Session 5 Parliamentary Inquiry into Rural Health and Care: 9 September 2019
Education and Training: Challenges & Opportunities

Present:

Witnesses

Andy Tilden – Interim CEO, Skills for Care
Sir Tom Hughes-Hallett – Founder, Helpforce, former Chair of Marie Curie & Chelsea & Westminster Hospital Foundation Trust
Dr Gill Garden – Director of Clinical Skills, Lincoln Medical School
Dr Jayne Clarke – Associate Medical Director – Education - Wye Valley NHS Trust
Dr Sue Fish – Clinical Senior Lecturer CARER Programme (Aberystwyth), Cardiff University
Dr Paul Johnson – Clinical Chair, Devon CCG

Invited Observers

Professor Anne Green – City-REDI University of Birmingham
Dr Matthew Isom – Dispensing Doctors Association
Dr Adrian Tams – Health Education England
Gemma Hopkins – BMA
James Holden- County Councils Network
Jonathan Rallings – County Councils Network
Rose Ward - GMC

Secretariat Team

Ivan Annibal - Director of Operations, National Centre for Rural Health and Care
Jessica Sellick – Senior Research Fellow, National Centre for Rural Health and Care
Jonny Haseldine – Parliamentary Assistant, Office of Anne Marie Morris MP

Apologies

Ann Marie Morris MP
The Right Reverend and Right Honourable Dame Sarah Mullally DBE – Bishop of London
Professor Richard Parish CBE – Chair National Centre for Rural Health and Care

Ivan Annibal welcomed participants to the fifth session of the Inquiry focused on Education and Training: Challenges & Opportunities.

Andy Tilden – Interim CEO, Skills for Care

Ivan Annibal introduced Andy Tilden's evidence by identifying that there has been discussion around adult social care in previous sessions but this has not focused on the skills of the adult social care workforce. This includes discussions around the parity of esteem for care workers with NHS staff, recruitment and Local Authority resourcing.

Mr Tilden's evidence covered the following areas:

Background: the national minimum dataset reveals the following distinctive characteristics of rural areas: 4.1% higher turnover, vacancy rates 0.7% higher, average age of workers 0.2 years higher, average rural hourly rate for a carer is 9p, higher, workers travel 2.4km further to get to their place of work. In terms of regional differences: there is a 9% higher turnover rate in North East England and in South East England turnover rates are 1.5% lower than in urban areas.

Mr Tilden went on to highlight 7 key areas of distinctiveness in the context of rural areas: 1) transport (lack of public transport and car insurance costs are prohibitive to young workers); 2) accommodation costs (lack of affordable housing); 3) seasonal attraction in coastal areas (services find it easier to recruit in winter, less so in summer), 4) broadband coverage, 5) access to learning and development physically, 6) the age profile of clients, 7) the disconnect between people who need care to available workforce, characterized in part by the isolation that staff and managers describe.

Notwithstanding these distinctions Mr Tilden explained that from his perspective care providers do not see a significant difference in rural and urban areas in how they train, recruit and pay staff

Mr Tilden identified as a key priority the need for care workers having a parity with health colleagues working in other settings. Mr Tilden welcomed the NHS Interim People Plan. He expressed concern however over the challenge that would be provided (without parity of esteem) of care workers making the transition into other roles within health and care without a pipeline of individuals to replace them. He identified Hospitals as anchor organisations and established their pivotal role in the skills development and career evolution of care workers.

Mr Tilden also identified that volunteers have a crucial role to play in preventive activities in the context of health and care and support roles working alongside the paid workforce. Mr Tilden sees little distinction in terms of the role and nature of volunteers in the context of rural as opposed to urban settings apart from perhaps a higher premium being put on the ability to drive.

Ivan Annibal asked Mr Tilden to further reflect on the nature of rural/urban distinctions in the context of his evidence. Mr Tilden reiterated that any material differences were linked to the 7 key factors he had identified at the start of his presentation.

Ivan Annibal asked if recruitment was a different factor in a rural area. Mr Tilden did reflect that vacancy rates are higher in rural areas and the staff turnover rate is higher. It is an ongoing concern. Mr Tilden reflected that it was the difference in relation to terms and conditions and relative esteem that was more material in terms of the challenges facing the profession than whether people were in a rural or urban area.

After further discussion Mr Tilden did concur that skills in rural areas might need to be more generalist because of the travel time between appointments and the lack of other professionals to attend quickly to clients in the eventually of any complications with their care.

It was also acknowledged that Continuing Professional Development (due to distance of travel) was harder for care workers in rural settings as were complications with the mobile phone and broadband infrastructure, which make the management of wider contacts and communications within the social care profession more challenging for workers.

Sir Tom Hughes-Hallett – Founder, Helpforce, former Chair of Marie Curie & Chelsea & Westminster Hospital Foundation Trust

Sir Tom Hughes-Hallett began by stating, in terms of the background to his current work in relation to volunteers on his role at Marie Curie, which had 10,000 volunteers and those were people supporting clinical work in hospitals and hospices. At the Chelsea and Westminster Trust there were 150 volunteers. This led him to reflect on both the potency of focused volunteering and the challenges in terms of volunteers in relation to supply and demand.

Sir Tom Hughes-Hallett started Helpforce in 2016 and self-funded the initiative until the Community Fund and NHS England became interested. Helpforce currently work with 5 trusts. The trusts are in Northumbria, West Suffolk, London, Sandwell/ Birmingham and Southampton.

The purpose of Helpforce is to provide education and support to volunteers and volunteer managers, based around a deep-seated recognition that volunteering is a professional and important aspect of delivering health and care. Helpforce made a significant impact in the first year, which improved patient discharge from hospital, reduced staff stress and retention and improved mental health amongst volunteers.

Sir Tom Hughes-Hallett is currently setting up a new service for GPs/volunteers to improve their own mental health and wellbeing.

Helpforce has developed an online network – 96 trusts have applied to join. The network will provide open access where participants can exchange good practice.

Helpforce is about the NHS embracing volunteering in a more substantive way. It has full trade union support. It is underpinned by a charter, which is signed off by staff.

Sir Tom Hughes-Hallett took the view that in rural settings volunteers have to be reliable and well supported. He identified that there is a minimum level of competence that volunteers need to meet – we should be setting the same standards for volunteers as for our own staff. Helpforce had been working with Health Education England and Skills for Care to create a national training programme with the Open University that is accredited.

Sir Tom Hughes-Hallett explained that the problems challenging health and care are systems based and can be addressed in part by a new more professionalized approach to volunteering. Through a Christmas appeal in 2018 with a national newspaper asking for time not money, Helpforce developed a very significant increase in NHS volunteers. There is a huge demand to volunteer a fair proportion of which is in rural areas.

Sir Tom Hughes-Hallett provided a number of examples of the work of volunteers from Helpforce. In Camden the initiative has involved training people in mental health restraint where many volunteers are former mental health patients and this has resulted in a reduction in the incidence of cases of restraint. In another hospital setting there is a volunteering programme, which involves volunteers supporting people requiring a local anaesthetic.

Through Helpforce the NHS is to offer volunteering across all NHS service and all STP areas.

In rural areas the single biggest issue is transport and the single biggest challenge is regulation and legislation.

Helpforce doubles the income for its activities which is provided by the NHS contributing £1 for every £1 raised for a volunteering project.

Sir Tom Hughes-Hallett drew attention to a number of further examples of activity: In Warwickshire the fire service are involved in supporting hospital discahrge, in Norwich and Norfolk retired professionals wait at home for the patient to arrive providing a settling in home service this means hospitals can discharge patients sooner with reduced risk of rapid readmission.

Finally Sir Tom Hughes-Hallett reflected that there is an army of volunteers waiting to serve rural settings and that the fastest growth in volunteers is amongst the under the 30s. Health and Care is a natural magnet for volunteers in rural and town settings for example Northumbria NHS Health Trust is now the main employer in its area and same is true in terms for example of Huddersfield.

In terms of Helpforce the initiative is beginning to address the key question – can we get people into jobs in health or social care by giving them a taster in volunteering role?

Discussions arising from the presentation covered the following areas:

The fact that Helpforce, is redefining the nature and experience of volunteering, in the context of health and care.

The fact that whilst there is no template for the engagement between Helpforce and each area it supports, that a standardized suite of potential areas of support would be helpful in sharpening the engagement with and impact of the problem from the perspective of participating organisations.

The fact that the concept of the perfect rural village is an illusion– in reality there are examples of people not meeting their neighbours and the issue of loneliness is quite extensive.

Observers raised a number of issues including:

The regrettable trends around the closure of Sure Start Centres.

The importance of adequate reimbursement of volunteer travel and other out of the pocket expenses.

The desirability of an intern strategy focused on outcomes for the volnuteers in addition to impacts for the organisations, which host them.

Sir Tom Hughes-Hallett explained that Helpforce participation is not just another example of interning to get a job where people are expected to work for free. It provides a structured pathway (usually involving 6 months) of volunteering with accredited qualification.

Dr Gill Garden – Director of Clinical Skills, Lincoln Medical School

Ivan Annibal introduced the evidence of Dr Garden by referring to the role of medical schools in rural settings as a catalyst to the recruitment of new health professionals in rural areas. This is based on the fact that graduates tend to stay in the settings where they train.

Dr Garden's evidence covered the following principal areas:

Lincoln Medical School was approved in April 2018 and set up in partnership with University of Nottingham with a cohort of 80 5 year and 17 foundation year students starting in September 2019.

Part of the reason for the approval of the school was that Lincolnshire was the largest area in the country without a medical school. This was supplemented by an aspiration to invigorate the recruitment crisis facing the County in relation to health professionals.

In terms of challenges – it will take 5 years for students to qualify and another 5 years to complete any form of training. It will therefore be more than a decade before the area reaps the benefits of the first cohort of trainees

Dr Garden went on to reflect on a number of the rural characteristics of Lincolnshire:

The greatest socio-economic deprivation and morbidity is on east coast of Lincolnshire, which is 1.5 hours drive from Lincoln. There are areas in the county with no reasonable transport system and impassable roads in bad winter conditions.

It requires for example a 2 hour bus journey from Mablethorpe to access treatment services in Lincoln or Boston. At the GP practice in Mablethopre 76% of patients are frail and there are just 2 full time GPs. The area has the fewest clinicians per patient in the country. Professionals are professionally and socially isolated in places like this on the Lincolnshire coast. In such places there is always a danger that practices can develop which may not be up to date or desirable.

Dr Garden reflected on the current challenges of working with GPs to get medical students out to practices as well as hospitals. These are so acute that GPs have offered to collect students and drive them to their surgery.

More widely Lincolnshire as a whole has been a failing county health wise with a number of CQC judgements of trusts needing improvement or worse; there is a financial deficit £80 million in the acute trust. All of this suggests a radically different model of care is needed.

In the subsequent discussion a number of observes reflected that urban centres are more attractive for medical students. A further issue in terms of health professionals working in rural areas is the challenge of their partner's employment.

Dr Garden went on to identify that in seeking to change this we need to develop prestigious posts and we need to think more widely about access to social infrastructure. This is currently a problem in rural areas including simple challenges such as being able to stream a film and transport connections from A to B.

In terms of the development of more rural training hospitals Dr Garden identified that not all rural areas are alike and Lincolnshire is a relatively poor area. Different challenges and impacts might arise in more affluent rural areas.

It was acknowledged as part of the discussion that the progression to an ICS system in Lincolnshire might help bring a greater focus to addressing a number of the

challenges identified. A joined up approach to addressing the IT, transport and social infrastructure issues facing rural areas needs to be carefully considered and could be addressed by the joined up approach within the ICS concept.

Dr Garden explained how in planning for the successful operation of the Medical School this wider template of challenges was being considered. This has involved the creation of a number of Global Health Chairs.

More widely in terms of international good practice Dr Garden identified: The Northern Territories in Australia have an excellent example of rural specialist training and their incentive payment scheme for students underpins a successful strategy of recruitment. Variants of these approaches could be adopted successfully in England.

Dr Jayne Clarke – Associate Medical Director – Education - Wye Valley NHS Trust

Dr Clarke's evidence covered the following areas:

Wye Valley NHS Trust is based in Hereford where the District hospital is small and remote from major centres (50 miles from Bristol, Birmingham) and the next nearest centre is Worcester.

In terms of the impact of this rural setting the location of the Trust carries a 20% additional cost premium.

Dr Clarke identified that we need to make rural jobs more attractive in how they are viewed by health professionals and allied staff.

Dr Clarke identified that we need to expand opportunities to educate rurally – undergraduate and postgraduate trainees currently spend most of their time in urban centres and students often seek to avoid rural placements because of the challenges of travel.

Dr Clarke cited Roger Prosser's work as Dean of Northern Ontario medical school and has established a distributed and community education approach which involves following an apprenticeship approach to training doctors. This has delivered exceptional levels of the retention of skilled clinicians in the areas where it has been applied.

Wye Valley Trust are currently part of an initiative bidding to launch the 3 Counties Medical School to be run out of Worcester – covering Worcestershire, Herefordshire and Gloucestershire. A major aspect of the plans will focus on well-being and novel routes into training from the local community.

Dr Clarke went on to discuss postgraduate training. She referred to a an approach developed by Health Education England to recognise existing competencies and keep people in the NHS enabling them to transfer into other roles.

It is hoped that this could lead to a rural alternative at the consultant level. This involves sharing between royal colleges and their different training requirements through the development of blended role qualifications. It could reduce costs and make employment more interesting for clinicians.

Meeting national standards in career development is not possible for many small rural hospitals under the current royal college accreditation and competency requirements. There are a number of areas where more could be done to support rural settings for example colleges could commit to fill rural training places first and then urban which would reduce rota gaps and address the perception that roles in rural settings are second rate.

Dr Sue Fish – Clinical Senior Lecturer CARER Programme (Aberystwyth), Cardiff University

Dr Fish's evidence (from a Welsh perspective) covered the following areas:

The area around Aberystwith is 1.5 hours from next nearest town and 2 hours from a medical school. The area is too small to set up a medical school.

Dr Fish introduced an innovation developed in these circumstances which started in Cambridge, Australia and Western Ontario – longitudinal clerkships in general practice. This involves sending a medical student to live and practice in rural areas for an entire academic year. The first cohort of 7 students began in Cardiff last year supplemented by 5 in Bangor. A number of benefits of the scheme include:

Medical students are influenced by role models and this approach is powerful in that context.

Evidence suggests a prgromme like this impacts on the career choices of students going forward, this is the case in Australia with students considering rural careers even if they are not from a rural area.

The scheme provides an opportunity to promote the benefits of quality of life in rural areas and for students to value what rural areas offer including the variety of skills they need to work in rural settings.

The scheme involves students who spend half the week in a rural GP surgery, 1 day training and 1 day allocated to a specific project throughout the year with a GP and rural focus.

Feedback is that students enjoy the one to one relationship with a dedicated tutor and the intimacy of a small team working environment.

There is definitely growing interest in Cardiff Medical School in the programme and it seems to have exerted a positive influence on the medical lecturers as well as the students.

Application of a a programme of this type needs to start in Medical School not once participants have qualified.

During the training there is an option to study for an additional year to focus on rural areas and to get an honours degree.

The issue at the heart of this approach is that you need a wider set of skills to practice in rural areas that may not be recognised by urban colleagues, this approach validates that point via crudentialing.

More widely Dr Fish identified a number of other issues including:

Remuneration of GPs in rural areas is challenging. Many practices do not have full list sizes, funding via the GP contract is often therefore less than urban areas.

Royal Colleges have a massive role to play in this agenda. Many curricula have become super specialised, governance of training and development in rural settings is difficult to achieve because of a dearth of supervising specialists and maintenance of professional networks is also problematic due to small numbers of specialist staff.

Dr Paul Johnson – Clinical Chair, Devon CCG

Dr Johnson offered the following evidence:

A poor perception of rural practice in Medical Schools persists – newer Medical Schools can change that narrative. Primary care is first clinical contact students have and this is a good starting point.

In terms of challenges in rural health – rural is heterogeneous and can be linked with affluence as well as deprivation. Policy needs to take this into account.

From the perspective of a GP in Devon Dr Johnson highlighted core skills requirements were linked in part to isolation (you have to be able to deliver competent emergency care), maintaining core competencies is sometimes challenged because areas of experience are often not utilised on a frequent basis around themes such as management of minor injuries, sexual health support etc.

Dr Johnson pointed to a correlation between proximity of major treatment centres and use of secondary care – rural GPs hold on to complexity for longer and this is often down to patient preference and choice too.

Dr Johnson went on to identify that palliative care and dying in a preferred place (ie home) is challenging in a rural setting. This is in relation to having consistent outreach support from a hospice so end of life skills are needed on an enhanced basis by rural GPs.

Dr Johnson also raised the fact that the skills sets needed for dispensing in rural practices are significant and explained that this raises extra skills needs for rural GPs.

Dr Johnson also drew attention to the challenges in primary care in terms of travel and the home visits required and time taken to reach appointments coupled often with the complexity presented by patients on arrival. It is his view that rural patients often present later in terms of their needs than urban patients.

Dr Johnson drew attention to the powerful role the Voluntary Sector can play in the delivery of health services. He identified that due to sparsity it is more difficult to engage with this sector in rural areas.

Poor IT connectivity was cited as a further challenge preventing the full realization of the growing pool of resources set up to support the provision of effective health and care.

The physical estates agenda was also raised with many young GPs being wary or having limited means to acquire a partnership with property owning GPs. Dr Johnson feels that the restricted scope for movement arising from the ownership of property is a risk and not a “nest egg” in the current economic climate. Bringing services together and using the wider public estate to do that is more difficult in a rural setting due to amore limited stock buildings. IT is a driver for delivering safer general practice in a rural area but there is also a perception that this is inferior in rural places.

Remuneration – needs to be more flexible to address the health component of the wider net loss of young people in rural communities. This is made more challenging with a net increase in the arrival of retired people. GP practices rely on younger patients who rarely access primary care to offset the increased cost of providing care for the older population. In terms of new approaches to locality working Primary Care Networks are urban in flavour as a concept and additional work will be required to enable them to effectively operate in rural settings.

Ivan Annibal asked Dr Johnson to reflect on how good practice is communicated so rural areas can learn from each other? Participants as a whole in in response to this question agreed that capturing and transferring good practice more widely would be really beneficial if curated and effectively managed. The importance of peer to peer learning was also acknowledged.

Conclusion

At the end of the session Ivan Annibal thanked the witnesses and the invited audience for their participation and insights. He indicated that the next session is planned for November 2019 and will concentrate on systems approaches and impacts in rural settings.