RURAL SERVICES NETWORK

Effectively Meeting the Health Needs of Rural Communities

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Presentation content

Effectively Meeting the Health Needs of Rural Communities

By understanding:
Health risks specific to **rural** communities
Current **government policy** and **funding constraints**
Rural Service Network's health **policy asks**
Covid-19 and the **impact on rural health** care provision
The use of **digital technology** to improve access to services
Benefits of a **district-based** partnership delivery approach
Importance of **rural proofing**
Research still to come

All in 20 minutes!

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4 Key Points

1. An illness or condition or disability is **the same** whether the person with the condition and their carers are in an urban or a rural location. It is **coping with the condition in a rural context** and accessing treatment and support where the issues arise. I will start out by addressing what makes rural communities marginalised.
2. Without fair funding for public services fair outcomes from those services cannot be achieved. **Funding must reflect the costs of meeting service needs in rural areas.**
3. More people live in **rural areas** across England than live in the **whole of Greater London.**
4. When you have seen one rural area: you have seen one rural area **they are all different.**

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Government Policy

From the Queen's Speech, May 2021

"…. ensuring everyone has access to excellent public services, **regardless of where they live**. A Levelling Up White Paper will set out bold new policy interventions to improve livelihoods and opportunity in all parts of the UK as we recover from the pandemic, grasping the opportunities of Brexit."

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Are rural communities in England marginalised for health care?

The current health and care system is **modelled on urban areas** from both **funding and formulae** and a **policy delivery** perspective.

As a result, **rural areas receive less grant** and **yet it costs more** to deliver comparable **services in a rural area**.

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Local Government Services

Funding per head of resident population				
	Predominantly rural	Predominantly urban	Difference	
Public health allocations for local authorities to improve health in local populations. (Public health grants: 2021 to 2022)	£43.53	£68.25	£24.72	**36% less**
Social care grant within the final local government finance settlement: England, 2020 to 2021	£27.63	£32.08	£4.40	**14% less**
Improved Better Care Fund grant within the final local government finance settlement: England, 2020 to 2021	£33.08	£39.45	£6.37	**16% less**
Total government funded spending power within the final local government finance settlement: England, 2020 to 2021	£267.32	£379.67	£112.35	**30% less**

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Key funding health stats

- Nearly a **25%** of England's **rural population** (nearly 2.5 million people) is aged **65 or over** compared to 17% in urban areas. The issue being that people in this **older age group** generally have more **expensive** and **complex** care needs.

- **21% of rural council** expenditure is on Adult Social Care compared to **17% in urban areas.** Resulting in **less funding** being available for other council services in **rural areas**.

- Council **expenditure** per head in **rural areas is 32% lower** on public health and **25% lower** on Children's Social care **compared with urban** areas.

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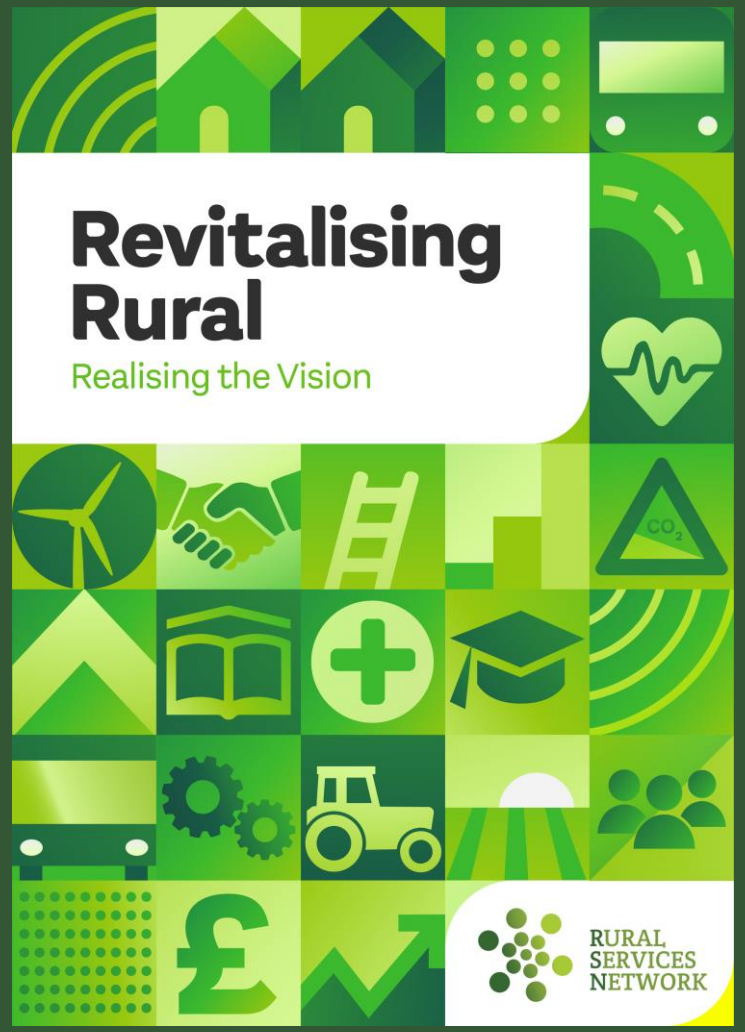

We want a fairer distribution of national resources to rural areas and for more nuanced national policies that reflect rural circumstances.

NHS Funding

- No simple pounds per head assessments are available
- Nuffield Trust report on behalf of the National Centre for Rural Health and Care on “A rapid review of the impact of rurality on the cost of delivering healthcare” concluded that:

“these adjustments (for rurality) may not be compensating enough to avoid some rural Trusts facing increased difficulties”

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NHS Funding continued

- The Nuffield Trust report also showed that the 7 NHS Trusts with "unavoidable small sites" on average had:
  - **Longer** waiting times
  - **Longer** lengths of stay
  - More **delayed** transfers of care
  - **Higher** unit costs
  - **Worse** financial positions
  - 6 of the 7 of these Trusts ended 2017/18 in **deficit** amounting to **over £¼ billion**
  - These **7 Trusts account** for 3% of all Trusts but **23% of the overall deficit** for Trusts

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Pressures facing rural health care services

Workforce

- Recruitment and retention difficulties
- Higher overall staff costs

Distance

- Higher travel costs
- Unproductive staff time when travelling

Size

- Scale of fixed costs, for example safe staffing-level guidelines
- Difficulties in realising economies of scale

Access to resources

- Some resources are more expensive or difficult to access, for example telecommunications, training and consultancy

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Examples of rural health impacts due to under resourcing in rural areas

Impact	Rural v Urban
Alcohol specific conditions in under 18s	30% higher
Mental health admissions in under 18s	3% higher
Self harm hospital admissions for 10-24 year olds	8% higher
Looked after children 5-16 year olds	15% higher
Ambulance response times	Over 4 minutes slower
Stroke mortality rates	4% higher
Informal care provision	6% higher
Type 2 diabetes	18% higher

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Specific RSN Policy Asks on Rural Health and Care

Access and Travel to Hospitals

- Local Health Partnerships and Trusts should take better account of accessibility and transport availability when drawing up plans to reconfigure acute and emergency services
- The hospital building programme should be used to improve access to hospitals in rural areas which are not well served.

Primary and Community Care Services

- Local Health Partnerships should seize opportunities to create locally based multi-disciplinary teams and to develop health hubs in rural town locations. This could reduce the need for many patients to travel to main hospitals.
- Local pharmaceutical services need to be retained in rural areas, which may mean supporting dispensing GP Surgeries.

Public and Mental Health Services

- Public health and mental health should have more prominence and need properly resourcing in rural areas. Historic funding allocations for public health cannot be justified and need urgent overhaul to even out provision.

Specific RSN Policy Asks on Rural Health and Care

Social Care Provision

- Govt should implement findings of Fair Funding Review to help level up the provision of social care services in rural areas, taking full account of their deliver cost in more sparsely populated areas.
- This would also enable improved or more consistent engagement with and commissioning of low level support services for vulnerable rural residents, typically delivered by 3rd sector.

Workforce and Recruitment

- Delivery of the NHS Workforce Plan should include an explicit rural dimension.
- Pay bonuses should be considered to attract recruits into rural places with the highest vacancy and turnover rates.

Impact of COVID-19

- COVID-19 has had a **detrimental effect** on **hospital waiting times**: the proportion of patients seen for their first appointment for cancer fell by 66% in rural trusts between 2019 and 2020, compared to 59% in urban trusts.

- Activity has fallen in rural areas: **emergency admissions declined by 57%** in rural trusts, compared to 45% elsewhere. Referrals for talking therapies in rural areas was below half the level in 2020 than it was a year before.

- The pandemic has **exacerbated workforce issues** in rural trusts. Rural trusts spend more on temporary staff (8% of their staffing budget) compared with other areas (6%). While hospital and community health staff increased by 7% nationally during 2020, the workforce of rural trusts grew by only 5%.

- The **underlying financial position** of rural trusts has worsened: with their debt equivalent to more than half (56%) of their annual operating income.

- The fragility of the **care market**: 43% of Directors reported that providers in their area had closed, ceased trading or handed back contracts [ADASS survey].

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Digital technology

Can using digital technology to improve access to services and to support isolated and vulnerable people help?

- Average minimum travel times demonstrate the issue for rural residents in physically accessing health services.

Overcoming geographical and infrastructure challenges to deliver services				
	By public transport/walking		By car	
To reach the nearest:	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

- It is important to remember that these are the average times, and hence do not represent the reality for the most isolated. The figures also do not reflect the frequency (or lack of) public transport services in rural areas.

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Digital technology continued

- Digital technology can help, BUT some 7% of rural premises (or **240,000 rural households and businesses**) in England **cannot access** a decent fixed **broadband** connection of 10 Mbit/s download, 1Mbit/s upload, AND some **16% of rural premises** in England **cannot access a superfast broadband** connection of 30 Mbps.

- **Digital technology** (or the lack of it) can also be a **contributor to isolation**

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District-based delivery

Jointly delivering Public Health initiatives through a district-based approach: Developing public health strategies and overcoming geographical and infrastructure challenges to deliver services. Points to consider:

- Local delivery to **reflect local needs** and circumstances is key
- **Funding allocations** need to reflect those local needs and circumstances as do service delivery arrangements
- Joint working across delivery bodies and agencies and with the **community and voluntary sectors**
- Those designing commissioning services need **to consider the needs** of their rural populations when they develop strategies, initiatives and service delivery plans.
- Importance of **rural proofing**

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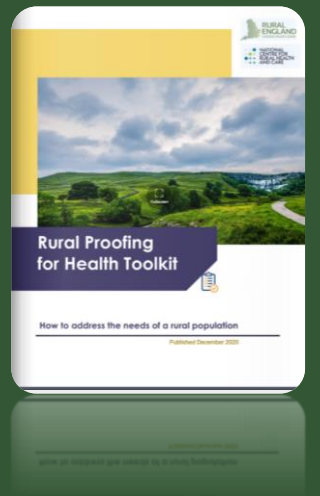
What is Rural Proofing?

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.



Rural Proofing can help to:

- **Optimise** the **outcomes achieved** in strategies and plans
- Demonstrate a **commitment to act equitably** and benefit all communities
- **Support locality-based** approaches
- **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

- **Click here to access the Rural Proofing for Health Toolkit** a tool to review:
  Main hospital services; primary and community health services, mental health prevention services, social care service and workforce.

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Further best practice coming soon

The report of the Parliamentary Inquiry by the Rural Health All Party Parliamentary Group led by Anne-Marie Morris MP and the National Centre for Rural Health and Care will be published soon. Areas covered include:

- How Government does not have a **clear definition of rural** in guidelines or statute to inform policy
- How **data masks health & care issues in rural areas** and an increasing recognition of place as a component in strategy and delivery and how it affects the distinctive manifestation of rural inequalities
- Health and care needs of rural and remote populations are **not measured in their own right**
- The **wider/interdependence factors** influencing health issue in rural communities e.g. infrastructure, digital and physical connectivity, housing, public health, transport etc.
- Workforce **recruitment, retention and deployment** as a determinant of health inequalities
- And much **more**

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Thank you

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