport options** to main hospital sites exist, including from smaller or more outlying settlements? What are the implications for those who do not drive, do not have access to a car or who are too ill to drive? How far does transport service frequency limit the ability of patients to attend hospital outpatient appointments through the day?

3. What scope is there to collaborate further with the **community transport** sector, who manage volunteer car schemes and minibus services, and who may be able to bring patients to health appointments, especially those without access to a car? How widely are non-emergency hospital transport services available as an option for rural users?

4. What scope is there to provide some (until now) main hospital services safely at a more local level or at **outreach** clinics within urgent treatment centres, community hospitals or care hubs? For example, minor procedures, diagnostics, in-patient rehab, baby clinics, re-enablement and end of life care.

5. What scope is there to offer outpatients greater **choice**, with options where they can go to receive treatment or care? Could further collaboration with neighbouring health authorities or providers enable cross-border options or pathways?

6. How might the **number of visits** that patients are required to make to a main hospital be reduced for those travelling from outlying areas? Could more examinations and tests be carried out during the same hospital visit or more common tests be carried out locally?

7. What opportunities might be pursued to offer **digital or online** consultations and advice, to reduce the need to travel to outpatient appointments? Could this include local health centres having access to online advice from hospital-based specialists?

8. How sufficient is provision for low-volume and **high-risk specialities** in geographies where population numbers are relatively small? (An example might be intrapartum care for childbirth involving high risk.) Could regional networks and cross-site working be strengthened?

9. What are typical **response times** for ambulance and paramedic services, when attending calls from rural and outlying areas? Could clinical emergency protocols take better account of rural needs, where time-critical intervention is necessary e.g. stroke, heart attack? How well distributed are resources such as ambulance bases, first responders and paramedics?

10. What is known about the location of public access **defibrillators** and those trained to use them, especially in rural settlements more distant from quick response services? Equally, how sufficient is **air ambulance** and rescue service cover to deal with time-critical cases which happen at remote locations or in coastal and mountainous settings?

11. What **resilience planning** is in place to work with the other first responder emergency services when incidents occur such as flooding and wild fires? Should this be reviewed?

12. Could **public and patient engagement**, by organisations such as the local Healthwatch, be used to gather feedback from service users who live in rural areas? How could this be used to generate useful lessons for service planning, design and implementation?

- Supporting high intensity users of NHS services in Cornwall
- Near Me delivering remote care in NHS Highland region, Scotland

Other solutions to rural service delivery challenges could include:

- Taking the service to the patient, by holding outreach clinics at local health centres or community hospitals, with visiting consultants or specialists from main hospitals.
- Upskilling and equipping GPs or Primary Care Teams to carry out some specialist services locally, which are traditionally delivered at more centralised sites e.g. memory clinics.
- Ensuring sufficient training is available for locally based healthcare workers in rural settings, so they can support patients returning home quickly from hospital and avoid others needing to go into hospital.
- Establishing a team of community-based paramedics, who can more quickly attend emergencies and provide a first response in hard-to-reach locations.
- Upgrading air ambulances so they are made capable of night flying, to reach emergencies at remote locations around the clock.
- Using Geographic Information Systems (GIS) to model and analyse typical travel times from different locations to main hospital sites and other service facilities.
- Maintaining a rural risk register, as part of a plan or strategy, to identify and monitor issues which need managing and addressing or mitigating.

PRIMARY AND COMMUNITY HEALTH SERVICES

Primary and community services are central to NHS reforms, which place a growing emphasis on out-of-hospital care, plan for further service integration and adopt more of a place-based approach. The NHS Long Term Plan for England seeks to remove "the historic barrier" between primary and community health services. GP practices and other health professionals are expected to work together in Primary Care Networks, that typically cover an area with 30,000 to 50,000 patients. Reflecting these reforms, the annual budget for primary and community health care is being increased in England by £4.5 billion over the five years to 2023/24.

These reforms have potential to improve primary and community health care provision in rural areas, depending how they are implemented. Challenges could include the large area of Primary Care Networks in sparsely populated geographies, expectations that specialist health professionals can serve such large areas and ensuring that health centres or health hubs remain accessible. In addition, service demands may reflect the (typically) older age profile found in rural areas, which may mean more patients with multiple morbidities.

The following questions are intended to help improve rural service planning and design:

1. How far do the Clinical Commissioning Group **funding priorities** match locally identified priorities at the Primary Care Network level? What effort has been made to ensure that these, in turn, incorporate the needs of the area's rural communities?

2. How large are (planned or implemented) **Primary Care Network areas** on the ground? Is there a justifiable operational case, in one of more localities, to drop below the expected 30,000 lower limit for patient numbers? Could operational concerns be monitored and addressed in other ways?

3. What scope exists to expand the **range of services delivered locally** at medical centres, health hubs or community hospitals, to meet local needs and avoid patients travelling to main hospitals? For example, for minor procedures, diagnostics, oncology blood tests, in-patient rehab, baby clinics, re-enablement and end of life care.

4. How easy do members of locality or hub-based **multi-disciplinary teams**, especially those who hold more specialist roles or who visit patients in their homes, find it to cover needs across the whole locality including any outlying areas?

5. Are there any proposals for **GP surgery alliances, mergers or relocations**? How are these likely to affect local access to surgeries and the services or clinics they host? If the proposals leave any local gaps in provision, how could these be addressed?

6. What **public transport options** exist to help patients travel to GP surgeries, community hospitals and other health facilities? Do those transport options serve the smaller rural settlements? Might community transport providers or schemes (such as volunteer car schemes) help to plug gaps?

7. What are the **travel costs and downtime** for health visitors, district nurses, etc if they are regularly visiting patients with long term conditions in their own homes in outlying areas? Is any additional burden from such travel accounted for in resource and workload planning?

8. What scope exists to offer and facilitate **virtual consultations** (by phone or online) for patients who may otherwise face difficult journeys to reach a traditional consultation? Similarly, could digital be used at surgeries or health centres to access advice from specialists based elsewhere (perhaps thereby obviating a hospital visit)?

9. What is the location of **community pharmacies** in the area and how adequately does that serve the dispensing needs of residents from rural settlements? Is there a role for dispensing surgeries to fill any particular gaps in provision?

10. What support services are provided to those who are living with a chronic condition or a disability and who **self-care**? What might improve the support and its delivery to those patients living in outlying areas?

11. When **commissioning community health services** what scope exists to do so from local providers or in ways that improve service availability in rural areas? Could this include an enhanced role for local voluntary and community sector organisations?

12. What **collaboration or networking challenges** arise, if any, for primary and community health professionals and managers where they are working across a geographically large rural area? Are there working practices which could alleviate these challenges?

- Guildford and Waverley Community Gynaecology Service in Surrey
- Enhanced primary care in Frome, Somerset

Other solutions to rural service delivery challenges could include:

- Mapping primary care services in the area (General Practice, dentistry, pharmacies, etc) to understand their distribution in relation to rural populations and transport networks.
- Deploying other trained healthcare professionals to undertake selected tasks that were previously carried out by a GP.
- Having pharmacy prescriptions delivered to village shops that agree to act as local collection points for residents, especially those who cannot easily travel.
- Engaging with any local projects which help people, especially from vulnerable groups, to enhance their online skills, so more patients can take-up the option of virtual consultations.

MENTAL HEALTH SERVICES

The NHS Long Term Plan for England increases the funding that is made available for mental health services, recognising that it has historically been under-resourced. It seeks to expand the size of the community mental health workforce and improve integration with physical health services. More specific objectives include growing 24/7 services for those in crisis and creating more comprehensive mental health services for children and young people.

One challenge for health care providers is how to plan and design child and adult mental health services which are sustainable across larger rural geographies and are accessible to their dispersed communities. This may be true both for frontline support services and for referrals to specialist treatment.

The following questions are intended to help improve rural service planning and design:

1. How accessible to rural communities are organisations or facilities which can promote public **information** (e.g. from the 'Every Mind Matters' website) and so help people to better understand and cope with common mental health conditions, such as stress and anxiety?

2. How geared up are smaller rural-located **GP surgeries** or health centres to offer mental health prevention services? Are there professional development needs for their GPs or primary care teams to improve diagnosis and early intervention? Is there evidence of late presentation by patients in small communities and how are confidentiality issues addressed?

3. Where is the nearest 24/7 service for those who have a mental health **crisis** and how can it be accessed or reached from rural locations? What other options could be adopted, such as an outreach crisis team or having access to facilities across administrative boundaries?

4. In cases where individuals are referred on to specialist **in-patient** care services, how easy to travel to are those services, not least for visiting family or carers? Again, could there be cross-boundary solutions? Are there specific rural challenges if organising an admission under the Mental Health Act and how could they be addressed?

5. How effectively do **Child and Adolescent** Mental Health Services work with rural based schools and colleges in the area and can any gaps in this provision be plugged? Is the service in rural areas consistent with the statutory framework for children and young people?

6. How do local plans to improve mental health services address the needs of **older people** in rural communities, including care for those with dementia or co-morbid frailty? Rural areas (especially those on the coast) typically have a high proportion of older residents.

7. What mental health or wellbeing initiatives or projects exist that seek to reach out to (often isolated) **farming communities**? How could they be promoted by working with the sector (e.g. the NFU) or at specific locations such as livestock markets?

8. How is support delivered in rural areas to those seeking help for **alcohol or substance misuse** and how can that support be improved? How might it be better coordinated with other mental health services, so those needing support do not fall through a gap?

9. Is there an Individual Placement and Support service (or equivalent) and how accessible is it to rural residents experiencing common mental health concerns, to help them to remain in or find **employment**? How could its rural delivery be improved?

10. What are the locations of **supported housing** for vulnerable people of varying ages who have mental health problems or learning disabilities? Are any in rural towns or otherwise accessible from rural areas? How might gaps in provision be addressed?

11. How does the **Health and Wellbeing Strategy** seek to analyse mental health needs and inequalities in rural areas? What does it use for measuring need, if a simple count of service take-up is likely to be affected by external factors, including poor accessibility in rural areas?

12. When seeking to improve mental health services by **consulting** with patients, their families and carers, what effort is made to gather views from across the geographic area and to analyse responses such that any rural-specific findings can be identified?

13. What recruitment or **workforce** challenges are identifiable (including specialist professions, such as psychiatrists and therapists, and generalists with mental health skills) which need addressing to maintain mental health teams able to operate across the area?

- Community Front Room in Bridport, Dorset
- MensCraft suicide prevention project in Norfolk

Other solutions to rural service delivery challenges could include:

- Providing intensive home treatment through Community Mental Health Teams, as an alternative to acute in-patient admission.
- Offering more anonymity for those using mental health services (for young people, in particular), by providing the option of video-conference or online chat facilities.
- Delivering mental health services within facilities which also host other types of service, so it is not obvious that those entering are there for mental health reasons.
- Using a 'whole life approach' to mental health service provision, which includes access to support on housing, money and employment issues, as appropriate.
- Enhanced working with rural-facing voluntary and community sector agencies, with resources allocated to help them deliver certain services. This could be especially suited to support for those with enduring mental health issues.
- Adopting a community asset-based approach to aid the provision of support to those with mental health needs. This would identify or map relevant support groups, skills and facilities that could improve support at a community level, and it would also identify gaps.
- Supporting Mental Health Champions who can raise awareness, change perceptions and encourage mental health initiatives in each rural locality.
- Seizing opportunities with organisations from the natural environment and outdoor leisure sectors, who can offer activities for those experiencing common mental health problems. This could include social farming, which offers activity on small farms as a support service.

PUBLIC HEALTH AND PREVENTATIVE SERVICES

The NHS Long Term Plan for England commits to placing much greater emphasis on prevention, so that people remain healthier for longer. The Prevention Green Paper similarly seeks to bring about 'prevention at scale', thereby reducing premature ill-health and disability. Tackling health inequalities is also a headline objective, to reduce the social gradient in healthy life expectancy. The Public Health England strategy document lists ten issues which form the focus of its work. These include lifestyle issues (e.g. smoking, diet), environmental issues (e.g. clean air), educational issues (e.g. with mental health) and scientific advances (e.g. antimicrobial resistance, predictive prevention).

One likely challenge is measuring and targeting health inequalities where needs are scattered across rural geographies and so less visible. Promoting public health messages to outlying communities may also require tailored approaches that make use of different opportunities. Furthermore, ensuring prevention programmes or projects are accessible to residents from both large and small settlements will inevitably impact their effectiveness.

The following questions are intended to help improve rural service planning and design:

1. Does the area's Health and Wellbeing Strategy (or other prevention strategies) seek to measure and monitor **indicators of public health** and its determinants at a locality level? What does doing so show about public health needs and priorities for rural localities?

2. When assessing **health inequalities** to target relevant initiatives, what attempt is made to account for varying spatial patterns? Does the approach identify both geographically scattered need, typical in rural areas, and clusters of need, typical in urban neighbourhoods? How well do inequality indicators used cover both urban and rural aspects of deprivation?

3. What approaches are used to promote **public health messages**, such as with campaigns on smoking cessation, a healthy diet and vaccination take-up? How well do those approaches work in rural areas? Could community-based organisations assist, such as parish councils, WI groups and village hall committees?

4. How well equipped are those **community pharmacies** which are based in rural towns or settlements to offer health and wellbeing advice to their customers? What scope exists to use them to improve access to professional health advice in rural areas?

5. How are **public health programmes** providing lifestyle interventions delivered equitably and accessibly to rural communities, for example to reduce obesity or prevent diabetes? Is there scope to extend their reach by making use of rural assets, such as village and church halls?

6. How are programmes delivered in rural areas which assist with **personal or sensitive** issues, such as mental health, sexual health and alcohol or substance misuse? How do they seek to address the potentially additional confidentiality risk within smaller communities?

7. How are early years or best start in life programmes, which support the health and wellbeing of **young children and their parents**, delivered in rural areas? Are there geographic gaps in their provision which should be addressed?

8. To what extent are regular **screening or health check** programmes accessible to those from rural communities (including those who don't drive or don't have access to a car)? Is there any evidence of low take-up or feedback citing access issues from some locations?

9. What **social prescribing** opportunities, offering referral to non-clinical interventions, are available to or accessible to those living in rural communities? Could social prescribing Link Workers be described as operating in ways that reach out to rural communities?

10. To what extent is the potential role of **digital technology**, such as mobile phone Apps, being exploited to help people adopt healthier lifestyles, including those from rural communities who may have less access to traditional wellbeing services?

11. Where public health goals are incorporated into **other local strategies** and plans, such as those for land use planning, transport planning and early years services, how far does that process consider whether there are particular rural needs or circumstances?

12. How widely and effectively is information disseminated to resident communities and countryside visitors to help them identify and deal with **outdoor hazards** they might experience, such as tick bites and Lyme disease?

13. Do **clean air and pollution** control programmes take account of issues which may affect specific rural communities, such as villages which sit astride busy trunk roads?

14. How do plans produced for **infectious disease control**, where outbreaks occur, ensure that they can be effective in rural areas, where there is likely to be less local capacity within the health care system?

- E-enabled social prescribing in Lincolnshire
- Farming Health Hub providing health and wellbeing services in Cornwall

Other solutions to rural service delivery challenges could include:

- Engaging with voluntary and community groups and their partnerships in rural areas, who are already likely to run a wide variety of health and wellbeing activities.
- Running webinars on priority public health topics (which could be run jointly with primary care colleagues), giving residents an opportunity to improve their understanding.
- Following the principals from the Ageing Better Programme, with coordinated actions and interventions aimed at those approaching old age, so that more avoid preventable disability.

SOCIAL CARE SERVICES

Further integration of social care and health services at the local level is a significant policy objective, as is evident from the models for Integrated Care Systems, Primary Care Networks and from the Better Care Fund programme. There is also an expectation the funding model will undergo (potentially major) reform and, to that end, further Government announcements are expected. However, a notable feature of social care provision is that it involves a wide array of large and small providers (regulated by the Care Quality Commission) that offer both privately and publicly funded care provision. Added to which, much care is given outside any formal system by families, neighbours and friends.

Social care services support children and adults of all ages. The highest volume of demand is that from older age groups, though a major financial pressure for the public sector is provision for profoundly disabled working age adults. Older people form a relatively high proportion of the rural population, especially in coastal areas, and that proportion is expected to increase further. Other specific challenges for providers may be associated with providing domiciliary care to clients in outlying areas and ensuring that rural users have fair access to services, so they can continue living independently at home wherever possible.

The following questions are intended to help improve rural service planning and design:

1. What scope is there, when conducting service planning, to access information about the population **age profile** (and other relevant metrics) at a locality level, so that any spatial patterns which might impact on demand can be identified?

2. What scope is there, when planning service needs and designing commissioning processes, to involve some **rural based service providers** or rural interest groups, as a means to ensure that learning from rural experience is incorporated?

3. How well embedded are social care staff within any **locality-based structures** or multi-disciplinary teams? Does such a team approach offer opportunities to improve support to rural clients? Could further partnership working with other frontline service organisations also prove beneficial e.g. to information sharing?

4. Where domiciliary care providers visit clients living independently in outlying areas, what is known about their **travel costs and downtime**? How do contracts awarded for provision to local authority funded clients ensure that all locations are served and clients living in remoter areas receive an equitable service?

5. How robust and effective is the **lone worker policy** for those social care and NHS staff whose jobs involve them making home visits in or regularly travelling through rural areas, where mobile phone signal connectivity may be unreliable?

6. How readily can the rural **housing** stock, including older and more isolated dwellings, be **adapted** to meet the needs of residents, whether or working age or retired, who develop disabilities? Do local policies to support independent living address the needs of rural residents?

7. What is the geographic **distribution of residential and nursing home** settings across the area being served? Does that distribution provide users (or potential users) from rural areas with the option to remain close to the locality and community they have lived in?

8. How adequately supported by health professional are those that live in rural-located **residential care homes** (including nursing homes)? Do those residents and their care homes have arranged access to a visiting team of health professions and to a named GP? Do they also have good access to health professionals who can provide end of life care?

9. What is the geographic distribution of **day care centres** and the activities that they offer across the area being served? Does that distribution provide users (or potential users) from rural areas with fair access to day care centres?

10. To what extent do rural communities in the area benefit from befriending schemes or good neighbour schemes that help combat **loneliness and isolation**? Are there gaps in provision and, if so, what local organisation(s) could support their development?

11. What support services are in place, which are accessible to rural residents, to help those that need advice with **financial planning** to help them manage their future care costs or to access allowances they are eligible for?

12. What initiatives or projects are in place to support and to provide respite for **those who care informally** for a partner, a parent or a child with special care needs? Are those initiatives or projects sufficiently accessible to informal carers in rural areas?

13. What opportunities exist to introduce **digital or online** solutions, to assist with the delivery of social care support? Could care at-a-distance prove especially useful as a means to enhance support to clients in outlying areas?

14. Do rural geographies create any additional challenge for social care teams and multi-agency networks seeking to deliver prompt and effective safeguarding and other support to **vulnerable children and young people**, including those requiring intensive intervention? What options exist to mitigate such rural challenges?

- Commissioning local micro-providers of care in Somerset
- South West Care Collaborative improving care home provision in Devon

Other solutions to rural service delivery challenges could include:

- Plugging gaps in service provision by developing (or repurposing existing buildings to become) social care hubs located in rural towns, thus addressing rural needs whilst still achieving some economies of scale.
- Partnering with local voluntary sector organisations to ensure that befriending or good neighbour schemes are widely available across the area for vulnerable and older people in its communities.
- Supporting care sector providers to adapt to changing needs in their local area in a more coordinated and sustainable way, through a representative body which can offer them advice and development opportunities (as LinCA does in Lincolnshire).
- Exploring the potential of digital innovation to complement domiciliary care provision in rural areas and to enhance support for those living independently at home.
- Utilising social farms or gardens to provide opportunities for older people with care needs (not least those in care homes) who have worked outdoors for much of their life and who may benefit from the stimulation that such facilities offer.

WORKFORCE

The NHS People Plan seeks to address workforce shortages, to build leadership capability and to develop a workforce with the skills to match future service delivery plans. This includes creating skills to work in multidisciplinary teams and to enable more digital adoption. The NHS Long Term Plan for England flags the scale of workforce shortages, aiming to more than halve the vacancy rate for hospital nurses. Within the social care sector, which has a larger workforce than the NHS, high vacancy and turnover rates are also a notable feature, most obviously in domiciliary care services.

A particular challenge in rural areas has been attracting and retaining doctors, both in GP practice and at smaller hospitals, which can impact the availability of specialist skills. However, rural health and care workforce issues are much broader than this and partly reflect the impact that vacancies have within small teams. Small teams are also likely to offer fewer opportunities for career development. Relevant, too, is that most training institutions are based in urban centres.

The following questions are intended to help improve rural service planning and design:

1. How well does **workforce planning** match with the evidence base about local health needs and trends? How can it ensure that any specific needs from rural locations are identified? How could monitoring of staff vacancy and turnover rates be used to gather rural data?

2. How realistic and sustainable are future workforce plans for rural parts of the area? How will those plans ensure there are professional teams with the capacity and **range of skills** to serve across rural geographies? Is there a need to build team working or collaboration skills?

3. What options can be explored to ensure that professional staff have **career development** or progression opportunities, without them necessarily needing to move away from the area? Could this be expanded to offer some health research or teaching opportunities nearby?

4. In rural areas which have a modest resident population, but which experience a seasonal influx of **visitors or tourists**, how much variation in demand for services is experienced? What approaches could improve planning for and management of this variation?

5. What policies are in place to ensure the **wellbeing of professionals** who work in rural and more isolated settings? How accessible is support for any that develop mental health needs? Is a lone worker policy in place for staff whose jobs involve home visits or regular travel in rural areas, where a mobile phone signal may be patchy?

6. To what extent is the extra **time and cost** involved taken into account for staff whose roles involve home visits or regular travel to outlying locations and is that realistic? When such services are commissioned e.g. domiciliary care, how do contracts cover extra travel costs?

7. What training or development opportunities exist to prepare professionals, including GPs, who move into more remote areas, giving them the **breadth of knowledge** and confidence to work alone (with less access to professional back up)? How might that be improved?

8. How could rural based professionals be helped to access opportunities to maintain and update their knowledge, not least for **CPD and mandatory training**? For example, could training sessions be held at more local facilities or as outreach training on site?

9. How could valuable **networking and peer learning** opportunities be facilitated for rural based professionals, without them having to make long or time-consuming journeys? For example, can easier locations be found for face-to-face meetings and can these be supplemented by digital options?

10. What opportunities arise from the formation of Integrated Care Systems, **Primary Care Networks** and community multidisciplinary teams to address workforce issues that are prevalent in rural areas? For example, could they assist professional networking, career development and gap filling where vacancies arise?

11. What opportunities exist to extend training and networking opportunities to those working or volunteering for organisations in the **voluntary and community sector**, that support or complement statutory health and social care services?

12. What measures are in place to ensure that professionals moving into **agricultural areas** have sufficient knowledge of diseases most likely to be found among farming communities, such as zoonoses and farmer's lung?

- Training GPs for rural practice in Northumberland
- Refugee doctors project in Lincolnshire

Other solutions to rural service delivery challenges could include:

- Deploying other trained health care staff into selective tasks that were previously carried out by a GP.
- Seeking to attract into vacancies in rural areas those health and care professionals who have plans to return to the workforce after a spell away.
- Addressing local gaps in specialist knowledge or experience by giving local professionals access to specialist support via digital means or telehealth.
- Making use of e-learning and distance learning approaches to improve access to training opportunities.
- Forging links with a university medical school in the region, who could offer rural skills teaching, placements or similar. Rural experience could be offered at different levels, from Foundation students to those achieving their Certificate of Completion of Training.
- Considering whether rural working can be turned into a selling point when recruiting to fill vacancies. Positives could include the rural environment, community strength and a chance to develop a broader set of medical skills.
- Putting in place buddying or mentoring arrangements for less experienced staff who may feel isolated working in rural locations. This could involve mentoring by recently retired professionals.

CASE STUDIES

Supporting high intensity users of NHS services in Cornwall

In common with many areas, NHS Kernow – which covers the mainly rural geography of Cornwall and the Isles of Scilly – is aware that a small number of service users account for a disproportionate number of avoidable, unscheduled contacts, such as visits to A&E and 999 calls. This scheme seeks to explore and address the underlying reasons behind this high intensity use, by using a whole person approach.

In late 2018 Volunteer Cornwall was commissioned by Kernow Clinical Commissioning Group to deliver support for high frequency users of ambulance services, emergency departments and other NHS resources, in order to reduce pressures on the NHS in Cornwall and to improve individual wellbeing.

The scheme became operational in January 2019, initially with a single co-ordinator post. Two additional co-ordinators joined in early 2020 and a further co-ordinator appointment is planned (in 2020) with service partners Portreath, who are a mental health charity.

Through the High Intensity User service (HIU) co-ordinators work one-to-one with frequent users of NHS services to help them access alternative support. Clients are typically very vulnerable and can sometimes be quite challenging. Although many have little faith in statutory services, individuals are often more willing to trust the voluntary sector.

"Coordinators listen to the needs of the service users with a friendly approach, supporting them into finding solutions to their issues, aiming to reconnect them back to a better life, to their families, to their communities and often helping them to access the appropriate services in a less chaotic style."[1]

The county-wide scheme sought to identify the top 50 users of health resources and it works "down from the top of the list". Initially, referrals came mostly from South West Ambulance Trust, but difficulties in obtaining timely information led to a change of approach.

Now the focus has switched to the most frequent attenders at hospital emergency departments. To enable this to work an honorary NHS contract allows HIU staff to access appropriate data. The scheme is now in discussion with Clinical Directors at the area's Primary Care Networks so it can engage more widely with GPs.

The large geographical area of Cornwall presented another challenge to the scheme. Initially, based on similar schemes in more urban locations, it had been hoped to engage with up to 50 clients in the first year. However, it soon became apparent that this was unrealistic given the considerable distances and travel times between clients. To minimise this constraint the scheme now operates with co-ordinators who each cover a specific part of the county.

Typically, co-ordinators work intensively with clients and their families for around 6 weeks and then seek to gradually withdraw support. During the first year of the service, the scheme supported people into volunteering, clubs, gym-on-prescription, social prescribing, detox, new accommodation, debt support, court support, house clearing, walking groups, growing clubs and more.

The financial benefits of the scheme have been substantial. Between January 2019 and February 2020 the scheme had engaged with 37 clients at a total cost of £49,000. Savings generated totalled £295,000 and the client usage costs of health services were reduced by 58%. Those savings comprised:

- 276 fewer ambulance trips;
- 212 fewer emergency hospital attendances;
- 103 fewer non-elective admissions; and
- 192 fewer hospital bed days.

Clients have also reported huge benefits to their personal wellbeing.

> *"If I never had Nat to help me, I would not have come this far. My boys are also receiving support and it has helped them a great deal. Since Nat I've joined Tae Kwando, that Nat got funding for, I also do more with the boys and am less anxious and engaging with people a lot more. I go out more and am meeting new people."*[1]

Appointing the right people as co-ordinators has been crucial to the success of the scheme. They need the right balance of empathy, strength and determination or "*a cross between an angel and a Rottweiler*" as one client described the co-ordinator who helped him.

As well as expanding the current scheme, work is underway to collaborate more closely with GPs in the hope that working with high intensity users of primary care may help address clients' problems at an earlier stage.

Source:

1. https://volunteercornwall.org.uk/how-we-help/health-social-care/integrated-care-system/hiu-service

The case studies included in this toolkit have been selected as examples of good rural practice. Their inclusion does not infer that they have necessarily been developed as a result of a systematic rural proofing process.

Back to Main Hospital Services Section

‘Near Me’ delivering remote care in NHS Highland, Scotland

‘Near Me’ video consulting is transforming the way that people are accessing health and care services in Scotland. It is now used in every NHS Board area in Scotland and is being expanded to care services. In 2019 it received the Institute for Healthcare Improvement (IHI) Lucian Leape Institute Medtronic Safety and Culture Technology Innovator Award for improving patient safety through the successful implementation of technology and culture change.

Prior to the ‘Near Me’ scheme being introduced, many patients, particularly those in the most rural parts of the country, faced long, inconvenient and sometimes challenging journeys to attend hospital outpatient appointments. For example, a patient otherwise having to travel from Caithness to hospital in Inverness would face a round trip of over 200 miles. The project addresses such access issues by delivering convenient person-centred care, with outpatient consultations being delivered either at a patient’s home or at a local clinic. Other benefits include the ability of clinicians to work remotely and a reduced carbon footprint.

‘Near Me’ is powered by the ‘Attend Anywhere’ platform, which the Scottish Government procured for use across Scotland. Early use was largely limited to rural areas, especially in the north of Scotland in NHS Highland and NHS Grampian.

‘Near Me’ was the service name picked by patients in the Highlands, where the first test clinic opened in January 2018. It was then rolled out across the health board area through 2018 and 2019. Funding came from NHS Highland (for salary costs) and from the Scottish Government Technology Enabled Care Programme (for equipment and estates). There was also a small grant from the Health Foundation towards the co-design work.

In order to use the ‘Near Me’ service at home patients must have internet access and an appropriate device for making a video call. Not all patients have this and the constraint was addressed in Highland by the provision of a network of 15 clinic rooms located in rural areas, where people can use health service devices. In some cases, the clinic rooms are supported

by a local health worker who can offer checks, such as those for blood pressure or blood tests.

Such was the success of the scheme that, by November 2019, the service was said to have provided 2,700 video consultations across 31 clinical specialties. This equated to a saving of an estimated 350,000 travel miles a year for patients and clinicians across Highland.[1]

The Covid-19 pandemic gave a major impetus to expansion of the service. As part of the response, 'Near Me' was adopted as the service name across Scotland, a supported scale-up programme was put in place and 'Near Me' was made available at nearly every hospital and GP practice. Prior to March 2020, there were around 300 'Near Me' consultations a week across Scotland, but by June 2020 it was nearly 17,000 a week.[2] Satisfaction rates with the service are high, with 98% of patients giving feedback saying that they would be happy to use the scheme again.

The Project Lead emphasises the importance of co-designing the service with participation from everyone involved, including not only patients and clinicians, but every staff group involved in the outpatient process. Indeed, co-design has been at the heart of the project since the earliest, pre-launch design stage and has led to numerous beneficial changes. 'Near Me' also had to be fully embedded into the ways that outpatient appointments are provided, which necessitated a whole-system approach.

> *"The main hurdle to overcome is that people think of this as a technology project: it isn't. The main issue is how to embed a new method of consulting into existing processes and care pathways, so that it is as easy for both patient and clinician to have a video consultation as it is a face-to-face consultation. So it's really a process change project."*
>
> *"Effectively implementing telehealth is about more than just technology. It's about co-design, using a whole-system approach, and ultimately about delivering person-centred care."*
> **(Project Lead)[3]**

Looking to the future, it is hoped that use of the 'Near Me' service will continue to grow across the whole of Scotland, in urban as well as rural areas. Its wider use in care and nursing home environments is also identified as a significant opportunity.

Sources:

1. https://www.recruitnorthhighlands.com/2019/11/27/award-winning-healthcare-in-the-north-highlands/
2. https://www.nearme.scot/wp-content/uploads/2020/06/near-me-vision-public-june-20.pdf
3. http://www.ihi.org/communities/blogs/technology-isnt-enough-co-designing-patient-centered-telehealth

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Back to Main Hospital Services Section

Guildford and Waverley Community Gynaecology Service in Surrey

The Guildford and Waverley Community Gynaecology Service (GWCGS) has been running since 2014 and it won a Women's Health Award in 2018. Following a successful three-year pilot project, the service is now fully integrated with the Royal Surrey County Hospital. The aim of the service is to improve access for women with gynaecological needs and to provide them with the care they need without having to attend the main hospital.

Prior to this service the only option for women living in Guildford and Waverley who needed gynaecological care, beyond the remit of their GP, was to go to hospital. The concept of starting the Community Gynaecology Service (CGS) arose from the drive to bring some services out of a hospital setting and into primary or community care, thereby improving access for patients, including those living in rural areas. It was an innovation led by the GPs involved.

The service is accessible to all patients registered with a GP in Guildford and Waverley. The gynaecology clinics, based at St Luke's surgery in Guildford and at the rural surgery in the village of Shere, are provided by a team of expert GPs with a special interest in women's health. The rural location is very beneficial for those living outside of the city. It has the advantage of plenty of parking and a tranquil setting, whilst the city centre location has good access by public transport.

The pilot was commissioned and funded directly by Guildford and Waverley Clinical Commissioning Group (CCG). Now the service is fully integrated with the Royal Surrey County Hospital whose contract with the CCG states that they must provide a primary care-led, community-based, tier 2 gynaecology service. The CCG, in turn, subcontracts that service to the CGS (as part of Shere surgery).

There are typically 3 to 4 clinics held each week, seeing a total of 20 to 25 patients, offering a range of services which include 3D ultrasound diagnostics. Approximately half of the patients attend at each of the centres. Patient satisfaction ratings are outstanding and local GP

involvement is good. Part of the offer to involved GPs is training, which is both practical and part of the CCG's GP education programme.

There is some cost saving for the CCG as the CGS tariff is lower than the standard hospital outpatient appointment tariff. Keeping costs down is helped by the CGS adopting a one-stop model for visiting patients wherever possible. If the project did not exist all of its patients would have to be seen in a main hospital.

A key benefit for patients is good access. Not having to be seen in hospital means not having to spend time finding a parking space and negotiating busy hospital environments. The service also offers holistic care, as the GPs are passionate about women's wider health and wellbeing. Being in a GP surgery, with longer opening hours than a hospital outpatient department, also enables the team to provide clinics earlier and later in the day.

The service is very responsive, having changed its remit since the initial pilot to adapt to changes in other local services (such as a reduction in local complex family planning services) and evolving NICE guidance.

> *"It [the CGS] could certainly be replicated, but it depends on the availability of GPs with the appropriate specialist skills and interest. The way our service is set up means we, as GPs with Special Interest, are very autonomous: we have oversight and governance from the hospital, but if it involved significant consultant time for supervision it would most likely not be financially viable as this would increase costs. Therefore, the level of skill and accreditation of the GPSIs involved does define the service model."*
>
> *"Commissioning this model definitely requires the CCG/STP to have an appetite to commission tier 2 services and for them to be able to negotiate with the secondary care stake holders to ensure support for governance."*
> **(Lead GPSI, Guildford and Waverley Community Gynaecology Service)**

Two further factors are said to be key to the success of this service:

- The ability, and contract, to 'triage' all gynaecology referrals made by Guildford and Waverley GPs means that patients are seen in the most appropriate clinic to meet their needs, based on their medical problem. It also ensures that the service only sees patients who are within its remit, which minimises the risk of needing to make onward referrals to secondary care (these being costly and a less satisfying journey for patients);

- Good relationships with the hospital consultants are also vital. The GPSIs have agreed shared pathways and they can take referrals from the consultants for things that fit their remit better than the hospital team.

The GPSIs would like to expand the GWCGS service and hope to discuss this further with the Royal Surrey County Hospital and the area's Sustainability and Transformation Partnership. Potentially, activity could be increased if the area covered was to be expanded.

Sources:
Guildford and Waverley gynaecology http://www.gwcgs.co.uk/?page_id=25

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Back to Primary and Community Health Services Section

Enhanced primary care in Frome, Somerset

In 2013 Health Connections Mendip (HCM) was set up as a social prescribing, community development service, formed through a collaboration between the eleven GP practices that are based in the district of Mendip, Somerset. At around the same time the GP practices also set up their unplanned admissions teams.

These two initiatives first came together in Frome, a hub town in Mendip, and together they form the core of the Frome Model for Enhanced Primary Care. This innovative approach, therefore, combines a programme of community development, social prescribing and unplanned admissions work, which runs alongside routine medical care. It helps to connect patients with support and activities in the community that will have a positive impact on their health. It is rooted in an understanding that health is heavily influenced by social factors and that whole population health is improved by working together across organisations and communities.

> *"The aim is to break a familiar cycle of illness reducing people's ability to socialise, which leads in turn to isolation and loneliness, which then exacerbates illness."*
> **(Dr Helen Kingston, Frome medical practice)**[1]

The project uses principles of personalised care planning. Its offer is not limited to those with long-term conditions or to older people, and anyone who gives cause for clinical concern, who is at risk of hospital admission or is discharged from hospital can be referred into the unplanned admissions team. Carers are also supported. Furthermore, anyone can choose to become involved with HCM by self-referring or simply making contact to find out how to be involved with the service.

Fundamental to the success of the model is its whole system approach. A multi-disciplinary approach within the surgeries is combined with strong support from individuals and organisations within the area's communities. Key elements of this model are: regular multi-disciplinary meetings which facilitate easy interaction between the GPs and other medical or

care professionals; and the Health Connector (from HCM) who provides the social prescribing. A social worker also visits the Frome surgery on a regular, weekly basis.

Initially, through HCM's work, there was a single Health Connector post based in the Frome surgery, which covered the whole of the mainly rural Mendip area. However, the success of the scheme rapidly led to that service being expanded. From 2015 the area's Clinical Commissioning Group has funded Health Connectors in each of the eleven GP practices in Mendip. (They are all employed by the Frome surgery on behalf of the other practices.)

Support from the local community is essential in enabling the model to work effectively. In this context, HCM plays a key role in helping to grow social capital. It achieves this by:

- **Mapping community assets and identifying gaps:** there is now a readily available directory, which lists over 400 services in the local community;
- **Helping local people to fill gaps:** it helps people to create valuable new services and activities in a sustainable way, providing support with aspects of establishing a new group. Groups that HCM has supported are numerous, but they include Macular Degeneration, Stroke and Diabetes Support Groups;
- **Providing effective signposting:** to ensure people can access and benefit from the many community services and activities. This signposting is achieved in many ways, including:

    - Through active citizens, who act as Community Connectors to signpost family, friends and neighbours to services that may be helpful. There are now around 1,500 of these active citizens;
    - Through social prescribing by the Health Connectors, who focus on what will prove most important to the individual patient;
    - By writing out to suitable patients that have been identified from practice registers;
    - By promoting services on the Health Connections Mendip website;
    - At Talking Cafes, which are physical places where people can discover community support; and
    - Via a monthly local radio slot, on social media and in a monthly newsletter.

The project's headline achievement, according to a paper in the British Journal of General Practice, has been a "highly significant reduction in unplanned admissions to hospital", over a period when admissions rose elsewhere in Somerset. Cost reduction was not the main objective when establishing the model. However, a reduction in emergency admissions to secondary and tertiary health care has reduced costs to the NHS.

"The results of this project show that doing the right thing isn't more costly and that we can offer better care, better medicine. For every £1 put into our scheme, we saved £6 in emergency admissions."
(Dr Helen Kingston, Frome medical practice)[1]

Frome has had many enquiries about its approach from elsewhere and those involved have been working with various locations around the UK and abroad. They have also created a website template for the approach, which is available at a modest cost.

"The model can happen anywhere, but you do need the right people. It is really important to allow things to happen organically, as success is so easily stifled by bureaucracy."
(Health Connector, Frome Surgery)

Sources:
1. http://www.frometimes.co.uk/2018/02/27/frome-leads-the-way-in-easing-the-nhs%E2%80%88crisis/
Also:
https://www.compassionate-communitiesuk.co.uk/projects
https://bjgp.org/content/68/676/e803
https://www.pointsoflight.gov.uk/compassionate-frome/
https://shiftdesign.org/case-study-compassionate-frome/
https://healthconnectionsmendip.org/

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Back to Primary and Community Health Services Section

Community Front Room in Bridport, Dorset

Responding to concerns that the previous service was not supporting people as well as it could do, the Dorset Clinical Commissioning Group (CCG) undertook a thorough review of its Mental Health Acute Care Pathway (MHACP). That review was co-produced along with Dorset HealthCare, Dorset Mental Health Forum, users of the service and their carers, plus a range of external partners such as local authorities. An extensive formal public consultation also formed part of the process which led to the presentation of the final business case in September 2017.

Central to the proposed changes was a desire to make services more locally accessible to everyone, including those living in rural areas, and part of that initiative involved the creation of Community Front Rooms in the three market towns of Bridport, Shaftsbury and Wareham. Mirroring a successful pilot drop-in facility in (urban) Bournemouth, the CCG commissioned three rural Community Front Rooms which opened in 2019. All of them are run by local charities.

The Bridport Community Front Room is run by the Burrough Harmony Centre, a small mental health charity that already operated in the town. The facility is open between 3.00 pm and 11.00 pm from Thursday to Sunday (when other facilities are typically closed). It is operated by two members of staff, one with a mental health qualification and the other with direct specialist knowledge of mental health issues.

Located close to the town centre, the Community Front Room provides a safe, welcoming and understanding environment for adults who are in or are heading towards a crisis. It is a place where people can talk things through, be listened to or just sit quietly. Quite deliberately the ambience is homely rather than clinical.

The rules are relaxed and people can just turn up without any need for an appointment or referral – they just ring the doorbell. Staff cannot admit anyone showing too much aggression or severely intoxicated, who would generally be asked to come back at another time. Ambulance and police services often bring people along, which avoids a trip to hospital A&E

or the unnecessary use of cells. However, the Community Front Room is not a formal Place of Safety and sometimes, if the person cannot be kept safe, there is a need to escalate things for an assessment in Dorchester.

Since opening in July 2019 this Community Front Room has received between 78 and 100 visits each month. Some have been by first time contacts who are not known to mental health services. The benefits from the service have been both financial and personal.

Whilst no formal evaluation of savings to the NHS was available at the time of writing this case study, an approximation based on the much larger Bournemouth scheme (and divided pro-rata by the number of visits) suggests potential savings in the order of £45,000 per annum.

As for the benefit to service users, feedback has been extremely positive.

"I don't know what I would do without the Community Front Room now; it is an oasis of calm, a beacon of hope, and no matter how you are feeling, you will be welcome here.
Sometimes, just having a cup of tea with someone is all you need – a chat with people who have 'been there'; or just space to sit quietly, knowing you are safe.
But it's there for the times of crisis too. Hands reach out to hold you when you feel as if you are falling.
Hope, acceptance, safety, and empathy sum up the Community Front Room ... "
(Service user)

The service manager believes that the scheme could be replicated in many rural market towns. In her own words, her advice would be:

"Stay true to the model and maintain compassion and humanity in all delivery;

Develop a strong team, with high quality training;
Ensure consistent and compassionate support for all staff, as it is a challenging role;

Ensure the buy-in of local agencies and emergency services and that they understand the ethos and values of the service, which are very different to traditional clinical services."

The service is looking to offer more digital or virtual support in future, to supplement, though not replace, the existing provision. It is hoped that this will enable those living in more outlying rural areas to access support when they can't physically travel to the Community Front Room. It may also make the service feel more accessible to young adults.

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Back to Mental Health Services Section

MensCraft suicide prevention project in Norfolk

Suicide rates are above the national average in Norfolk and particularly high in the Norwich area (where they were 75% above the national average in 2018).[1] Three quarters of those who commit suicide are male.

In response a multi-agency project, led by MensCraft, appointed a Prevention and Positive Activities Co-ordinator [the co-ordinator] in January 2019 to work with vulnerable men in the greater Norwich area. That area extends well beyond the city and covers a rural area within approximately a ten mile radius. The project was enabled by a successful bid for national suicide prevention funding, which was made by the Norfolk and Waveney Sustainability and Transformation Partnership and was managed by Norfolk County Council Public Health.

Based in Norwich, MensCraft is a Community Interest Company which aims to provide 'activity, identity and meaning' via a range of different programmes for men and boys. As their website notes, "men tend to be affected by the indirect consequences of enforced under-employment and significant life events … leading to substantial negative effects on their wellbeing ... Typically men do not access mainstream health, community information and advice services for support."[2]

The co-ordinator works alongside a mental health nurse and offers initial support within 48 hours, until the patient is seen by the Community Mental Health Team which, in emergency cases, must take place within 120 hours. Initially, referrals came via a single point of access from GPs or from the Norfolk and Suffolk NHS Foundation Trust (NSFT) Escalation and Avoidance Team. However, to optimise use of the service this was changed in September 2019 so that referrals can now come from a variety of local organisations and with self-referrals also welcome.

The project gives men the chance to talk about how they are feeling, as well as providing opportunities to take part in groups or social activities. Where appropriate, they will be signposted to other sources of support, such as organisations which can help with debt, homelessness and drug or alcohol problems.

"Men can find it really hard to communicate. I'm not a clinician so am not there to help them find solutions, but instead offer them the space to talk about how they are feeling so that they can feel understood and heard. Just being there can be massive and can make a real difference, especially to someone who is feeling isolated and alone."

"When I first meet the patient, I'll ask him to tell me his story and we work together to develop a safety plan. I will also do what I can to alleviate his stress in the short term, to make him safer while opening up other sources of support which could benefit him."
(Prevention and Positive Activities Co-ordinator, MensCraft)[3]

The co-ordinator has provided non-judgemental support by phone and often by home visits to over 40 men, of all adult ages, in the 18 months that he has been in post. Each client is unique but, on average, he estimates that he spends around 10 hours with each one over a six week period.

Participants' reactions are very positive:

"I was in a right state, I was thinking about suicide a lot. Just being able to speak with someone was good. It really helped me understand where I was and helped me focus on what my next steps should be. I wasn't used to talking about myself and what I needed, so it helped to have that extra support."

"The other activities MensCraft offer are good. People don't label you as someone that's worked with you (the Co-ordinator) they just let you be you. It's good to be a part of something and build relationships with people on your own terms and at your own speed."
(Project client)

Notably, the Covid-19 lockdown caused additional pressures on the service, as many clients experienced additional stress and anxiety and home visits had to be suspended temporarily. However, great care was taken to ensure that connections were maintained virtually through a mixture of video meetings, phone calls and via a talking group.
When asked why the project was so successful, the co-ordinator emphasised the support of MensCraft as an organisation.

"Working for an amazing organisation is key to the success of this role. They work hard to promote the scheme and to support men's needs, more generally, and they back it up with action … They also care for my wellbeing".
(Prevention and Positive Activities Co-ordinator, Menscraft)

Such has been the success of the project that four additional co-ordinator posts are being created which, from September 2020, will cover the whole of Norfolk, much of which is very rural in character.

Sources:
1. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/datasets/suicidesbylocalauthority
2. https://www.menscraft.org.uk
3. https://www.nsft.nhs.uk/Pages/Additional-support-for-men-at-risk-of-suicide.aspx

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Back to Mental Health Services Section

E-enabled social prescribing in Lincolnshire

Social prescribing is a means of enabling primary care services to refer patients with social, emotional or practical needs to a range of locally based, non-clinical services, when medical intervention is not getting to the root of an individual's problem. Participants might have a number of needs, including long term medical conditions, mental health issues, loneliness, debt concerns or complex social needs.

GPs, nurses, emergency services, housing providers, social care teams and family members can make referrals to the organisations providing social prescribing in Lincolnshire. They are Voluntary Centre Services (covering west Lincolnshire) and Lincolnshire Community and Voluntary Service (covering the remainder of the county). Depending on the level of need, the individual may be assigned a link worker who will support them to think about their goals and how they can move towards achieving them. The link worker can also provide or signpost to the help they will need.

Social prescribers offer three levels of support, depending on need. These are:

1. Where the person knows what help they need, but would like advice on where to access relevant local activities;
2. Where the person needs guidance to know what help they might need and where to find it; and
3. Where the person would like help to think about their goals and someone to support them as they start moving towards those goals.[1]

The large area and rural character of the county, combined with often poor public transport links, present particular problems and can compound issues with social isolation. Many people, estimated at around 20% of those in the 45-54 age group, would prefer to have a digital option to access social prescribing so good connectivity is considered a priority.

The context is a very successful scheme developed by the Digital Health Team at Lincolnshire Community Health Services NHS Trust, which has been taken up by some 4,000

students at the University of Lincoln. That scheme, combining information, health, and wellbeing services, was first offered in September 2019. It is accessed via the Vitucare system, comprising an online platform with separate tiles for different services. Importantly, students can use Vitucare from either home or university. This has proven to be beneficial to students wanting to find services and activities, to self-care and to access e-consultations. It is also an effective channel for urgent health messaging, such as how to check for signs of meningitis when a case was discovered on campus.

During the Covid-19 lockdown Social Prescribing Link Workers have video-called a number of their clients, which has been well received by participants.

An online social prescribing platform for wider public use, has since been created in its test format in conjunction with a group of co-producers who have lived experience of the approach. This again uses Vitucare and provides a bespoke, individualised digital offer which includes:

- Information tiles for an online advice library, for 'One You Lincolnshire' and for social prescribing;
- Tiles for staying in contact, which offers secure messaging, care documents and video calls with a therapist; and
- Self-care tiles which relate to personal goals, how clients are feeling and their lifestyles.

The team is currently developing some additional tiles, which will include a health tracker (self-tracking sleep, exercise and hydration), a 'meet the team' function and a wellbeing area (with hints and tips on how to stay happy and healthy). The platform is expected to be brought properly into use in late summer or early autumn 2020.

The scheme aims to optimise its relevance by customising to an individual's characteristics (such as their age, gender, interests, health conditions and residential location). If the user agrees, information in Virtucare can be shared with local GPs or other clinicians, to alert them to any concerns. For example, a patient using psychological services might be offered specialist tracker tiles for their needs, such as depression or psychosis. To facilitate this, the scheme has been carefully designed so that the coding used fits with existing GP systems.

"By providing a digital social prescription we hope to empower people to feel more in control and manage their own health and wellbeing. This will be achieved by connecting people with their communities thereby reducing isolation, encouraging opportunities to participate in activities and impacting positively on physical health. Resources will be available to support people to manage practical issues such as debt, housing and relationships, and digital campaigns will be used to 'nudge and nurture'. This can all be delivered from the comfort of the citizen's home and negate time and expense travelling."
(Project Support Officer)

As a further development the Digital Health Team at Lincolnshire Community Health Services NHS Trust has started work with 'Active Lincs', with the intention of being able to connect citizens up to their local leisure centres.

Sources:

1. http://www.lincolnshirecvs.org.uk/social-prescribing-home/ also
https://lincolnshire.nhs.uk/latest-news/social-prescribing-proving-success-lincolnshire
https://voluntarycentreservices.org.uk/wp-content/uploads/2019/11/2019-SP-Leaflet-Practitioners.pdf

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Back to Public Health and Preventative Services Section

Farming Health Hub providing health and wellbeing services in Cornwall

The Farming Health Hub is committed to creating opportunities that engage with a wide range of partners across the public, private and voluntary sectors to enhance and develop support for the Cornish farming community.

It is widely recognised that farmers can face particular health related challenges. These range from physical safety issues in their working environment to mental health concerns exacerbated by isolation, by long hours and often by financial challenges over which they may have little control.

For a variety of reasons farmers often fail to engage with health services at an early stage.

"Both male and female farmers don't tend to seek health care as often as they should. It is hard for them to take the time out of the farm and they also tend to be a bit stoical, so will soldier on. We see people for all sorts of issues, including bad backs and joint and hip problems."
(Rural physiotherapist)[1]

Farmers from Cornwall are especially likely to face challenges for several reasons, including:

- Farms in the county are typically smaller and many have issues with financial viability;
- Livestock farms predominate and external market forces, with fluctuating prices, cause concerns;
- Many are family farms where there is increased pressure to keep them going.

Sadly, suicides in the agricultural sector are significantly higher than the average for England[2]. Whilst there is no available statistical breakdown by occupation for Cornwall, it is notable that the county suicide rate for males is 49% above the national average.[3]

The Farming Health Hub Cornwall was set up in 2019 and it aims to offer a range of support within three main areas:

- General physical health checks, such as eye and hearing tests, diabetes, cholesterol levels and dental health;
- Mental health support, including managing stress, anxiety and depression, plus coping with rural isolation and loneliness;
- Support to develop the farm businesses, including financial and legal advice, help accessing education or training, and applications for grant funding or welfare.

As a new organisation it is still shaping its operational model. However, it intends to create a better connection between farmers and existing resources, signposting rather providing services directly. Ideas include making health checks available at local livestock markets and offering drop-in opportunities at locations where farmers naturally gather, thus avoiding the need to make special trips to more formal settings.

Starting out as an idea shared by three volunteers, all with close ties to farming communities, the hub has already succeeded in establishing a strong partnership board. That board brings together representatives from public, private, voluntary and educational sectors including the National Farmers Union, Young Farmers, Cornwall Health Watch, the Police, Exeter University, auctioneers, Citizens Advice, Cornwall Council and the Royal Agricultural and Benevolent Institute.

The hub has already had a presence at local agricultural shows and it held two events partnering with Mole Valley Farmers (a local farm supplies retailer) where health checks were made available. Another notable success has been the production of a leaflet, drawn up during the Covid-19 pandemic, which provides contact details for sources of help and advice on business issues, physical health and mental health. This has been widely distributed through partnership board members.

A recent grant (in 2020) has enabled the recruitment of the Farming Health Hub's Manager, who comes with a wide range of experience, to help the Hub develop to its full potential. She said,

"I am delighted to be part of this journey. We hope to bring the Farming Health Hub into the heart of the farming community as a valued resource and a go-to place."

Jon James, a founding volunteer, emphasised the significance of the work underway.

"The importance of this approach and need to collaborate has been further highlighted by Covid-19, and throughout 2020 we are building a programme of work that will further develop our offer for the farming community."

Sources:

1 https://www.fwi.co.uk/business/business-management/health-and-safety/farmers-offered-nhs-check-ups-bakewell-market

2. ONS suicide by occupation in England

3. PHE Suicide prevention profile Cornwall 2016-2018

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Back to Public Health and Preventative Services Section

Commissioning local micro-providers of care in Somerset

The Somerset Community Micro-enterprise Project helps local people to set up micro businesses of nine or fewer people that provide local services for people who need some help and support at home.

The scheme, which became operational in 2015, was commissioned by Somerset County Council in response to acute challenges in providing quality care to clients in rural parts of the county.

The scheme, which has received financial support from a variety of funders, initially operated in partnership within Community Catalysts CIC. However, since 2019 it has been managed by the Council directly.

Its main objectives are twofold:

1. To support the development of very small, community-based care and support services that:
   - Provide personal, flexible and responsive support and care;
   - Give local people more choice and control over the support they get;
   - Offer an alternative to more traditional services; and
   - Provide employment opportunities to local people.

2. To provide an accessible directory of information for people who are seeking care or support.

"We want people, wherever they live in Somerset, to have a great choice of local, responsive, high quality support to live their lives. Micro-providers offer what people value most … Continuity, flexibility and the ability to build a trusting relationship with a local person."
(Scheme manager)

The current directory lists over 440 providers and it is estimated that, in total, they support some 2,000 local residents and provide around 11,000 hours of support and care each week.

Inclusion in the directory means that providers have completed a development journey and have offered evidence that they have set up according to best practice. In February 2020 a new accreditation scheme was launched enabling Somerset to officially endorse micro-providers and their local peer networks.

Because of their small scale and the way they operate, providers do not fit the criteria for being regulated by the Care Quality Commission (CQC). However, the approach offers confidence to families and professionals in Somerset, through a shared "doing it right" quality commitment. A quality assurance process is in place, where providers may be removed if their conduct is incompatible with the standards of the scheme. This approach is said to work well with many local networks in Somerset being effectively self-monitoring.

This increased capacity from developing local, responsive support services has meant that:

- People are well-supported at home or in the community by people from their own neighbourhood;
- Support is co-designed, with creative people on both sides of the care equation finding ways to do things differently;
- Clients of the services can be offered an effective choice;
- People can work locally, with hours that suit their family circumstances, earning an income and making a positive difference;
- People and families know that good support is available and, as a result, many come home earlier from hospital and delayed discharges can be avoided;
- People stay connected to their community, contributing to it and avoiding loneliness;
- Lower overheads, compared to larger care businesses, mean that costs to the client are typically lower, yet the carers can still earn a better hourly rate; and
- The scheme is inherently more resilient than relying on larger providers, as the impact arising from the loss of one small business can more readily be absorbed by others.

In summary, the project is considered a win-win, with good work being provided at a fair cost. The scheme is, however, best suited to clients who are self-funding or who hold personal budgets. Lack of CQC accreditation and administrative complexity, unfortunately, make it unsuitable for the Council to use for direct commissioning.

The scheme manager considers that the model could operate well in any rural area. However, key to the particular success of the Somerset scheme has been the high level of support and responsiveness from Somerset County Council and the strong network of more than 100 ‘community connectors’, many called Village Agents, that operate in the county.

The scheme continues to grow as positive feedback from existing providers and clients encourages more people to participate.

For more details see:
https://www.facebook.com/somersetmicroproviders/

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Back to Social Care Services Section

South West Care Collaborative improving care home provision in Devon

There are over 500 care homes located in the Devon, Plymouth and Torbay area and many of these are in rural locations. Compared to the rest of England a much higher percentage are owned by small operators, each running one or two homes. Individual homes also tend to have fewer residents than the national average. These smaller businesses can face greater challenges retaining staff and achieving or maintaining excellence across the many aspects of their care provision.

The organisation now known as the South West Care Collaborative (SWCC) – formally the Devon Care Home Kite Mark initiative – was set up in 2012 by George Coxon, the owner of two care homes. He recognised a role for a proactive, provider led coalition to promote best practice and to provide a stronger voice for the (often maligned) care home sector. His diverse work background, which included various roles within the NHS, also helped him to plug into relevant networks.

Members opt into the collaborative based on a consensus of supporting one another. There are some core features, which include:

- Sharing to Learn, with members learning from each other;
- Peer Review, as a credible way to drive up standards, using an empowering approach that is based on cooperation rather than competition in a sector that faces increasing challenges; and
- Embedding strong values in the initiative, such as pride, sound evidence, positive atmospheres or environments for those needing 24/7 care and a culture of improvement, with enthusiastic and skilled staff looking after happy residents.[1]

It receives no external funding and members each pay a small subscription.

"SWCC emphasises the importance of co-operation and collaboration. If you share a piece of work, someone will share back. This helps everyone to improve."
(George Coxon)

The SWCC has grown steadily and in 2020 has some 100 participating members. These are generally providers and managers, mostly from care homes, but also including some nursing homes. It is supported by a steering group of 7 members who collectively represent 18 homes, just over 600 beds and over 725 staff from across Devon.

Members receive a number of benefits, which include:

- Skills Academy workshops with specialist expert speakers and discussions about what members do well and how they can improve. These have covered key care areas such as fall prevention, diabetes, stroke prevention, dementia, skin care, end of life care, nutrition and hydration, and guidance on safeguarding;
- An opportunity to participate in Peer Review. Members agree a reciprocal visit to each other's homes to conduct an "appreciative inquiry". The topic chosen for review is usually drawn from the latest Skills Academy master class. Members find these reviews a useful part of their quality assurance and good evidence when completing CQC Provider Information Returns;
- A bi-annual Masterclass Programme for managers and their deputies focused around leadership and improving lives of those in their care; and
- An annual event which has a diverse range of speakers and workshops.

The SWCC also emphasises the importance of establishing strong, trustful and effective external networks and so it works closely with other organisations. Examples include:

- The Care Quality Commission - looking at their key lines of enquiry questions (namely safe, effective, caring, responsive and well led);
- The area's NHS Sustainability and Transformation Partnership on policy matters;
- Devon County Council, Torbay Council, and Plymouth City Council as commissioners;
- The South West Academic Science Health Network, particularly to share workshop provision; and
- The Royal Devon and Exeter NHS Foundation Trust, seeking to help avoid preventable admissions and delayed transfers of onward care.[1]

South West Care Collective aims to continue to grow its membership of care providers who share a genuine commitment to continuous improvement.

"When the time is right, we should all be able to look forward to wrap-around care in a safe and caring environment."
(George Coxon)

Source:

1. https://www.swahsn.com/south-west-care-collaborative/#:~:text=The%20South%20West%20Care%20Collaborative,sharing%20best%20practice%20and%20innovation

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Back to Social Care Services Section

Training GPs for rural practice in Northumberland

"Recruitment and retention of the GP workforce is becoming a serious issue for the profession as a whole, but it is nearing crisis point in many rural areas across the UK."[1]

Health Education England (HEE) statistics[2] indicate that there has been a significant improvement in the fill rate for GP training posts in recent years, but the majority of areas cited on the HEE list of 'hard to recruit areas' are still rural or coastal.

Although there are various contributory factors, such as rural practice funding and limited employment opportunities for spouses, many of the factors that discourage trainee GPs from selecting rural areas relate to workload characteristics and concerns about professional isolation.

After they have completed a medical degree and two years of foundation training, doctors that wish to become an independent GP must complete at least three years of specialty training. This normally comprises 18 months in an approved training practice and 18 months in an approved hospital setting.

Two particular challenges that face GPs in rural Northumberland are the local demographic and the dispersed pattern of secondary care. A higher than average proportion of the population is over retirement age, so chronic diseases – such as heart disease, cancer and diabetes – are more prevalent and are often identified at a late stage. Accidents amongst those in high risk occupations, such as agriculture and forestry, occur more frequently and mental health issues, often related to isolation, are common across the age range.

Access to hospitals can be difficult, particularly for the elderly, leading to GPs providing more intermediate care. These issues are compounded by generally poor connectivity, with internet and mobile signals not always available or reliable, which presented a significant problem during the COVID-19 pandemic.

In response to local challenges, Dr Lambourn at the Cheviot Medical Group set up a bespoke GP training programme, drawing from experience in rural Scotland. This scheme, which lasts for 42 months (and is 6 months longer than usual) appointed its first trainee GP in 2017. It aims to enable the trainee GP to develop additional, rural-specific skills and to gain confidence in areas of work which, in more urban areas, might be less commonly encountered or treated in other settings. Examples include community hospital work, community outpatients, minor surgery, emergency accidents and rescues, and dealing with a range of mental health problems.

It is hoped that by providing a quality and bespoke training course suited to the needs and interests of the particular individual, and supported by a number of GPs that offer specialist expertise, trainees will feel confident and will enjoy working in a rural context. Furthermore, that they will choose to continue their careers in rural practice.

Whilst it is too early to evaluate the success of this initiative in that respect, there is some evidence of success from schemes in Scotland, where *"those trainees that do come [to less popular locations] usually stay on after training, as they discover these locations' hidden attractions"*[3].

However, it must be acknowledged that salary supplements of £20,000 which apply to Rural Track training in Scotland and to designated hard to fill areas in England may well be a major incentive. Northumberland is not currently eligible for such a supplement.

The recruitment process is underway to take on another trainee in 2020. The scheme is constantly being refined and, whilst no decisions have yet been made, it is possible it will move to a model more similar to the Rural Track GP Specialty Training programme developed by NHS Education Scotland or to a 3 year GP specialist qualification with a supplementary 1 year of further professional development to enhance rural focused skills.

Sources:

1 Royal College of GPs Rural Forum, February 2014.

2.Specialty recruitment: round 1 - acceptance and fill rate

3. Enhanced recruitment scheme

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Back to Workforce Section

Refugee doctors project in Lincolnshire

There is a shortage of doctors in Lincolnshire and that shortage is most acute in the rural areas, outside the city of Lincoln. It is estimated that over the whole county there are perhaps 150 vacancies for hospital doctors and 100 for GPs. Although this scheme cannot solve that issue, it is hoped it will nonetheless make a positive contribution.

It is notable that all other refugee doctor schemes currently operating in the UK are based in large urban centres. This project, based in Grimsby, is a pioneering one serving a rural area.

Learning from the earlier successes of those urban projects, the Lincolnshire Refugee Doctor Project (LRDP) set up as a Community Interest Company in 2016, with a Board of Directors that comprised 3 people from the health sector and 4 others, including representation from the business sector.

At the end of 2016 a funding request was made to Health Education England - East Midlands for a project covering the central and southern parts of the county. Although this had a positive scoping report and despite strong stakeholder support, funding was not forthcoming at that time. However, a subsequent approach to Health Education England - Yorkshire and Humber did receive a positive response. This resulted in the project being based further north in Grimsby.

The scheme, supporting doctors who are refugees back into medical practice in the UK, includes not only clinical training to meet the standards of the General Medical Council, but also clinically focused English language training, which must be satisfactorily completed. It also offers wider help to settle doctors with their families into Lincolnshire. That help can address issues such as finding accommodation, accessing benefits and understanding public transport.

Between August and October 2019 eight doctors were recruited. Two of them, who were already part way through their studies, have so far successfully completed the course. Most

are at a much earlier stage, but it is hoped that when the scheme is fully established it will generate around four new NHS doctors each year.

Costs vary considerably depending on the individual doctor's starting point, but on average it is likely to be around £12,000 for each doctor satisfactorily completing the course to foundation 2 level (so the stage immediately prior to specialist training). This is a fraction of the estimated £350,000 cost for a doctor qualifying via the traditional route.[1]

> *"The scheme is a clear win-win. It provides a refugee doctor with the hope of working in the NHS in future and provides our NHS with the hope of having doctors to work locally in future."*
> **(LRDP Director)**

This early success has led Health Education England - East Midlands to review its position and funding has been offered for an additional scheme, to be based in Lincoln and commencing in 2020. Once both schemes are fully established it is likely that there will be 20 to 30 refugee doctors in training at any one time.

The project has however faced some challenges along the way, including:

- Disappointment that the initial project application for funding was not successful;
- Transport difficulties in rural Lincolnshire necessitating much virtual teaching (especially during the pandemic lockdown); and
- Strict definitions applied to Universal Credit eligibility, which has led to the course running over 3 days per week to allow an opportunity for participants to find paid work.

The project Directors consider that it could be replicated in other rural areas. It is their ambition to put together a package which explains how to set up a Company, as well as outlining both the language training and the clinical curriculum. They advise that considerable determination and commitment are needed as experience from this scheme indicates that,

"there is an awful lot of effort at the beginning for little visible result". However, *"success comes at unexpected times."* **(LRDP Director)**

Looking to the future, in addition to establishing the Lincoln-based project, it is hoped to extend the scope of the scheme in 2021 or 2022 to include some other professional health roles.

Source:

1. Department for Health and Social Care, 2017

The case studies included in this toolkit have been selected as examples of good rural practice. Their inclusion does not infer that they have necessarily been developed as a result of a systematic rural proofing process.

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